UTAH STATE BULLETIN

OFFICIAL NOTICES OF UTAH STATE GOVERNMENT
Filed May 3, 2005, 12:00 a.m. through May 16, 2005, 11:59 p.m.

Number 2005-11
June 1, 2005

Kenneth A. Hansen, Director
Nancy L. Lancaster, Editor

The *Utah State Bulletin (Bulletin)* is an official noticing publication of the executive branch of Utah State Government. The Department of Administrative Services, Division of Administrative Rules produces the *Bulletin* under authority of Section 63-46a-10, *Utah Code Annotated* 1953.

Inquiries concerning administrative rules or other contents of the *Bulletin* may be addressed to the responsible agency or to: Division of Administrative Rules, 4120 State Office Building, Salt Lake City, Utah 84114, telephone (801) 538-3218, FAX (801) 538-1773. To view rules information, and on-line versions of the division's publications, visit: http://www.rules.utah.gov/

The information in this *Bulletin* is summarized in the *Utah State Digest (Digest)*. The *Digest* is available by E-mail or over the Internet. Visit http://www.rules.utah.gov/publicat/digest.htm for additional information.

Division of Administrative Rules, Salt Lake City 84114

Printed in the United States of America

Library of Congress Cataloging-in-Publication Data

Utah state bulletin.
Semimonthly.
1. Delegated legislation--Utah--Periodicals. 2. Administrative procedure--Utah--Periodicals.
I. Utah. Office of Administrative Rules.

KFU440.A73S7
348.792'025--DDC 85-643197

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SPECIAL NOTICES

Governor's Executive Order 2005-0007: Wildland Fire Management

EXECUTIVE ORDER

Wildland Fire Management

WHEREAS, the danger from wildland fires is extremely high throughout the State of Utah;

WHEREAS, numerous wildland fires are burning and continue to burn in various areas statewide and present a serious threat to public safety, property, natural resources and the environment;

WHEREAS, some of the areas are extremely remote and inaccessible and the situation has the potential to greatly worsen if left unattended;

WHEREAS, immediate action is required to suppress the fires and mitigate post-burn flash floods to protect public safety, property, natural resources and the environment;

WHEREAS, these conditions do create a disaster emergency within the intent of the Disaster Response and Recovery Act of 1981,

NOW, THEREFORE, I, Jon M. Huntsman, Jr., Governor of the State of Utah by virtue of the power vested in me by the constitution and the laws of the State of Utah, do hereby order that:

It is found, determined and declared that a "State of Emergency" exists statewide due to the threat to public safety, property, natural resources and the environment for thirty days, effective as of May 10, 2005, requiring aid, assistance and relief available pursuant to the provisions of state statutes, and the State Emergency Operations Plan, which is hereby activated.

IN WITNESS, WHEREOF, I have hereunto set my hand and caused to be affixed the Great Seal of the State of Utah this 10th day of May, 2005

(State Seal)

Jon M. Huntsman, Jr.
Governor

ATTEST:

Gary R. Herbert
Lieutenant Governor

2005/0007

Governor's Executive Order 2005-0008: Creating the Blue Ribbon Fisheries Advisory Council

EXECUTIVE ORDER

Creating the Blue Ribbon Fisheries Advisory Council

WHEREAS, Utah is home to a wide array of pristine fisheries located throughout the State;

WHEREAS, these fisheries attract tourists from outside Utah as well as within;

WHEREAS, the resultant tourism dollars represent a significant factor in rural and urban economies;

WHEREAS, the states surrounding Utah are also home to a variety of pristine fisheries with which Utah competes to attract tourists;

WHEREAS, pristine fisheries contribute to our quality of life; and

WHEREAS, it is necessary to enhance, protect and promote the fisheries of our State for economic as well as recreational benefit;

NOW, THEREFORE, I, Jon M. Huntsman, Jr., Governor of the State of Utah, by virtue of the authority vested in me by the laws and Constitution of the State of Utah, hereby order the following:

1. There is created the Blue Ribbon Fisheries Advisory Council.

2. The Council shall have no more than 13 members, appointed by the Governor to a term of three years, and shall be comprised of two members representing organized cold-water fishing interests, two members representing organized warm-water fishing interests, one member representing the commercial fishing industry, one member representing each of the five regions of the Division of Wildlife Resources, and three at-large members representing general fishing interests. An ex-officio non-voting representative from the Division of Wildlife Resources shall serve as executive secretary to the Council.

3. The Council shall:

a. Identify fisheries throughout the State to be designated as "Blue Ribbon Fisheries."

b. Make recommendations as to the enhancement of the fishing ecosystems and aesthetic values of such "Blue Ribbon Fisheries."

c. Make recommendations as to the protection of "Blue Ribbon Fisheries" through collaboration with government agencies and private groups.

d. Make recommendations as to the promotion of "Blue Ribbon Fisheries" to attract tourists from within and outside the State.

4. The Council shall meet as often as necessary to perform its duties, and shall meet at least quarterly.

5. Council members shall serve without per diem or expenses.

6. A majority of the Council constitutes a quorum for meeting and voting purposes.

IN WITNESS, WHEREOF, I have hereunto set my hand and caused to be affixed the Great Seal of the State of Utah. Done in Salt Lake City, Utah this 19th day of May, 2005.

(State Seal)

Jon M. Huntsman, Jr.
Governor

ATTEST:

Gary R. Herbert
Lieutenant Governor

2005/0008

Transportation
Motor Carrier, Ports of Entry

Public Hearing on Proposed New Rule R912-6, Ports-of-Entry By-Pass Permit Provisions

The Department of Transportation, Division of Motor Carrier will hold a hearing on Thursday, June 16, 2005, from 8:00 to 10:00 a.m. at the Calvin Rampton Complex, 4501 S 2700 W, First Floor Conference Room, Salt Lake City, Utah.

The purpose of the hearing is to hear comments from interested parties on the proposed administrative rule that allows the Motor Carrier Division to issue temporary port of entry by-pass permits to accommodate multi-trip, highway transportation needs.

The proposed new Rule R912-6 was published in the April 15, 2005, *Bulletin* under DAR No. 27790 (2005-8, pg 39).

For further information, please contact James Beadles by phone at 801-965-4168, by FAX at 801-965-4796, or by Internet E-mail at jbeadles@utah.gov

End of the Special Notices Section

NOTICES OF
PROPOSED RULES

A state agency may file a PROPOSED RULE when it determines the need for a new rule, a substantive change to an existing rule, or a repeal of an existing rule. Filings received between May 3, 2005, 12:00 a.m., and May 16, 2005, 11:59 p.m. are included in this, the June 1, 2005, issue of the *Utah State Bulletin*.

In this publication, each PROPOSED RULE is preceded by a RULE ANALYSIS. This analysis provides summary information about the PROPOSED RULE including the name of a contact person, anticipated cost impact of the rule, and legal cross-references.

Following the RULE ANALYSIS, the text of the PROPOSED RULE is usually printed. New rules or additions made to existing rules are underlined (e.g., example). Deletions made to existing rules are struck out with brackets surrounding them (e.g., [~~example~~]). Rules being repealed are completely struck out. A row of dots in the text (· · · ·) indicates that unaffected text was removed to conserve space. If a PROPOSED RULE is too long to print, the Division of Administrative Rules will include only the RULE ANALYSIS. A copy of each rule that is too long to print is available from the filing agency or from the Division of Administrative Rules.

The law requires that an agency accept public comment on PROPOSED RULES published in this issue of the *Utah State Bulletin* until at least July 1, 2005. The agency may accept comment beyond this date and will list the last day the agency will accept comment in the RULE ANALYSIS. The agency may also hold public hearings. Additionally, citizens or organizations may request the agency to hold a hearing on a specific PROPOSED RULE. Section 63-46a-5 (1987) requires that a hearing request be received "in writing not more than 15 days after the publication date of the PROPOSED RULE."

From the end of the public comment period through September 29, 2005, the agency may notify the Division of Administrative Rules that it wants to make the PROPOSED RULE effective. The agency sets the effective date. The date may be no fewer than 31 days nor more than 120 days after the publication date of this issue of the *Utah State Bulletin*. Alternatively, the agency may file a CHANGE IN PROPOSED RULE in response to comments received. If the Division of Administrative Rules does not receive a NOTICE OF EFFECTIVE DATE or a CHANGE IN PROPOSED RULE, the PROPOSED RULE filing lapses and the agency must start the process over.

The public, interest groups, and governmental agencies are invited to review and comment on PROPOSED RULES. *Comment may be directed to the contact person identified on the RULE ANALYSIS for each rule.*

PROPOSED RULES are governed by *Utah Code* Section 63-46a-4 (2001); and *Utah Administrative Code* Rule R15-2, and Sections R15-4-3, R15-4-4, R15-4-5, R15-4-9, and R15-4-10.

The Proposed Rules Begin on the Following Page.

Administrative Services, Records Committee

R35-1

State Records Committee Appeal Hearing Procedures

NOTICE OF PROPOSED RULE
(Amendment)
DAR FILE NO.: 27880
FILED: 05/12/2005, 10:13

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: After conducting a five-year review of this rule, the State Records Committee determined that additional information was necessary.

SUMMARY OF THE RULE OR CHANGE: Under Section R35-1-2, the additions to this section expand the options for adjournment, describe Ex Parte Communication between the Parties and the Committee Members, and provide for electronic participation at the meetings either by the parties or Committee Members.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Subsection 63-2-502(2)(a)

ANTICIPATED COST OR SAVINGS TO:
❖ THE STATE BUDGET: There will be no fiscal impact to the state since this rule clarifies the procedures for appeal hearings.
❖ LOCAL GOVERNMENTS: There will be no fiscal impact to local government since this rule clarifies the procedures for appeal hearings.
❖ OTHER PERSONS: There will be no fiscal impact to other persons since this rule clarifies the procedures for appeal hearings.

COMPLIANCE COSTS FOR AFFECTED PERSONS: There will be no fiscal impact to any persons since this rule clarifies the procedures for appeal hearings.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: This rule change clarifies the procedures for appeal hearings and does not create any fiscal impact on businesses. D'Arcy Dixon Pignanelli, Executive Director

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
ADMINISTRATIVE SERVICES
RECORDS COMMITTEE
ARCHIVES BUILDING
346 S RIO GRANDE
SALT LAKE CITY UT 84101-1106, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
Janell Tuttle at the above address, by phone at 801-531-3862, by FAX at 801-531-3867, or by Internet E-mail at jtuttle@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 07/01/2005.

THIS RULE MAY BECOME EFFECTIVE ON: 07/02/2005

AUTHORIZED BY: Patricia Smith-Mansfield, Director

R35. Administrative Services, Records Committee.
R35-1. State Records Committee Appeal Hearing Procedures.
R35-1-1. Scheduling Committee Meetings.

(1) The Executive Secretary shall respond in writing to the notice of appeal within 3 business days.

(2) Two weeks prior to the Committee meeting or appeal hearing the Executive Secretary shall send a notice of the meeting to at least one newspaper of general circulation within the geographic jurisdiction.

(3) One week prior to the Committee meeting or appeal hearing the Executive Secretary shall post a notice of the meeting indicating the agenda, date, time and place of the meeting at the building where the meeting is to be held and at the Utah State Archives.

R35-1-2. Procedures for Appeal Hearings.

(1) The meeting shall be called to order by the Committee Chair.

(2) Opening statements will be presented by the petitioner and the governmental entity. Each party shall be allowed five minutes to present their opening statements before the Committee.

(3) Testimony shall be presented by the petitioner and the governmental entity. Each party shall be allowed thirty minutes to present testimony and evidence and to call witnesses.

(4) Witnesses providing testimony shall be sworn in by the Committee Chair.

(5) Questioning of the evidence presented and the witnesses by Committee members shall be permitted.

(6) The Committee may view documents in camera.

(7) Third party presentations shall be permitted. At the conclusion of the testimony presented, the Committee Chair shall ask for statements from any third party. Third party presentations shall be limited to ten minutes.

(8) Closing arguments may be presented by the petitioner and the governmental entity. Each party shall be allowed five minutes to present a closing argument and make rebuttal statements.

(9) Committee deliberations.

(a) Following deliberations, a motion to grant in whole or part or to deny the petitioner's request shall be made by a member. Following discussion of the motion, the Chair shall call for the question. The motion shall serve as the basis for the Committee Decision and Order. The Committee shall vote and make public the decision of the Committee during the hearing.

(10) Adjournment.

(a) The Committee may adjourn, reschedule, continue, or reopen a hearing on the motion of a member.

(11) Ex Parte Communication between the Parties and the Committee Members.

(a) Except as expressly authorized by law, there shall be no communication between the parties and the members of the Committee concerning the subject matter of the appeal before the hearing or prior to the issuance of a final Decision And Order. Any other oral or written communication from the parties to the members of the Committee, or from the members of the Committee to the parties, shall be directed to the Executive Secretary for transmittal.

(12) Electronic participation at meetings. The following provisions govern any meeting at which one or more members of the Committee or a party appears telephonically or electronically pursuant to Utah Code Section 52-4-7.8.

(a) The anchor location is the physical location from which the electronic meeting originates or from which the participants are connected. The anchor location, unless otherwise designated in the notice, shall be at the offices of the Division of State Archives, Salt Lake City, Utah.

(b) If one or more members of the Committee or a party may participate electronically or telephonically, public notices of the meeting shall so indicate. In addition, the notice shall specify the anchor location where the members of the Committee not participating electronically or telephonically will be meeting and where interested persons and the public may attend and monitor the open portions of the meeting.

(c) When notice is given of the possibility of a member of the Committee appearing electronically or telephonically, any member of the Committee may do so and shall be counted as present for purposes of a quorum and may fully participate and vote on any matter coming before the Committee. At the commencement of the meeting, or at such time as any member of the Committee initially appears electronically or telephonically, the Chair shall identify for the record all those who are appearing telephonically or electronically. Votes by members of the Committee who are not at the physical location of the meeting shall be confirmed by the Chair.

R35-1-3. Issuing the Committee Decision and Order.

(1) The Decision and Order shall be signed by the Committee Chair and distributed by the Executive Secretary within three business days after the hearing. Copies of the Decision and Order will be distributed to the petitioner, the governmental entity and all other interested parties. The original order shall be maintained by the Executive Secretary. A copy of the order shall be made available for public access at the Utah State Archives[~~, Research Center~~] website.

R35-1-4. Committee Minutes.

(1) All meetings of the Committee shall be recorded. Access to the audio recordings shall be provided by the Executive Secretary at the Utah State Archives, Research Center.

(2) Written minutes of the meetings and appeal hearings shall be maintained by the Executive Secretary. A copy of the approved minutes shall be made available for public access at the Utah State Archives[~~, Research Center~~].

KEY: government documents, state records committee[~~*~~], records appeal hearings[~~*~~]
[~~March 18, 1999~~]2005
Notice of Continuation July 2, 2004
63-2-502(2)(a)

▼ ▼

Health, Community and Family Health Services, Immunization

R396-100

Immunization Rule for Students

NOTICE OF PROPOSED RULE
(Amendment)
DAR FILE NO.: 27897
FILED: 05/13/2005, 13:03

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: This rule change is necessary to: 1) update Utah's immunization rule specific to the addition of the Hepatitis B, Varicella, and Tetanus/Diphtheria vaccines for 7th grade entry effective July 2006; 2) establish routine vaccination of adolescents not previously vaccinated as an effective strategy to more rapidly lower the incidence of and assist in the elimination of these diseases in the United States. It may also assist in establishing a routine visit to health-care providers for adolescents ages 11-12 years who previously may not visit their provider after childhood; and 3) prevent susceptible older children from entering adulthood without immunity to these diseases.

SUMMARY OF THE RULE OR CHANGE: This amendment adds the requirement of Hepatitis B, Varicella, and Tetanus/Diphtheria vaccines for 7th grade entry effective July 1, 2005, and to be implemented by July 1, 2006. It updates references of the United States Public Health Service's Advisory Committee on Immunization Practices (ACIP) recommended vaccines and dosing requirements which are incorporated into this rule. It also updates reporting time periods for schools.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Sections 53A-11-303 and 53A-11-306

THIS RULE OR CHANGE INCORPORATES BY REFERENCE THE FOLLOWING MATERIAL: This amendment incorporates the following: 1) General Recommendations on Immunization: February 8, 2002/Vol 51/No.RR-2; 2) Immunization of Adolescents: November 22, 1996/Vol. 45/No. RR-13; 3) Combination Vaccines for Childhood Immunization; May 14, 1999/Vol. 48/No.RR-5; 4) Diphtheria, Tetanus, and Pertussis: Recommendations for Vaccine Use and Other Preventive Measures: August 8, 1991/Vol. 40/No. RR-10; 5) Pertussis Vaccination: Use of Acellular Pertussis Vaccines Among Infants and Children: March 28, 1997/Vol. 46/No. RR-7; 6)

Use of Diphtheria Toxoid-Tetanus Toxoid-Acellular Pertussis Vaccine as a Five-Dose Series: Supplemental Recommendations of the Advisory Committee on Immunization Practices: November 17, 2000/Vol. 49/No. RR-13; 7) Protection Against Viral Hepatitis: February 9, 1990/Vol. 39/No. RR-2; 8) Hepatitis B: A Comprehensive Strategy for Eliminating Transmission in the United States Through Universal Childhood Vaccination: November 22, 1991/Vol. 40/No. RR-13; 9) Haemophilus b Conjugate Vaccines for Prevention of Haemophilus influenzae Type b Disease Among Infants and Children Two Months of Age and Older: January 11, 1991/Vol. 40/No. RR-1; 10) Recommendations for Use of Haemophilus b Conjugate Vaccines and a Combined Diphtheria, Tetanus, and Pertussis, and Haemophilus b Vaccine: September 17, 1993/Vol. 42/No. RR-13; 11) Measles, Mumps, and Rubella-Vaccine Use and Strategies for Elimination of Measles, Rubella, and Congenital Rubella Syndrome and Control of Mumps: May 22, 1998/Vol. 47/No. RR-8; 12) Poliomyelitis Prevention in the United States: May 19, 2000/Vol. 49/No. RR-5; 13) Prevention of Varicella: July 12, 1996/Vol. 45/No. RR-11; 14) Prevention of Varicella: Updated Recommendations of the Advisory Committee on Immunization Practices: May 28, 1999/Vol. 48/No. RR-6; and 15) Prevention of Hepatitis A Through Active or Passive Immunization: October 1, 1999/Vol. 48/No. RR-12

ANTICIPATED COST OR SAVINGS TO:

❖ THE STATE BUDGET: It is difficult to estimate the amount of vaccine necessary due to the following situations: 1) Hepatitis B has been required for kindergarten entry since 1999. By the effective date of July 1, 2006, these students will enter the 7th grade, and most students will have already completed the series; 2) Varicella vaccine has been licensed since 1995, before many potential 7th graders were born. Many of these children will have had Varicella disease instead. Only those who have not had Varicella disease will be required to receive the vaccine. It is impossible to estimate how many children have already had Varicella disease and thus do not need the vaccine; and 3) Tetanus/Diphtheria booster is recommended between ages 11-12. Some children will have already received their booster. The following data represents the maximum estimated costs: 1) Hepatitis B - $32,911 from current state vaccine funds. The remainder of the costs for publicly funded vaccine comes from the federal Vaccines for Children (VFC) and federal 317 funds. Since this has been a requirement for kindergarten entry since 1999, this cohort of children should have already received the full series; 2) Varicella - $58,508 from current state vaccine funds. The remainder of the costs for publicly-funded vaccine comes from the federal VFC and federal 317 funds. Varicella vaccine has been licensed since 1995, before many of this cohort were born. Many of these children will have had Varicella disease instead and will not need the vaccine; and 3) Tetanus - $12,189 from current state vaccine funds. The remainder of the costs for publicly-funded vaccine comes from the federal VFC and federal 317 funds. Tetanus/Diphtheria booster is recommended between ages 11-12. Some children will have already received their booster.

❖ LOCAL GOVERNMENTS: The following data represents the maximum estimated costs. Of the total 38,271 children, 45.5% or 17,413 children are estimated to be covered in the public sector. Publicly-funded vaccines are currently provided to local health departments at no cost to the local health departments through the VFC program to cover children on Medicaid, Children's Health Insurance Program (CHIP), without insurance, who are American Indian/Alaskan Native and those who are underinsured. Local health departments choosing to serve children with private health insurance with vaccines as a covered service would have to purchase vaccine and be reimbursed by contracts with insurance providers. As a public entity they may purchase at a lower Center for Disease Control (CDC) contract price.

❖ OTHER PERSONS: The following data represents the maximum estimated costs: 1) Hepatitis B - of the total 38,271 children, 52% or 19,901 are estimated to receive immunizations through private means. This includes insurance providers, Medicaid managed care providers, and CHIP providers. The costs for this would be $537,327. Hepatitis B has been a standard immunization for many years and is a covered service by the majority of the insurance providers in the state. Most insurance plans will cover all ACIP recommended vaccines; 2) Varicella - of the total 38,271 children, 52% or 19,901 are estimated to receive immunizations through private means. This includes insurance providers, Medicaid managed care providers, and CHIP providers. The costs for this would be $955,248. Varicella has been a standard immunization since 1995 and is a covered service by the majority of insurance providers in the state. Most insurance plans will cover all ACIP recommended vaccines; and 3) Tetanus - of the total 38,271 children, 52% or 19,901 are estimated to receive immunizations through private means. This includes insurance providers, Medicaid managed care providers, and CHIP providers. The costs for this would be $199.010. Tetanus has been a standard immunization for many years and is a covered service by the majority of insurance providers in the state. Most insurance plans will cover all ACIP recommended vaccines.

COMPLIANCE COSTS FOR AFFECTED PERSONS: The costs to an individual not covered by insurance or under a public program would be $27 for a 3 dose Hepatitis B series, $48 for a single dose of Varicella, and $10 for a single dose of Tetanus. Administrative fees to defray part of the labor cost for administering the vaccine may also be charged. $10.50 is the administrative fee paid by Medicaid. Local Health Departments establish their own fee for administration which can range from $0 - 10.50. Most are at $5 or above and they charge the same for public or private vaccine. Private providers may have higher fees than $10.50. Costs for individuals covered by private insurance are dependent upon the co-pay or deductible charged by the insurer.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: I have carefully reviewed the cost estimates detailed in the cost information above and believe they accurately set forth a good faith estimate of the fiscal impact of this proposed amendment. I believe the benefit to public health outweighs any fiscal impact on business. I will carefully review all public comments received, including any new issues on the fiscal impact that they may raise. David N. Sundwall, MD, Executive Director

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

HEALTH
COMMUNITY AND FAMILY HEALTH SERVICES,
IMMUNIZATION
CANNON HEALTH BLDG
288 N 1460 W
SALT LAKE CITY UT 84116-3231, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:

Caroline Green or Linda Abel at the above address, by phone at 801-538-9219 or 801-538-9450, by FAX at 801-538-9440 or 801-538-9440, or by Internet E-mail at carolinegreen@utah.gov or label@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 07/01/2005.

THIS RULE MAY BECOME EFFECTIVE ON: 07/02/2005

AUTHORIZED BY: David N. Sundwall, Executive Director

R396. Health, Community and Family Health Services, Immunization.

R396-100. Immunization Rule for Students.

R396-100-3. Required Immunizations.

(1) A student born before July 1, [~~1994~~]1993 must meet the minimum immunization requirements of the ACIP prior to school entry for the following antigens: Diphtheria, Tetanus, Pertussis, Polio, Measles, Mumps, and Rubella.

(2) A student born after July 1, [~~1994~~]1993 must meet the minimum immunization requirements of the ACIP prior to school entry for the following antigens: Diphtheria, Tetanus, Pertussis, Polio, Measles, Mumps, Rubella, and Hepatitis B.

(3) Commencing July 1, 2006, a student born after July 1, 1993, must also meet the minimum immunization requirements of the ACIP prior to entry into the seventh grade for the following antigens: Adult Tetanus/Diphtheria and Varicella.

(4) [~~Commencing July 1, 2002, a~~]A student born after July 1, 1996 must meet the minimum immunization requirements of the ACIP prior to school entry for the following antigens: Diphtheria, Tetanus, Pertussis, Polio, Measles, Mumps, Rubella, Hepatitis B, Hepatitis A, and Varicella.

([~~4~~]5) To attend a Utah early childhood program, a student must meet the minimum immunization requirements of the ACIP for the following antigens: Diphtheria, Tetanus, Pertussis, Polio, Measles, Mumps, Rubella, and Haemophilus Influenza Type b prior to school entry.

([~~5~~]6) The vaccinations must be administered according to the recommendations of the United States Public Health Service's Advisory Committee on Immunization Practices (ACIP) as listed below which are incorporated by reference into this rule:

(a) General Recommendations on Immunization: [~~January 28, 1994/ Vol. 43/No. RR-1~~]February 8, 2002/Vol.51/No. RR-2;

(b) Immunization of Adolescents: November 22, 1996/Vol. 45/No. RR-13;

(c) Combination Vaccines for Childhood Immunization: May 14, 1999/Vol. 48/No.RR-5;

(d) Diphtheria, Tetanus, and Pertussis: Recommendations for Vaccine Use and Other Preventive Measures: August 8, 1991/Vol. 40/No. RR-10;

([~~d~~]e) Pertussis Vaccination: Use of Acellular Pertussis Vaccines Among Infants and Children: March 28, 1997/Vol. 46/No. RR-7;

([~~e~~]f) Use of Diphtheria Toxoid-Tetanus Toxoid-Acellular Pertussis Vaccine as a Five-Dose Series: Supplemental Recommendations of the Advisory Committee on Immunization Practices: November 17, 2000/Vol. 49/No. RR-13;

([~~f~~]g) Protection Against Viral Hepatitis: February 9, 1990/Vol. 39/No. RR-2;

([~~g~~]h) Hepatitis B: A Comprehensive Strategy for Eliminating Transmission in the United States Through Universal Childhood Vaccination: November 22, 1991/Vol. 40/No. RR-13;

([~~h~~]i) Haemophilus b Conjugate Vaccines for Prevention of Haemophilus influenzae Type b Disease Among Infants and Children Two Months of Age and Older: January 11, 1991/Vol. 40/No. RR-1;

([~~i~~]j) Recommendations for Use of Haemophilus b Conjugate Vaccines and a Combined Diphtheria, Tetanus, and Pertussis, and Haemophilus b Vaccine: September 17, 1993/Vol. 42/No. RR-13;

([~~j~~]k) Measles, Mumps, and Rubella-Vaccine Use and Strategies for Elimination of Measles, Rubella, and Congenital Rubella Syndrome and Control of Mumps: May 22, 1998/Vol. 47/No. RR-8;

([~~k~~]l) Poliomyelitis Prevention in the United States: May 19, 2000/Vol. 49/No. RR-5;

([~~l~~]m) Prevention of Varicella: July 12, 1996/Vol. 45/No. RR-11;

([~~m~~]n) Prevention of Varicella: Updated Recommendations of the Advisory Committee on Immunization Practices: May 28, 1999/Vol. 48/No. RR-6; and

([~~n~~]o) Prevention of Hepatitis A Through Active or Passive Immunization: October 1, 1999/Vol. 48/No. RR-12.

R396-100-6. Reporting Requirements.

(1) Each school and early childhood program shall report the following to the Department in the form or format prescribed by the Department:

(a) by November 30 of each year, a statistical report of the immunization status of students enrolled in a licensed day care center, Head Start program, and kindergartens;

(b) by November 30 of each year, a [~~written~~]statistical report of the two-dose measles
immunization status of all kindergarten through twelfth grade students;[~~and~~]

(c) [~~by January 31 of each year, a written statistical report of the immunization status of all students kindergarten through twelfth grade new to a school after the school's regular registration period ends.~~]by November 30 of each year, a statistical report of diphtheria, tetanus, hepatitis B, varicella, and the two-dose measles immunization status of all seventh grade students; and

(d) by June 15 of each year, a statistical follow-up report of those students not appropriately immunized from the November 30 report in all public schools, kindergarten through twelfth grade.

(2) The information that the Department requires in the reports shall be in accordance with the Centers for Disease Control and Prevention guidelines.

R396-100-8. Exclusions of Students Who Are Under Exemption and Conditionally Enrolled Status.

(1) A local or state health department representative may exclude a student who has claimed an exemption to all vaccines or to one vaccine or who is conditionally enrolled from school attendance if there is good cause to believe that the student has a vaccine preventable disease and:

(a) has been exposed to a vaccine-preventable disease; or

(b) will be exposed to a vaccine-preventable disease as a result of school attendance.

(2) An excluded student may not attend school until the local health officer is satisfied that a student is no longer at risk of contracting or transmitting a vaccine-preventable disease.

KEY: immunization, rules and procedures
[~~July 19, 2001~~]2005
Notice of Continuation April 24, 2003
53A-11-303
53A-11-306

Health, Health Care Financing, Coverage and Reimbursement Policy
R414-14A
Hospice Care

NOTICE OF PROPOSED RULE
(Repeal and Reenact)
DAR FILE NO.: 27925
FILED: 05/16/2005, 16:57

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: This rulemaking is necessary to update policies that comply with the Medicare hospice program.

SUMMARY OF THE RULE OR CHANGE: The reenacted rule details information regarding Medicare regulations for administration and reimbursement that reflect current Medicaid practice. In addition, this rule includes detailed information regarding dual eligibility for Medicare and Medicaid clients. It restricts retroactive payment for services that were provided prior to enrollment as a Medicaid provider. It allows for the re-election of a hospice benefit by a Medicaid client and allows clients to change hospice providers at will. It provides a review process for involuntary disenrollment of hospice patients due to escalating costs, changing behavior, etc. It also allows the Division of Health Care Financing (DHCF) to use a physician knowledgeable in end-of-life care to conduct an independent review of extended hospice services that go beyond 12 months. In-home physician services not included in the previous hospice rule are now included. The previous rule required prior authorization for all hospice services while the new rule designates specific instances where prior authorization is required. The new rule also contains a prior authorization grace period that allows the hospice to begin service for a new enrollee up to five days prior to notifying DHCF of the enrollment, and allows for service requiring prior authorization up to five days in advance of contacting DHCF for authorization. In addition, the new rule provides reimbursement for hospice services while an individual is in the Medicaid eligibility determination stage if the person becomes eligible within the allowed time period. Further, the rule has a provision for DHCF to review the appropriateness of the service and to deny reimbursement if found to be inconsistent with the requirements for hospice care. Finally, this new rule includes language to allow the reimbursement rate for hospice services to be held constant when the legislature provides no money for inflationary adjustments.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 26-1-5, Subsection 26-18-3 (2)(a), and 42 USC 1396(d)(o)

ANTICIPATED COST OR SAVINGS TO:

❖ THE STATE BUDGET: There is no impact to the state budget associated with this rulemaking because it does not change the way Medicare/Medicaid certified hospices or the Department of Health conduct business.

❖ LOCAL GOVERNMENTS: There is no budget impact to local governments because there is no funding from local governments for the hospice care program.

❖ OTHER PERSONS: There is no budget impact to other persons because this rulemaking does not change the way Medicare/Medicaid certified hospices or the Department of Health conduct business.

COMPLIANCE COSTS FOR AFFECTED PERSONS: There are no compliance costs for affected persons because this rulemaking does not change the way Medicare/Medicaid certified hospices or the Department of Health conduct business.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: This rule appears to have the support of regulated businesses. It should remove unnecessary hurdles to Medicaid reimbursement for hospice services. Although no measurable fiscal impact is predicted by this filing, there is a reduction in regulatory burden which will have a positive impact. David N. Sundwall, MD, Executive Director

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

HEALTH
HEALTH CARE FINANCING,
COVERAGE AND REIMBURSEMENT POLICY
CANNON HEALTH BLDG
288 N 1460 W
SALT LAKE CITY UT 84116-3231, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
Craig Devashrayee at the above address, by phone at 801-538-6641, by FAX at 801-538-6099, or by Internet E-mail at cdevashrayee@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 07/01/2005.

THIS RULE MAY BECOME EFFECTIVE ON: 07/02/2005

AUTHORIZED BY: David N. Sundwall, Executive Director

R414. Health, Health Care Financing, Coverage and Reimbursement Policy.
R414-14A. Hospice Care.
[**~~R414-14A-0. Policy Statement.~~**

~~A. Hospice care derives from the recognition that the impending death of an individual warrants a change in focus from curative care to palliative care.~~

~~B. Hospice care shall be rendered by a Medicare-certified hospice and shall be provided in accordance with Medicare regulations.~~

~~C. Hospice coverage shall be available for at least 210 days.~~

~~R414-14A-1. Authority and Purpose.~~

~~A. Authority~~

~~Section 9505 of Public Law 99-272, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), enacted on April 7, 1986, amended Title XIX of the Social Security Act to permit hospice care benefits as defined under sections 1905(a)(18) and 1905(o) of the Act to be provided to individuals eligible for Medicaid under the State Plan.~~

~~B. The purpose of hospice care is to help terminally ill individuals continue life with minimal disruption in normal activities while remaining primarily in the home environment.~~

~~R414-14A-2. Definitions as Used in this Chapter.~~

~~A. "Hospice" means a public agency or private organization that is primarily engaged in providing care to terminally ill individuals, meets the Medicare conditions of participation for hospices, and has a valid provider agreement.~~

~~B. "Terminally ill" means that the individual has a medical prognosis that his life expectancy is six months or less.~~

~~C. "Attending physician" means a physician who is identified by the individual, at the time he elects to receive hospice care, as having the most significant role in the determination and delivery of the individual's medical care.~~

~~D. "Bereavement counseling" means counseling services provided to the individual's family after the individual's death.~~

~~E. "Medical social services" means the provision of counseling and assessment activities which contribute meaningfully to the treatment of a recipient's condition.~~

~~F. "Inpatient care" means the hospice services provided by an inpatient facility to a recipient who has been admitted to a hospital, long-term care facility, or facility of a hospice that provides care 24 hours a day.~~

~~G. "Interdisciplinary group" means a group of qualified individuals with expertise in meeting the special needs of hospice recipients and their families, which includes at least:~~

~~1. one physician;~~

~~2. one registered nurse;~~

~~3. one social worker; and~~

~~4. one pastoral or other counselor.~~

~~H. "Election statement" means a written statement electing hospice care and filed by a recipient, or his representative, with a hospice.~~

~~I. "Respite care" means short-term inpatient care provided to the recipient only when necessary to relieve the family members or other persons caring for the recipient.~~

~~R414-14A-3. Eligibility Requirements/Coverage.~~

~~To be covered, hospice services shall meet the following requirements:~~

~~A. Services shall be reasonable and necessary for the palliation or management of the terminal illness as well as related conditions.~~

~~B. A certification that the individual is terminally ill shall be completed.~~

~~C. The individual shall elect hospice care by filing an election statement with a particular hospice.~~

~~D. A plan of care shall be established by the interdisciplinary group.~~

~~R414-14A-4. Program Access Requirements.~~

~~Hospice care is available to categorically and medically needy individuals under Medicaid.~~

~~R414-14A-5. Service Coverage.~~

~~The following services are required hospice services:~~

~~A. nursing care provided by or under the supervision of a registered nurse;~~

~~B. medical social services provided by a qualified social worker under the direction of a physician;~~

~~C. administrative and general supervisory activities performed by physicians who are employees of, or working under arrangements made with, the hospice;~~

~~D. counseling services for the individual and family members or other persons caring for the person at home;~~

~~E. short-term inpatient care in a participating hospice inpatient unit, or a hospital, skilled nursing or intermediate care facility that additionally meets the special hospice standards regarding staffing and patient areas;~~

~~F. medical appliances and supplies, including drugs and biologicals. Only drugs which are used primarily for the relief of pain and symptom control related to the individual's terminal illness are covered;~~

~~G. home health aide and homemaker services furnished by qualified aides;~~

~~H. physical therapy, occupational therapy, and speech-language pathology services provided for purposes of symptom control.~~

~~R414-14A-6. Standards of Care.~~

~~The State shall enforce the Medicare standards of care as outlined in 42 CFR, Part 418, which are hereby adopted and incorporated by reference.~~

~~**R414-14A-7. Limitations.**~~

~~A. Recipients of hospice care shall sign an election of hospice care which waives all other Medicaid coverage except the services of a designated family physician, ambulance service, and services unrelated to the terminal illness.~~

~~B. Medicaid shall make no payment to the hospice, selected by the Medicaid recipient, for any services or supplies other than the hospice service.~~

~~C. The hospice shall not charge any amount to or collect any amount from the recipient or recipient's family for a covered hospice service during the period of hospice coverage.~~

~~D. Payments to a hospice for inpatient care shall be limited according to the number of days of inpatient care furnished to Medicaid patients. During the 12-month period beginning November 1 of each year and ending October 31, the aggregate number of inpatient days (both for general inpatient care and inpatient respite care) may not exceed 20 percent of the aggregate total number of days of hospice care provided to all Medicaid recipients during that same period.~~

~~E. Respite care shall be provided only on an occasional basis and shall not be reimbursed for more than five consecutive days at a time.~~

~~F. Respite care shall not be provided when the hospice recipient is a nursing home resident.~~

~~**R414-14A-8. Prior Authorization.**~~

~~Prior authorization procedures are not applicable to hospice services provided to a Medicaid recipient.~~

~~**R414-14A-9. Reimbursement for Services.**~~

~~A. Medicaid payments for hospice services shall be made at one of the four predetermined rates established under Medicare.~~

~~B. The rates shall be based on the Medicare rates for Utah.~~

~~C. For each day that an individual is under the care of a Medicare-certified hospice, the hospice shall be reimbursed in accordance with the established Medicaid fee schedule.~~

~~D. Payment rates are based on the type and intensity of the services furnished to the individual for that day according to one of the following levels of care: routine home care, continuous home care, inpatient respite care, or general inpatient care.~~

~~E. For recipients in a skilled nursing facility or intermediate care facility who elect to receive hospice service from a Medicare-certified hospice agency, Medicaid shall pay the hospice agency an additional per diem for routine home care and continuous home care days only, to cover the cost of room and board.~~

~~1. The room and board rate shall be based on the statewide average base rate for nursing homes (weighted averages without rate differential factors) less a percentage for nursing and related costs.~~

~~2. The nursing and related costs are defined as cost centers 07 and 08 on the facility's cost profile. The percentage is calculated by taking the percent of 07 and 08 to the total reported costs.~~

~~3. Medicaid reimbursement to the intermediate care or skilled nursing facility for the recipient shall cease.~~

~~4. The hospice agency shall reimburse the intermediate care or skilled nursing facility for the cost of room and board.~~

~~5. Room and board costs, in this context, shall include: performance of personal care services (including assistance in the activities of daily living), socializing activities, administration of medication, maintaining the cleanliness of a resident's room, and supervision and assisting in the use of durable medical equipment and prescribed therapies.~~]

R414-14A-1. Introduction and Authority.

This rule is authorized by Utah Code sections 26-1-5 and 26-18-3(2)(a). It implements Medicaid hospice care services as found in 42 USCS 1396d(o).

R414-14A-2. Definitions.

The definitions in R414-1 apply to this rule. In addition:

(1) "Attending physician" means a physician who:

(a) is a doctor of medicine or osteopathy; and

(b) is identified by the recipient at the time he or she elects to receive hospice care as having the most significant role in the determination and delivery of the recipient's medical care.

(2) "Cap period" means the 12 month period ending October 31 used in the application of the cap on reimbursement for inpatient hospice care as described in R414-14A-22(5).

(3) "Employee" means an employee of the hospice provider or, if the hospice provider is a subdivision of an agency or organization, an employee of the agency or organization who is appropriately trained and assigned to the hospice unit. "Employee" includes a volunteer under the direction of the hospice provider.

(4) "Hospice care" means care provided to terminally ill recipients by a hospice provider.

(5) "Hospice provider" means a provider that is licensed under the provisions of R432-750 and is primarily engaged in providing care to terminally ill individuals.

(6) "Physician" means a doctor of medicine or osteopathy who is licensed by the state of Utah.

(7) "Representative" means an individual who has been authorized under state law to make health care decisions, including initiating, continuing, refusing, or terminating medical treatments for a recipient who is mentally unable to make health care decisions.

(8) "Terminally ill" means the recipient has a medical prognosis that his or her life expectancy is six months or less if the illness runs its normal course.

R414-14A-3. Client Eligibility Requirements.

(1) A recipient who is terminally ill may obtain hospice care pursuant to this rule.

(2) A recipient's certification of a terminal condition required for hospice eligibility must be based on a face-to-face assessment by a physician conducted no more than 90 days prior to the date of enrollment.

(3) A recipient dually enrolled in Medicare and Medicaid must elect the hospice benefit for both Medicare and Medicaid. The recipient must receive hospice coverage under Medicare. Election for the Medicaid hospice benefit provides the recipient coverage for Medicare co-insurance and coverage for room and board expenses while a resident of a Medicare-certified nursing facility, Intermediate Care Facility for the Mentally Retarded (ICF/MR), or freestanding hospice facility.

R414-14A-4. Program Access Requirements.

(1) Hospice care may be provided only by a hospice provider licensed by the Department, that is Medicare certified in accordance with 42 CFR 418, and that is a Medicaid provider.

(2) A hospice provider must have a valid Medicaid provider agreement in place prior to initiating hospice care for Medicaid clients. The Medicaid provider agreement is effective on the date a Medicaid provider application is received in the Department and shall not be made retroactive to an earlier date, including an earlier effective date of Medicare hospice certification.

(3) At the time of a change of ownership, the previous owner's provider agreement terminates as of the effective date of the change of ownership.

(4) The Department accepts all waivers granted to hospice agencies by the Centers for Medicare and Medicaid Services as part of the Medicare certification process.

(5) Hospice agencies participating in the Medicaid program shall provide hospice care in accordance with the requirements of 42 CFR 418.3 through 418.204 as contained in this rule.

R414-14A-5. Service Coverage.

Hospice care categories eligible for Medicaid reimbursement are the following:

(1) "Routine home care day" is a day in which a recipient who has elected to receive hospice care is at home and is not receiving continuous home care as defined in subsection (5)(b)of this section. For purposes of routine home care day, extended stay residents of nursing facilities are considered at home.

(2) "Continuous home care day" is a day in which a recipient who has elected to receive hospice care receives a minimum of eight aggregate hours of care from the hospice provider during a 24-hour day, which begins and ends at midnight. The eight aggregate hours of care must be predominately nursing care provided by either a registered nurse or licensed practical nurse. Continuous home care is only furnished during brief periods of crisis in which a patient requires continuous care that is primarily nursing care to achieve palliation or management of acute medical symptoms. For purposes of routine home care day, extended stay residents of nursing facilities are considered at home.

(3) "Inpatient respite care day" is a day in which the recipient who has elected hospice care receives short-term inpatient care when necessary to relieve family members or other persons caring for the individual at home.

(4) "General inpatient care day" is a day in which a recipient who has elected hospice care receives general inpatient care for pain control or acute or chronic symptom management that cannot be managed in a home or other outpatient setting. General inpatient care may be provided in a hospice inpatient unit, a hospital, or a nursing facility.

(5) "Room and Board" is medication administration, performance of personal care, social activities, routine and therapeutic dietary services, meal service including direct feeding assistance, maintaining the cleanliness of the recipient's room, assistance with activities of daily living, durable equipment, prescribed therapies, and all other services unrelated to care associated with the terminal illness that would be covered under the Medicaid State plan nursing facility benefit.

R414-14A-6. Hospice Election.

(1) A recipient who meets the eligibility requirement for Medicaid hospice must file an election statement with a particular hospice. If the recipient is physically or mentally incapacitated, his or her legally authorized representative may file the election statement.

(2) The election statement must include the following:

(a) identification of the particular hospice that will provide care to the recipient;

(b) the recipient's or representative's acknowledgment that he or she has been given a full understanding of the palliative rather than curative nature of hospice care, as it relates to the recipient's terminal illness;

(c) acknowledgment that the recipient waives certain Medicaid services as set forth in R414-14A-11;

(d) acknowledgment that the recipient or representative may revoke the election of the hospice benefit at any time in the future and therefore become eligible for Medicaid services waived at the time of hospice election as set forth in R414-14A-8; and

(f) the signature of the recipient or representative.

(3) The effective date of the election may be the first day of hospice care or a later date, but may be no earlier than the date of the election statement

(4) An election to receive hospice care remains effective through the initial election period and through the subsequent election periods without a break in care as long as the recipient:

(a) remains in the care of a hospice;

(b) does not revoke the election; and

(c) is not discharged from the hospice.

(5) The hospice provider must notify the Department at the time a Medicaid recipient selects the hospice benefit, including selecting the hospice provider under a change of designated hospice. The notification must include a copy of the hospice election statement and the recipient's plan of care for hospice care. Authorization for reimbursement of hospice care begins no earlier than the date notification is received by the Department for an eligible Medicaid client, except as provided in R414-14A-19.

(6) Subject to the conditions set forth in this rule, a recipient may elect to receive hospice care during one or more of the following election periods:

(a) an initial 90-day period;

(b) a subsequent 90-day period; or

(c) an unlimited number of subsequent 60-day periods.

R414-14A-7. Change in Hospice Provider.

(1) A recipient or representative may change, once in each election period, the designation of the particular hospice from which hospice care will be received.

(2) The change of the designated hospice is not a revocation of the election for the period in which it is made.

(3) To change the designation of hospice provider, the recipient must file, with the hospice provider from which care has been received and with the newly designated hospice provider, a statement that includes the following information:

(a) the name of the hospice provider from which the recipient has received care;

(b) the name of the hospice provider from which the recipient plans to receive care; and

(c) the date the change is to be effective.

(4) The recipient must file the change on or before the effective date.

R414-14A-8. Revocation and Re-election of Hospice Revocation.

(1) A recipient or representative may revoke the recipient's election of hospice care at any time during an election period.

(2) To revoke the election of hospice care, the recipient or representative must file a statement with the hospice provider that includes the following information:

(a) a signed statement that the recipient or representative revokes the recipient's election for Medicaid coverage of hospice care for the remainder of that election period; and

(b) the date that the revocation is to be effective, which may not be earlier than the date that the revocation is made.

(3) Upon revocation of the election of Medicaid coverage of hospice care for a particular election period, a recipient:

(a) is no longer covered under Medicaid for hospice care;

(b) resumes Medicaid coverage for the benefits waived under R414-14A-6; and

(c) may at any time elect to receive hospice coverage for any other hospice election periods that he or she is eligible to receive.

(4) If an election has been revoked, the recipient, or his or her representative if the recipient is mentally incapacitated, may at any time file an election, in accordance with this rule, for any other election period that is still available to the recipient.

R414-14A-9. Rights Waived to Some Medicaid.

(1) For the duration of an election for hospice care, a recipient waives all rights to Medicaid to the following services:

(a) hospice care provided by a hospice other than the hospice designated by the recipient, unless provided under arrangements made by the designated hospice; and

(b) any Medicaid services that are related to the treatment of the terminal condition for which hospice care was elected or a related condition or are duplicative of hospice care except for services:

(i) provided by the designated hospice;

(ii) provided by another hospice under arrangements made by the designated hospice; and

(iii) provided by the recipient's attending physician if the services provided are not otherwise covered by the payment made for hospice care.

(2) Medicaid services for illnesses or conditions not related to the recipient's terminal illness are not covered through the hospice program but are covered when provided by the appropriate provider.

R414-14A-10. Notice of Hospice Care in a Nursing Facility, ICF/MR, or Freestanding Inpatient Hospice Facility.

(1) The hospice provider must notify the Department at the time a Medicaid recipient residing in a Medicare certified nursing facility, a Medicaid certified ICF/MR, or a Medicare freestanding inpatient hospice facility elects the Medicaid hospice benefit or at the time a Medicaid recipient who has elected the Medicaid hospice benefit is admitted to a Medicare certified nursing facility, a Medicaid certified ICF/MR, or a Medicare freestanding inpatient hospice facility.

(2) The notification must include a prognosis of the time the individual will require skilled nursing facility services under the hospice benefit.

(3) Except as provided in R414-14A-20, reimbursement for room and board begins no earlier than the date the hospice provider notifies the Department that the recipient has elected the Medicaid hospice benefit.

R414-14A-11. Notice of Independent Attending Physician.

The hospice provider must notify the Department at the time a Medicaid recipient designates an attending physician who is not a hospice employee.

R414-14A-12. Independent Review of Extended Hospice Care.

Recipients who accumulate 12 or more months of hospice benefits are subject to an independent utilization review by a physician with expertise in end-of-life and hospice care selected by the Department.

R414-14A-13. Involuntary Discharge Review.

(1) A hospice provider may not involuntary discharge a Medicaid recipient from hospice care without first obtaining approval from the Department.

(2) The hospice provider must notify the Department in writing of the intent to involuntarily discharge the recipient from hospice care.

(3) The hospice provider may involuntary discharge the recipient only if it can demonstrate to the Department that the hospice, in conjunction with other Medicaid services, cannot protect the recipient's health and safety or cannot address the recipient's needs identified through the plan of care required as a condition of participation in 42 CFR 418.58

R414-14A-14. Hospice Room and Board Service.

If a recipient residing in a nursing facility, ICF/MR or a freestanding hospice inpatient unit elects hospice care, the hospice provider and the facility must have a written agreement under which the total care of the individual must be specified in a comprehensive service plan, the hospice provider is responsible for the professional management of the recipient's hospice care, and the facility agrees to provide room and board and services unrelated to the care of the terminal condition to the recipient. The agreement must include:

(1) identification of the services to be provided by each party and the method of care coordination to assure that all services are consistent with the hospice approach to care and are organized to achieve the outcomes defined by the hospice plan of care;

(2) a stipulation that Medicaid services may be provided only with the express authorization of the hospice;

(3) the manner in which the contracted services are coordinated, supervised and evaluated by the hospice provider;

(4) the delineation of the roles of the hospice provider and the facility in the admission process; needs assessment process, and the interdisciplinary team care conference and service planning process;

(5) requirements for documenting that services are furnished in accordance with the agreement;

(6) the qualifications of the personnel providing the services; and

(7) the billing and reimbursement process by which the nursing facility will bill the hospice provider for room and board and receive payment from the hospice provider.

R414-14A-15. In Home Physician Services.

In-home physician visits by the attending physician are authorized for hospice recipients if the attending physician determines that direct management of the recipient in the home setting is necessary to achieve the goals associated with a hospice approach to care.

R414-14A-16. Continuous Home Care.

When the hospice provider determines that a patient requires at least eight hours of primarily nursing care in order to manage an acute medical crisis, the hospice provider will maintain documentation to support the requirement that the services provided were reasonable and necessary and were in compliance with an established plan of care in order to meet a particular crisis situation. Continuous home care is a covered benefit only as necessary to maintain the terminally ill individual at home.

R414-14A-17. General Inpatient Care.

(1) General inpatient care is authorized without prior authorization for an initial five-day length of stay. Prior authorization is required for any additional general inpatient care days during the same stay to verify that the recipient's needs meet the requirements for general inpatient care. If a hospice provider requests additional days, the subsequent requests are subject to clinical review and approval by qualified Department staff.

(2) General inpatient care days may not be used due to the breakdown of the primary care giving living arrangements or the collapse of other sources of support for the recipient.

(3) Prior authorization for additional days beyond the initial five-day stay must be obtained before the hospice care is provided, except as allowed in R414-14A-19.

R414-14A-18. Inpatient Respite Care.

When the hospice provider determines that a patient requires a short-term inpatient respite stay in order to relieve the family members or other persons caring for the individual at home, the hospice provider will maintain documentation to support the requirement that the services provided were reasonable and necessary to relieve a particular caregiver situation. Inpatient respite care may not be reimbursed for more than five consecutive days at a time. Inpatient respite care may not be reimbursed for a patient residing in a nursing facility, ICF/MR, or freestanding hospice inpatient unit.

R414-14A-19. Notification and Prior Authorization Grace Periods.

During weekends, holidays, and after regular Department business hours, a hospice provider may begin service to a new Medicaid hospice enrollee, including covering room and board, or initiate a different hospice care requiring prior authorization for a period up to five days before notifying the Department. During the five-day period, the hospice provider must complete the required contact and notifications to the Department as outlined in R414-14A-4, 9, 15, 16, and 17. The Department pays for services during the allowed five-day grace period only if the hospice provider completes the required contact and notifications within the grace period and the Department determines that the individual met Medicaid eligibility requirements at the time the service was provided. If the hospice provider fails to complete the required contact and notifications to the Department within the allowed five day period, the Department does not reimburse the hospice provider for any hospice care delivered prior to the date the hospice provider completes the contact and notifications.

R414-14A-20. Post-Payment for Services Provided While in Medicaid-Pending Status.

(1) The Department will reimburse a hospice provider retroactively for up to three months prior to the individual's establishing Medicaid eligibility if:

(a) the Department determines that the individual met Medicaid eligibility requirements at the time the service was provided;

(b) the hospice care met the prior authorization criteria at the time of delivery; and

(c) the hospice provider reimburses the Department for care related to the individual's terminal illness delivered by other Medicaid providers during the retroactive period.

(2) The hospice provider must provide documentation to the Department adequate to demonstrate the service met prior authorization criteria at the time of delivery.

R414-14A-21. Hospice Care Reimbursement.

(1) Medicaid payment for covered hospice care is made in accordance with the methodology set forth in the Utah Medicaid State Plan.

(2) A hospice provider may not charge a Medicaid recipient for services for which the recipient is entitled to have payment made under Medicaid.

(3) Medicaid reimbursement to a hospice provider for services provided during a cap period is limited to the cap amount specified in R414-14A-22(5).

(4) Medicaid does not apply the aggregate caps used by Medicare.

(5) Payment for hospice care is made on the basis of the geographic location where the service is provided as described in the Medicaid State Plan.

(6) Routine home care, continuous home care, general inpatient care, inpatient respite care services, and hospice room and board, are reimbursable to the hospice provider only.

(7) Hospice general inpatient care and inpatient respite care are not reimbursed by Medicaid for services provided in a Veterans Administration hospital or military hospital.

R414-14A-22. Payment for Hospice Care Categories.

(1) The Department establishes payment amounts for the following categories:

(a) Routine home care.

(b) Continuous home care.

(c) Inpatient respite care.

(d) General inpatient care.

(e) Room and Board service.

(2) The Department reimburses the hospice provider at the appropriate payment amount for each day for which an eligible Medicaid recipient is under the hospice's care.

(3) The Medicaid reimbursement covers the same services and amounts covered by the equivalent Medicare reimbursement rate for comparable service categories.

(4) The Department makes payment according to the following procedures:

(a) Payment is made to the hospice for each day during which the recipient is eligible and under the care of the hospice, regardless of the amount of services furnished on any given day.

(b) Payment is made for only one of the categories of hospice care described in R414-14A-22(1) for any particular day.

(c) On any day in which the recipient is not an inpatient, the Department pays the hospice provider the routine home care rate, unless the recipient receives continuous home care as provided in subsection R414-14A-5(b) for a period of at least eight hours. In that case, the Department pays a portion of the continuous care day rate in accordance with subsection (5)(e).

(d) The hospice payment on a continuous care day varies depending on the number of hours of continuous services provided. The number of hours of continuous care provided during a continuous home care day is multiplied by the hourly rate to yield the continuous home care payment for that day. A minimum of eight hours of licensed nursing care must be furnished on a particular day to qualify for the continuous home care rate.

(e) Subject to the limitations described in subsection (5), on any day on which the recipient is an inpatient in an approved facility for inpatient care, the appropriate inpatient rate (general or respite) is paid depending on the category of care furnished. The inpatient rate (general or respite) is paid for the date of admission and all subsequent inpatient days, except the day on which the recipient is discharged. For the day of discharge, the appropriate home care rate is paid unless the recipient dies as an inpatient. In the case where the recipient dies as an inpatient, the inpatient rate (general or respite) is paid for the discharge day. Payment for inpatient respite care is subject to the requirement that it may not be provided consecutively for more than five days at a time.

(5) Payment for inpatient care is limited as follows:

(a) The total payment to the hospice for inpatient care (general or respite) is subject to a limitation that total inpatient care days for Medicaid recipients not exceed 20 percent of the total days for which these recipients had elected hospice care. Individuals afflicted with AIDS are excluded when calculating inpatient days.

(b) At the end of a cap period, the Department calculates a limitation on payment for inpatient care for each hospice to ensure that Medicaid payment is not made for days of inpatient care in excess of 20 percent of the total number of days of hospice care furnished to Medicaid recipients by the hospice.

(c) If the number of days of inpatient care furnished to Medicaid recipients is equal to or less than 20 percent of the total days of hospice care to Medicaid recipients, no adjustment is necessary.

(d) If the number of days of inpatient care furnished to Medicaid recipients exceeds 20 percent of the total days of hospice care to Medicaid recipients, the total payment for inpatient care is determined in accordance with the procedures specified in paragraph (5)(e) of this section. That amount is compared to actual payments for inpatient care, and any excess reimbursement must be refunded by the hospice.

(e) If a hospice exceeds the number of inpatient care days described in paragraph (5)(d), the total payment for inpatient care is determined as follows:

(i) Calculate the ratio of the maximum number of allowable inpatient days to the actual number of inpatient care days furnished by the hospice to Medicaid recipients.

(ii) Multiply this ratio by the total reimbursement for inpatient care made by the Department.

(iii) Multiply the number of actual inpatient days in excess of the limitation by the routine home care rate.

(iv) Sum the amounts calculated in subsections (5)(e)(ii) and (iii).

(6) The hospice provider may request an exception to the inpatient care payment limitation if the hospice provider demonstrates the volume of Medicaid enrollees during the cap period was insufficient to reasonably achieve the required 20% ratio.

R414-14A-23. Payment for Physician Services.

(1) The following services performed by hospice physicians are included in the rates described in R414-14A-21 and 22:

(a) General supervisory services of the medical director.

(b) Participation in the establishment of plans of care, supervision of care and services, periodic review and updating of plans of care, and establishment of governing policies by the physician member of the interdisciplinary group.

(2) For services not described in paragraph (1) of this section, direct care services related to the terminal illness or a related condition provided by hospice physicians are reimbursed according to the Medicaid reimbursement fee schedule for physician services. Services furnished voluntarily by physicians are not reimbursable.

(3) Services of the recipient's attending physician, including in-home services, are reimbursed according to the Medicaid fee schedule for State Plan physician services. Services furnished voluntarily by physicians are not reimbursable.

R414-14A-24. Hospice Payment Covers Special Modalities.

No additional Medicaid payment will be made for chemotherapy, radiation therapy, and other special modalities of care for palliative purposes regardless of the cost of the services.

R414-14A-25. Payment for Nursing Facility, ICF/MR, and Freestanding Inpatient Hospice Unit Room and Board.

(1) For recipients in a nursing facility, ICF/MR, or a freestanding hospice inpatient unit who elect to receive hospice care from a Medicaid enrolled hospice provider, Medicaid will pay the hospice provider an additional per diem for routine home care and continuous home care services to cover the cost of room and board in the facility. For nursing facilities and ICFs/MR, the room and board rate ise 95 percent of the amount that the Department would have paid to the nursing facility or ICF/MR provider for that recipient if the recipient had not elected to receive hospice care. For freestanding hospice inpatient facilities, the room and board rate is 95 percent of the statewide average paid by Medicaid for nursing facility services.

(2) Reimbursement for room and board is made to the hospice provider. The hospice provider is responsible to reimburse the facility the room and board payment received. The reimbursement is payment in full for the services described in R414-14A-14(2) The facility cannot bill Medicaid separately.

(3) If a hospice enrollee in a nursing facility, ICF/MR, or a freestanding hospice inpatient unit has a monetary obligation to contribute to his or her cost of care in the facility, the facility must collect and retain the contribution. The hospice must reimburse the facility the reduced amount received from Medicaid directly or from a Medicaid Health Plan.

R414-14A-26. Limitation on Liability for Certain Hospice Coverage Denials.

If a recipient is determined not to be terminally ill while hospice care were received under this rule, the recipient is not responsible to reimburse the Department. If the Department denies reimbursement to the hospice provider, the hospice provider may not seek reimbursement from the recipient.

R414-14A-27. Medicaid Health Plans and Hospice.

(1) If a Medicaid-only recipient is enrolled in a Medicaid health plan, the hospice selected by the recipient must have a contract with the health plan. The health plan is responsible to reimburse the hospice for hospice care. The Department will not directly reimburse a hospice provider for a Medicaid-only recipient covered by a health plan.

(2) If a Medicaid-only recipient enrolled in a health plan elects hospice care before being admitted to a nursing facility, ICF/MR, or a freestanding hospice inpatient unit, the health plan is responsible to reimburse the hospice provider for both the hospice care and the room and board until the individual is disenrolled from the health plan by the Department. At the point the health plan determines that the enrollee will require care in the nursing facility for greater than

30 days, the health plan will notify the Department of the prognosis of extended nursing facility services. The Department will schedule disenrollment from the health plan to occur in accordance with the terms of the health plan contract for care provided in skilled nursing facilities.

(3) If a hospice enrollee is covered by Medicare for hospice care, the Medicaid health plan is responsible for payment of the Medicare coinsurance and deductibles. The health plan is responsible for payment whether or not the Medicare covered service is rendered by a network provider or has been authorized by the health plan. If a Medicare covered service is rendered by an out-of-network Medicare provider or a non-Medicare participating provider, the health plan is responsible to pay the coinsurance and deductibles.

(4) The health plan is responsible for room and board expenses of a hospice enrollee receiving Medicare hospice care while the recipient is a resident of a Medicare-certified nursing facility, ICF/MR, or freestanding hospice facility until the individual is disenrolled from the health plan by the Department. . On the 31st day, the recipient is disenrolled from the health plan and enrolled in the Medicaid fee-for-service hospice program. At the point the Department determines that the enrollee will require care in the nursing facility for greater than 30 days, The Department will schedule disenrollment from the health plan to occur in accordance with the terms of the health plan contract for care provided in skilled nursing facilities. The room and board expenses will be set in accordance with R414-14A-25.

(5) The hospice provider is responsible for determining if an applicant for hospice care is covered by a Medicaid health plan prior to enrolling the recipient, for coordinating services and reimbursement with the health plan during the period the recipient is receiving the hospice benefit, and for notifying the health plan when the recipient disenrolls from the hospice benefit.

R414-14A-28. Medicaid LTC Managed Care Projects and Hospice.

(1) A recipient receiving the Medicaid hospice benefit may enroll in a Medicaid LTC Managed Care project only if the LTC Managed Care project contractor and the recipient's hospice provider agree that the hospice care must be provided in the home. Medicaid recipients are not eligible for enrollment in a Medicaid LTC Managed Care project if the hospice care will be provided in a congregate care setting.

(2) For hospice enrollees covered by a Medicaid LTC Managed Care project, the LTC managed care contractor may provide services unrelated to the recipient's terminal illness as part of a coordinated care plan with the hospice provider.

R414-14A-29. Medicaid 1915c HCBS Waivers and Hospice.

For hospice enrollees covered by a Medicaid 1915c Home and Community-Based Services Waiver, the waiver program may provide services unrelated to the recipient's terminal illness as part of a coordinated care plan with the hospice provider.

KEY: [~~m~~]Medicaid
[~~1989~~]2005
Notice of Continuation October 6, 2004
26-1-4.1
26-1-5
26-18-3

▼ ▼

Health, Health Care Financing, Coverage and Reimbursement Policy

R414-301

Medicaid General Provisions

NOTICE OF PROPOSED RULE
(Amendment)
DAR FILE NO.: 27902
FILED: 05/13/2005, 16:30

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: This rulemaking is to add a definition to the list of definitions used in Rules R414-301 through R414-308. It is also needed to correct a reference to a provision in Rule R414-308 which is being changed. Some clarifying language has been added to better explain the interaction between an agency conference and the fair hearing process.

SUMMARY OF THE RULE OR CHANGE: This rule adds a definition in Section R414-301-2. It also adds clarifications to the definitions of Qualified Individuals Group 1 (QI-1), Qualified Medicare Beneficiary (QMB), and Specified Low-Income Medicare Beneficiary (SLMB) to say that these are Medicare Cost-Sharing programs rather than Medicaid programs. In Section R414-301-5, the reference to a provision in Rule R414-308 is being corrected because Rule R414-308 is being changed. Also, clarifying language is being added in this section to better explain the interaction between an agency conference and the fair hearing process.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Title 26, Chapter 18

ANTICIPATED COST OR SAVINGS TO:

❖ THE STATE BUDGET: There are no costs or savings to the state because this just adds a definition, corrects a reference to another rule, and clarifies provisions for agency conferences.

❖ LOCAL GOVERNMENTS: There is no impact on local governments because this just adds a definition, corrects a reference to another rule, and clarifies provisions for agency conferences.

❖ OTHER PERSONS: There are no costs or savings to other persons because this just adds a definition, corrects a reference to another rule, and clarifies provisions for agency conferences.

COMPLIANCE COSTS FOR AFFECTED PERSONS: There are no compliance costs because this rulemaking just adds a definition, corrects a reference to another rule, and clarifies provisions for agency conferences.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: It does not appear that this housekeeping change to the rule will have any fiscal impact. A. Richard Melton, Acting Executive Director

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

HEALTH
HEALTH CARE FINANCING,
COVERAGE AND REIMBURSEMENT POLICY
CANNON HEALTH BLDG
288 N 1460 W
SALT LAKE CITY UT 84116-3231, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:

Ross Martin at the above address, by phone at 801-538-6592, by FAX at 801-538-6099, or by Internet E-mail at rmartin@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 07/01/2005.

THIS RULE MAY BECOME EFFECTIVE ON: 07/02/2005

AUTHORIZED BY: Richard Melton, Deputy Director

R414. Health, Health Care Financing, Coverage and Reimbursement Policy.
R414-301. Medicaid General Provisions.
R414-301-2. Definitions.

The following definitions apply in rules R414-301 through R414-308:

(1) "Agency" means any local office or outreach location of either the Department of Health or the Department of Workforce Services that accepts and processes applications for Medicaid and Medicare Cost-Sharing programs. In incorporated federal materials, "agency" means the Utah Department of Health.

([~~1~~]2) "Applicant" means any person requesting assistance under any of the programs listed in R414-301.

([~~2~~]3) "Assistance" means medical assistance under any of the programs listed in R414-301.

([~~3~~]4) "CHEC" means Child Health Evaluation and Care.

([4]5) "Client" means an applicant or recipient of any of the programs listed in R414-301.

([~~5~~]6) "Department" means the Department of Health.

([~~6~~]7) "Director" or "designee" means the director or designee of the Division of Health Care Financing.

([~~7~~]8) "Local" office means any community office location of the Department of Workforce Services, the Department of Human Services or the Department of Health where an individual may apply for medical assistance programs.

([~~8~~]9) "Outreach location" means any site other than a state office where state workers are located to accept applications for medical assistance programs. Locations include sites such as hospitals, clinics, homeless shelters, etc.

([~~9~~]10) "QI-1" means the Qualifying Individuals Group 1 program, a Medicare Cost-Sharing program.

([~~10~~]11) "QMB" means Qualified Medicare Beneficiary program, a Medicare Cost-Sharing program.

([~~11~~]12) "Recipient" means any individual receiving assistance under any of the programs listed in R414-301-1. It may also be used to mean someone who is receiving other assistance or benefits such as SSI, in which case the text will specify such other type of benefit or assistance.

([~~12~~]13) "Reportable change" means any change in circumstances which could affect a client's eligibility for Medicaid, including:

(a) change in the source of income;
(b) change of more than $25 in gross income;
(c) changes in household size;
(d) changes in residence;
(e) gain of a vehicle;
(f) change in resources;
(g) change of more than $25 in total allowable deductions;
(h) changes in marital status, deprivation, or living arrangements;
(i) pregnancy or termination of a pregnancy;
(j) onset of a disabling condition; and
(k) change in health insurance coverage including changes in the cost of coverage.

([~~13~~]14) "Resident of a medical institution" means a single client who is a resident of a medical institution from the month after entry into a medical institution until the month prior to discharge from the institution. Death in a medical institution is not considered a discharge from the institution and does not change the client's status as a resident of the medical institution. Married clients are residents of an institution in the month of entry into the institution and in the month they leave the institution.

([~~14~~]15) "SLMB" means Specified Low-Income Medicare Beneficiary program, a Medicare Cost-Sharing program.

([~~15~~]16) "Spenddown" means an amount of income in excess of the allowable income standard that must be paid in cash to the department or incurred through the medical services not paid by Medicaid, or some combination of these.

([~~16~~]17) "Spouse" means any individual who has been married to a client or recipient and has not legally terminated the marriage.

([~~17~~]18) "Worker" means a state employee who determines eligibility for Medicaid and Medicare Cost-Sharing programs.

R414-301-5. Complaints and Agency Conferences.

(1) A client may request an agency conference at any time to resolve a problem regarding the client's case. Requests shall be granted at the department's discretion. Clients may have an authorized representative attend the agency conference.

(2) Requesting an agency conference does not prevent a client from also requesting a fair hearing in the event the agency conference does not resolve the client's concerns.

(3) Having an agency conference does not extend the time period in which a client has to request a fair hearing. The client must request a fair hearing within 90 days of the date on the notice with which the client disagrees to assure the right to have a fair hearing if the client is not satisfied with the outcome of the agency conference.

(4) There is no appeal to the decisions made during an agency conference; however, if the client is not satisfied with the results of the agency conference, and makes a timely request for a fair hearing as defined in R414-306-6, the client may proceed with the formal fair hearing process.

(5) The department [~~must~~]provides proper notice as defined in R414-308-[~~802~~]5 [~~of~~]if there are any additional adverse changes in the client's eligibility that are made as a result of the agency conference. The client then has a right to request a fair hearing based on the new decision letter of an additional adverse action.

KEY: client rights, Medicaid
[~~September 9,~~]200[~~3~~]5
Notice of Continuation January 31, 2003
26-18

Health, Health Care Financing, Coverage and Reimbursement Policy
R414-304
Income and Budgeting

NOTICE OF PROPOSED RULE
(Amendment)
DAR FILE NO.: 27923
FILED: 05/16/2005, 16:07

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: This rulemaking is necessary to add some income exclusions for Family Medicaid such as excluding hostile fire pay for military personnel serving in combat zones and interest income earned on certain resources. These changes make Family Medicaid policy consistent with policy for Aged, Blind or Disabled Medicaid. Many provisions have been reworded and rearranged both for Family Medicaid rules and for Aged, Blind or Disabled Medicaid rules, to make them easier to understand.

SUMMARY OF THE RULE OR CHANGE: Some citations have been corrected, updated, and obsolete citations removed. Much of the language has been reworded to put statements in active voice, to improve clarity, and for simplification. Many provisions have been rearranged so that rules regarding "uncounted income" are grouped together and rules regarding "counted income" are grouped together as much as possible. A new Subsection R414-304-2(5) has been added to better explain how veteran's benefits are counted and to be consistent with the same provision modified in Section R414-304-4. The new Subsection R414-304-2(13) has been modified to follow educational income changes made to the Supplemental Security Income program. Changes in Section R414-304-3 are mostly rewording to make the rules easier to read and understand. In Subsection R414-304-4(3), deletes definitions that are no longer applicable in this rule. In Subsection R414-304-4(8), clarifies that deductions from benefit income to repay overpayments of the benefit income are not counted as income. Subsection R414-304-4(15) is a new income exclusion for interest earned on countable resources and specific excluded resources. Subsection R414-304-4(16) is a new income exclusion for the additional hostile fire pay or imminent danger pay that is received by individuals in the armed forces serving in combat zones. Subsection R414-304-4(18) is a clarification that either $30 or actual expenses, if greater, will be deducted from rental income. Subsection R414-304-4(19) is a clarification about when deferred income is counted or not counted, and that deductions from income such as health insurance premiums, child care, etc., are counted as income when they could have been received. Subsection R414-304-4(20) is a further clarification that deductions from income to pay obligations such as child support, alimony or other debts are counted as income when the amount being deducted would have been received except for the obligation to make such a payment. Subsection R414-304-4(22) includes a clarification about how the portion of veteran's benefits for dependents is counted.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Title 26, Chapter 18

THIS RULE OR CHANGE INCORPORATES BY REFERENCE THE FOLLOWING MATERIAL: 42 CFR 435.725, 435.726, 435.811 through 435.832, 2004 ed.; 45 CFR 233.20(a)(1), 233.20(a)(3)(iv), 233.20(a)(3)(vi)(A), 233.20(a)(4)(ii), 2004 ed.; 20 CFR 416.1102, 416.1103, 416.1120 through 416.1148, 416.1150, 416.1151, 416.1163 through 416.1166, and Appendix to Subpart K of 416, 2004 ed.; and Subsection 404(h)(4) and 1612(b)(22) of the Compilation of the Social Security Laws, in effect January 1, 2003

ANTICIPATED COST OR SAVINGS TO:
❖ THE STATE BUDGET: No cost or savings because this rulemaking mostly clarifies and rewords rules. The new income exclusions for hostile fire pay are expected to allow currently eligible families to remain eligible while a household member is serving in a combat zone. The income exclusion of certain interest income allows exclusion of small amounts of income that usually could have been excluded as infrequent income.
❖ LOCAL GOVERNMENTS: No cost or savings as this rulemaking does not impact local governments.
❖ OTHER PERSONS: No cost or savings as this rulemaking does not add any new requirements or take away any benefits. There may be some savings to individuals because some of their income will not be counted in determining eligibility.

COMPLIANCE COSTS FOR AFFECTED PERSONS: There are no compliance costs for affected persons as this rulemaking does not add any new requirements for eligibility or take away any benefits.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: These rule changes add clarity to the rule and maintain the status quo for eligibility in these programs. No fiscal impact is anticipated. David N. Sundwall, MD, Executive Director

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

HEALTH
HEALTH CARE FINANCING,
COVERAGE AND REIMBURSEMENT POLICY
CANNON HEALTH BLDG
288 N 1460 W
SALT LAKE CITY UT 84116-3231, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
Craig Devashrayee at the above address, by phone at 801-538-6641, by FAX at 801-538-6099, or by Internet E-mail at cdevashrayee@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 07/01/2005.

THIS RULE MAY BECOME EFFECTIVE ON: 07/02/2005

AUTHORIZED BY: David N. Sundwall, Executive Director

R414. Health, Health Care Financing, Coverage and Reimbursement Policy.
R414-304. Income and Budgeting.
R414-304-2. A, B and D Medicaid and A, B and D Institutional Medicaid Unearned Income Provisions.

(1) This rule establishes how the Department treats unearned income to determine eligibility for Aged, Blind and Disabled Medicaid and Aged, Blind and Disabled Institutional Medicaid coverage groups.

([~~1~~]2) The Department adopts 42 CFR 435.725, 435.726, 435.811 through 435.832, [~~2001~~]2004 ed., and 20 CFR 416.1102, 416.1103, 416.1120 through 416.1148, 416.1150, 416.1151, 416.1163 through 416.1166, and Appendix to Subpart K of 416, [~~2002~~]2004 ed., which are incorporated by reference. The Department adopts Subsection 404(h)(4) and 1612(b)(22) of the Compilation of the Social Security Laws in effect January 1, [~~2001~~]2003, which are incorporated by reference. The Department [~~shall~~]does not count as income any payments from sources that [~~are prohibited under other~~]federal laws specifically prohibit from being counted as income to determine eligibility for federally-funded medical assistance programs.

([~~2~~]3) The following definitions apply to this section:

(a) "Eligible spouse" means the member of a married couple who is either aged, blind, or disabled.

(b) "In-kind support donor" means an individual who provides food or shelter without receiving full market value compensation in return.

(c) "Presumed maximum value" means the allowed maximum amount an individual is charged for the receipt of food and shelter. This amount [~~shall~~]will not exceed 1/3 of the SSI federal benefit rate plus $20.

([~~3~~]4) [~~Only the portion of a VA check to which the client is legally entitled is countable income.~~]The agency does not count VA (Veteran's Administration) payments for aid and attendance [~~do not count as income. T~~]or the portion of a VA payment that is made because of unusual medical expenses[~~is not countable income~~]. Other VA income based on need is countable income, but is not subject to the $20 general income disregard.

(5) The agency only counts as income the portion of a VA check to which the client is legally entitled. If the payment includes an amount for a dependent, that amount counts as income for the dependent. If the dependent does not live with the veteran or surviving spouse, the portion for the dependent counts as the dependent's income unless the dependent has applied to VA to receive the payment directly, VA has denied that request, and the dependent does not receive the payment. In this case, the amount for a dependent also counts as income of the veteran or surviving spouse who receives the payment.

(6) SSA reimbursements of Medicare premiums are not countable income.

([~~4~~]7) The agency does not count as income, the value of special circumstance items [~~is not countable income~~]if the items are paid for by donors.

([~~5~~]8) For A, B and D Medicaid, the agency counts as income two-thirds of current child support received in a month for the disabled child[~~is countable unearned income~~]. It does not matter if the payments are voluntary or court-ordered. It does not matter if the child support is received in cash or in-kind. If there is more than one child for whom the payment is made, the amount is divided equally among the children unless a court order indicates a different division. Child support payments that are payments owed for past months or years are countable income to determine eligibility for the parent or guardian receiving the payments.

([~~6~~]9) For A, B and D Institutional Medicaid, court-ordered child support payments must be paid to the Office of Recovery Services (ORS) when the child resides out-of-home in a Medicaid 24-hour care facility. If the child has no income or insufficient income to provide for a personal needs allowance, ORS will allow the parent to retain up to the amount of the personal needs allowance to send to the child for personal needs. All other current child support payments received by the child or guardian that are not subject to collection by ORS [~~shall~~]count as unearned income to the child.

([~~7~~]10) The agency counts as unearned income, the interest earned from a sales contract on either or both the lump sum and installment payments [~~is countable unearned income~~]when it is received or made available to the client.

([~~8~~]11) If the client, or the client and spouse do not live with an in-kind support donor, in-kind support and maintenance is the lesser of the value or the presumed maximum value of food or shelter received. If the client, or the client and spouse live with an in-kind support donor and do not pay a prorated share of household operating expenses, in-kind support and maintenance is the difference between the prorated share of household operating expenses and the amount the client, or the client and spouse actually pay, or the presumed maximum value, whichever is less.

~~([9) SSA reimbursements of Medicare premiums are not countable income.~~

~~(10~~]12) Payments under a contract, retroactive payments from SSI and SSA reimbursements of Medicare premiums are not considered lump sum payments.

([~~11~~]13) The agency does not count as income [~~E~~]educational loans, grants, and scholarships received from Title IV programs of the Higher Education Act or from Bureau of Indian Affairs educational programs.[~~guaranteed by the U.S. Department of Education are not countable income if the recipient is an undergraduate. Income from service learning programs is not countable income if the recipient is an undergraduate.~~] The agency does not count as income grants, scholarships, fellowships, or gifts from other sources that are actually used to pay, or will be used to pay, allowable educational expenses.[~~Deductions are allowed from countable educational income if receipt of the income depends on school attendance and if the client pays the expense.~~] Any amount of grants, scholarships, fellowships, or gifts from other sources that are used or will be used for non-educational expenses including food and shelter expenses, counts as income in the month received. Allowable [~~deductions~~]educational expenses include:

(a) tuition;
(b) fees;
(c) books;
(d) equipment;
(e) special clothing needed for classes;
(f) travel to and from school at a rate of 21 cents a mile, unless the grant identifies a larger amount;
(g) child care necessary for school attendance.

([~~12~~]14) Except for an individual eligible for the Medicaid Work Incentive Program, the following provisions apply to non-institutional medical assistance:

(a) For A, B, or D Medicaid, the agency does not count income of a spouse or a parent [~~shall not be considered in determining~~]to determine Medicaid eligibility of a person who receives SSI or meets 1619(b) criteria. SSI recipients and 1619(b) status individuals who meet all other Medicaid eligibility factors [~~shall be~~]are eligible for Medicaid without spending down.

(b) If an ineligible spouse of an aged, blind, or disabled person has more income after deductions than the allocation for a spouse, [~~that income shall be deemed to be income~~]the agency deems the spouse's income to the aged, blind, or disabled spouse to determine eligibility.

(c) The [~~Department shall~~]agency determines household size and whose income counts for A, B or D Medicaid as described below.

(i) If only one spouse is aged, blind or disabled:

(A) the agency deems income of the ineligible spouse [~~shall be deemed to be income~~]to the eligible spouse when [~~it~~]that income exceeds the allocation for a spouse. The agency compares the combined income [~~shall then be compared~~]to 100% of the federal poverty guideline for a two-person household. If the combined income exceeds that amount, the agency compares it[~~, shall be compared~~], after allowable deductions, to the BMS for two to calculate the spenddown.

(B) If the ineligible spouse's income does not exceed the allocation for a spouse, the agency does not count the ineligible spouse's income [~~shall not be counted~~]and does not include the ineligible spouse [~~shall not be included~~]in the household size. Only the eligible spouse's income [~~shall be~~]is compared to 100% of the federal poverty guideline for one. If the income exceeds that amount, it [~~shall be~~]is compared, after allowable deductions, to the BMS for one to calculate the spenddown.

(ii) If both spouses are either aged, blind or disabled, the income of both spouses is combined and compared to 100% of the federal poverty guideline for a two-person household. SSI income is not counted.

(A) If the combined income exceeds that amount, and one spouse receives SSI, only the income of the non-SSI spouse, after allowable deductions, [~~shall be~~]is compared to the BMS for a one-person household to calculate the spenddown.

(B) If neither spouse receives SSI and their combined income exceeds 100% of the federal poverty guideline, then the income of both spouses, after allowable deductions, [~~shall be~~]is compared to the BMS for a two-person household to calculate the spenddown.

(C) If neither spouse receives SSI and only one spouse will be covered under the applicable program, the agency deems income of the non-covered spouse [~~shall be deemed~~]to the covered spouse when [~~it~~]that income exceeds the spousal allocation. If the non-covered spouse's income does not exceed the spousal allocation, then the agency counts only the covered spouse's income[~~, shall be counted~~]. In both cases, the countable income [~~shall be~~]is compared to 100% of the two-person poverty guideline. If it exceeds the limit, then income, after allowable deductions, [~~shall be~~]is compared to the BMS.

(I) If the non-covered spouse has deemable income, the countable income, after allowable deductions, [~~shall be~~]is compared to a two-person BMS to calculate a spenddown.

(II) If the non-covered spouse does not have deemable income, then only the covered spouse's income, after allowable deductions, [~~shall be~~]is compared to a one-person BMS to calculate the spenddown.

(iii) In determining eligibility under (c) for an aged or disabled person whose spouse is blind, both spouses' income is combined.

(A) If the combined income after allowable deductions is under 100% of the federal poverty guideline, the aged or disabled spouse will be eligible under the 100% poverty group defined in 1902(a)(10)(A)(ii) of the Social Security Act, and the blind spouse is eligible without a spenddown under the medically needy group defined in 42 CFR 435.301.

(B) If the combined income after allowable deductions is over 100% of poverty, both spouses are eligible with a spenddown under the medically needy group defined in 42 CFR 435.301.

(iv) If one spouse is disabled and working, [~~and~~]the other is aged, blind, or disabled and not working, [~~but is~~]and neither spouse is an SSI recipient nor a 1619(b) eligible individual[~~ and is not working~~], the working disabled spouse may choose to receive coverage under the Medicaid Work Incentive program. If both spouses want coverage, however, the [~~Department shall~~]agency first determines eligibility for them as a couple. If a spenddown is owed for them as a couple, they must meet the spenddown to receive coverage for both of them.

(e) Except when determining countable income for the 100% poverty-related Aged and Disabled Medicaid programs, income will not be deemed from a spouse who meets 1619(b) protected group criteria.

(f) The [~~Department shall~~]agency determines household size and whose income counts for QMB, SLMB, and QI-1 assistance as described below.

(i) If both spouses receive Part A Medicare and both want coverage, the agency combines income of both spouses[~~shall be combined~~] and [~~compared~~]compares it to the applicable percentage of the poverty guideline for a two-person household.

(ii) If one spouse receives Part A Medicare, and the other spouse is aged, blind, or disabled and that spouse either does not receive Part A Medicare or does not want coverage, then the agency deems income of the ineligible spouse [~~shall be deemed~~]to the eligible spouse when [~~it~~]that income exceeds the allocation for a spouse. If the income of the ineligible spouse does not exceed the allocation for a spouse, then only the income of the eligible spouse [~~shall be~~]is counted. In both cases, the countable income [~~shall be~~]is compared to the applicable percentage of the federal poverty guideline for a two-person household.

(iii) If one spouse receives Part A Medicare and the other spouse is not aged, blind or disabled, the agency deems income of the ineligible spouse [~~shall be deemed~~]to the eligible spouse when [~~it~~]that income exceeds the allocation for a spouse. The combined countable income [~~shall be~~]is compared to the applicable percentage of the federal poverty guideline for a two-person household. If the ineligible spouse's deemable income does not exceed the allocation for a spouse, only the eligible spouse's income [~~shall be~~]is counted, and compared to the applicable percentage of the poverty guideline for a one-person household.

(iv) SSI income will not be counted to determine eligibility for QMB, SLMB or QI-1 assistance.

(g) If any parent in the home receives SSI or is eligible for 1619(b) protected group coverage, the agency will not count the income of [~~a~~]either parent [~~shall be considered~~]to determine a child's eligibility for B or D Medicaid.

(h) Payments for providing foster care to a child are countable income. The portion of the payment that represents a reimbursement for the expenses related to providing foster care is not countable income.

([~~13~~]15) For institutional Medicaid including home and community based waiver programs, the agency[~~Department shall only~~] counts only the client in the household size, and [~~only~~]counts only the client's income[~~,~~] and income deemed from an alien client's sponsor, to determine contribution to cost of care.

([~~14~~]16) [~~I~~]The agency does not count interest accrued on an Individual Development Account as defined in Sections 404-416 of Pub. L. No. 105-285 effective October 27, 1998[~~, shall not count as income~~].

([~~15~~]17) [~~I~~]The agency deems income, unearned and earned, [~~shall be deemed~~]from an alien's sponsor, and the sponsor's spouse, if any, when the sponsor has signed an Affidavit of Support pursuant to Section 213A of the Immigration and Nationality Act on or after December 19, 1997.

([~~16~~]18) Sponsor deeming will end when the alien becomes a naturalized U.S. citizen, or has worked 40 qualifying quarters as defined under Title II of the Social Security Act or can be credited with 40 qualifying work quarters. Beginning after December 31, 1996, a creditable qualifying work quarter is one during which the alien did not receive any federal means-tested public benefit.

([~~17~~]19) Sponsor deeming does not apply to applicants who are eligible for Medicaid for emergency services only.

([~~18~~]20) If income such as retirement income has been divided between divorced spouses by the divorce decree pursuant to a Qualified Domestic Relations Order, only the amount paid to the individual is counted as income.

R414-304-3. Medicaid Work Incentive Program Unearned Income Provisions.

(1) This rule establishes how the Department treats unearned income for the Medicaid Work Incentive program.

([~~1~~]2) The Department adopts 20 CFR 416.1102, 416.1103, 416.1120 through 416.1148, 416.1150, 416.1151, and Appendix to Subpart K of 416, [~~2002~~]2004 ed., which are incorporated by reference. The Department adopts Subsection 404(h)(4) and 1612(b)(22) of the Compilation of the Social Security Laws in effect January 1, [~~2001~~]2003. The Department [~~shall~~]does not count as income any payments from sources that [~~are prohibited under other~~]federal laws specifically prohibit from being counted as income to determine eligibility for federally-funded medical assistance programs.

([~~2~~]3) The Department [~~shall~~]allows the provisions found in R414-304-2 ([~~3~~]4) through ([~~11~~]13), and ([~~14~~]16) through ([~~18~~]20).

([~~3~~]4) The agency determines income from an ineligible spouse or parent [~~shall be determined~~]by the total of the earned and unearned income using the appropriate exclusions in 20 CFR 416.1161, except that court ordered support payments [~~would~~]are not [~~be~~]allowed as an income deduction.

([4]5) For the Medicaid Work Incentive Program, the income of a spouse or parent [~~shall not be~~]is not considered in determining eligibility of a person who receives SSI. SSI recipients who meet all other Medicaid Work Incentive Program eligibility factors [~~shall be~~]are eligible without paying a Medicaid buy-in premium.

([~~5~~]6) The [~~Department shall~~]agency determines household size and whose income counts for the Medicaid Work Incentive Program as described below:

(a) If the Medicaid Work Incentive Program individual is an adult and is not living with a spouse, the agency counts only the income of the individual. [~~Include in~~]The agency includes in the household size, any dependent children under age 18, or who are 18, 19, or 20 and are full-time students. These dependent children must be living in the home or be temporarily absent. After allowable deductions, the net income [~~shall be~~]is compared to 250% of the federal poverty guideline for the household size involved.

(b) If the Medicaid Work Incentive Program individual is living with a spouse, the agency combines their income before allowing any deductions. [~~Include in~~]The agency includes in the household size the spouse and any children under age 18, or who are 18, 19, or 20 and are full-time students. These dependent children must be living in the home or be temporarily absent. [~~C~~]The agency compares the net income of the Medicaid Work Incentive Program individual and spouse to 250% of the federal poverty guideline for the household size involved.

(c) If the Medicaid Work Incentive Program individual is a child living with a parent, the agency combines the income of the Medicaid Work Incentive Program individual and the parents before allowing any deductions. [~~Include in~~]The agency includes in the household size the parents, any minor siblings, and siblings who are age 18, 19, or 20 and are full-time students, who are living in the home or temporarily absent. [~~C~~]The agency compares the net income of the Medicaid Work Incentive Program individual and the individual's parents to 250% of the federal poverty guideline for the household size involved.

R414-304-4. Family Medicaid and Institutional Family Medicaid Unearned Income Provisions.

(1) This rule establishes how the Department treats[~~section provides eligibility criteria governing~~]unearned income [~~for the~~]to determine[~~ation of~~] eligibility for Family Medicaid and Institutional Family Medicaid coverage groups.

([~~1~~]2) The Department adopts 42 CFR 435.725, 435.726, 435.811 through 435.832, [~~2001~~]2004 ed., and 45 CFR 233.20(a)(1), 233.20(a)(3)(iv), 233.20(a)(3)(vi)(A), [~~233.20(a)(3)(xxi),~~]and 233.20(a)(4)(ii), [~~and 233.51, 2003~~]2004 ed., which are incorporated by reference. The Department adopts Subsection 404(h)(4) of the Compilation of the Social Security Laws in effect January 1, 2003, which is incorporated by reference. The Department [~~shall~~]does not count as income any payments from sources that [~~are prohibited under other~~]federal laws specifically prohibit from being counted as income to determine eligibility for federally-funded medical assistance programs.

([~~2~~]3) The [~~following definitions apply to this section:~~

~~(a) A "bona fide loan" is a loan that has been contracted in good faith without fraud or deceit and genuinely endorsed in writing for repayment.~~

~~(b) "Unearned~~]term "unearned income" means cash received for which the individual performs no service.[

~~(c) "Quarter" means any three-month period that includes January through March, April through June, July through September or October through December.~~]

([~~3~~]4) [~~Bona fide loans are not countable income~~]The agency does not count as income money loaned to the individual if the

individual proves the money is from a loan that the individual is expected to repay.

([~~4~~]5) The agency does not count as income [~~S~~]support and maintenance assistance provided in-kind by a non-profit organization certified by the Department of Human Services[~~ is not countable income~~].

([~~5~~]6) The agency does not count as income [~~T~~]the value of food stamp assistance, USDA food donations or WIC vouchers received by members of the household[~~ is not countable income~~].

[~~(6) SSI and State Supplemental Payments are income for children receiving Child, Family, Newborn, or Newborn Plus Medicaid.~~

~~(7) If rental income is unearned income, deduct $30. If the rental income is consistent with community standards, additional deductions are allowed if the client can prove greater expenses. The following expenses in excess of $30 may be allowed:~~

~~(a) taxes and attorney fees needed to make the income available;~~

~~(b) upkeep and repair costs necessary to maintain the current value of the property. This includes utility costs.~~

~~(c) only the interest can be deducted on a loan or mortgage made for upkeep or repair;~~

~~(d) if meals are provided to a boarder, the value of a one-person food stamp allotment.~~]

([~~8~~]7) The agency does not count income that is received too irregularly or infrequently to count as regular income, such as [~~C~~]cash gifts, [~~that do not exceed~~]up to $30 a calendar quarter per [~~person in the assistance unit~~]household member[~~ are not countable income~~]. Any amount that exceeds $30 a calendar quarter per household member counts as income when received. [~~A cash gift~~]Irregular or infrequent income may be divided equally among all members of the [~~assistance unit~~]household.

[~~(9) Deferred income that was not deferred by choice is countable income when it is received by the client if receipt can be reasonably anticipated. If the income was deferred by choice, count it as income when it could have been received.~~]

(8) The agency does not count as income the amount deducted from benefit income that is to repay an overpayment of such benefit income.

([~~10~~]9) The agency does not count as income the value of special circumstance items [~~is not countable income if the items are~~]paid for by donors.

([~~11~~]10) The agency does not count as income [~~H~~]home energy assistance[~~ is not countable income~~].

([~~12~~]11) The agency does[~~D o~~] not count payments from any source that are to repair or replace lost, stolen or damaged exempt property. If the payments include an amount for temporary housing, the agency only counts [~~only~~]the amount that the client does not intend to use or that is more than what is needed for temporary housing.

([~~13~~]12) The agency does not count as income SSA reimbursements of Medicare premiums[~~ are not countable income~~].

[~~(14) Payments from trust funds are countable income in the month the payment is received or made available to the individual.~~]

([~~15~~]13) The agency does not count as income [~~P~~]payments from the Department of Workforce Services under the Family Employment program, the Working Toward Employment Program, and the Refugee Cash Assistance program[~~ are not countable income~~]. To determine eligibility for Medicaid, the agency counts [~~I~~]income used to determine the amount of these payments[~~ is counted to determine eligibility for Medicaid~~], unless the income is an excluded income under other laws or regulations.

[~~(16) Only the portion of a Veteran's Administration check to which the client is legally entitled is countable income.~~

~~(17) If the entitlement amount of a benefit differs from the payment, the full entitlement amount is counted as income unless the amount being withheld from the entitlement is due to an overpayment of such benefits, in which case the entitlement less the amount withheld to repay the overpayment is counted. If deductions are being withheld that are purely voluntary, or are to repay a debt or meet a legal obligation other than an overpayment of the benefit, the full entitlement is counted as income.~~

~~(18) Deposits to joint checking or savings accounts are countable income, even if the deposits are made by a non-household member. Clients who dispute ownership of deposits to joint checking or savings accounts shall be given an opportunity to prove that the deposits do not represent income to them. Funds that are successfully disputed are not countable income.~~

~~(19) Income, unearned and earned, is deemed from an alien's sponsor, and the sponsor's spouse, if any, when the sponsor has signed an Affidavit of Support pursuant to Section 213A of the Immigration and Nationality Act on or after December 19, 1997.~~

~~(20) Sponsor deeming ends when the alien becomes a naturalized U.S. citizen, or has worked 40 qualifying quarters as defined under Title II of the Social Security Act or can be credited with 40 qualifying work quarters. Beginning after December 31, 1996, a creditable qualifying work quarter is one during which the alien did not receive any federal means-tested public benefit.~~

~~(21) Sponsor deeming does not apply to applicants who are eligible for Medicaid for emergency services only.~~

~~(22) The interest earned from a sales contract on either or both the lump sum and installment payments is countable unearned income when it is received or made available to the client.~~]

([~~23~~]14) The agency does not count as income the [~~I~~]interest accrued on an Individual Development Account as defined in 42 U.S.C. 604(h)[~~ does not count as income~~].

(15) The agency does not count as income interest or dividends earned on countable resources. The agency does not count as income interest or dividends earned on resources that are specifically excluded by federal laws from being counted as available resources to determine eligibility for federally-funded, means-tested medical assistance programs, other than resources excluded by 42 U.S.C. 1382b(a).

(16) The agency does not count as income the increase in pay for a member of the armed forces that is called "hostile fire pay" or "imminent danger pay," which is compensation for active military duty in a combat zone.

(17) The agency counts as income SSI and State Supplemental payments received by children who are included in the coverage under Child, Family, Newborn, or Newborn Plus Medicaid.

(18) The agency counts unearned rental income. The agency deducts $30 a month from the rental income. If the amount charged for the rental is consistent with community standards, the agency deducts the greater of either $30 or the following actual expenses that the client can verify.

(a) taxes and attorney fees needed to make the income available;

(b) upkeep and repair costs necessary to maintain the current value of the property, including utility costs paid by the applicant or recipient;

(c) interest paid on a loan or mortgage made for upkeep or repair; and,

(d) the value of a one-person food stamp allotment, if meals are provided to a boarder.

(19) The agency counts deferred income when it is received by the client if it was not deferred by choice and receipt can be reasonably anticipated. If the income was deferred by choice, it counts as income when it could have been received. The amount deducted from income to pay for benefits like health insurance, medical expenses or child care counts as income in the month the income could have been received.

(20) The agency counts the amount deducted from income that is to pay an obligation such as child support, alimony or debts in the month the income could have been received.

(21) The agency counts payments from trust funds as income in the month the payment is received by the individual or made available for the individual's use.

(22) The agency only counts as income the portion of a Veterans Administration check to which the client is legally entitled. If the payment includes an amount for a dependent, that amount counts as income for the dependent. If the dependent does not live with the veteran or surviving spouse, the portion for the dependent counts as the dependent's income unless the dependent has applied to VA to receive the payment directly, VA has denied that request, and the dependent does not receive the payment. In this case, the amount for a dependent counts as income of the veteran or surviving spouse who receives the payment.

(23) The agency counts as income deposits to financial accounts jointly owned between the client and one or more other individuals, even if the deposits are made by a non-household member. If the client disputes ownership of the deposits and provides adequate proof that the deposits do not represent income to the client, the agency does not count those funds as income. The agency may require the client to terminate access to the jointly held accounts.

(24) The agency counts as unearned income the interest earned from a sales contract on lump sum payments and installment payments when the interest payment is received by or made available to the client.

([~~24~~]25) The agency counts [~~C~~]current child support payments [~~are countable~~]as income to the child for whom the payments are being made. If a payment is for more than one child, the amount is divided equally among the children unless a court order indicates a different division. Child support payments made for past months or years (arrearages) are countable income to determine eligibility of the parent or guardian who is receiving the payment. Arrearages are payments collected for past months or years that were not paid on time and are like repayments for past-due debts. If [~~ORS~~]the Office of Recovery Services is collecting [~~the~~]current child support, it is counted as current even if [~~it is mailed late by ORS~~]the Office of Recovery Services mails the payment to the client after the month it is collected.[~~Arrearages are payments collected for past months or years that were not paid on time and are like repayments for past-due debts. ORS may be collecting both current child support and arrearages.~~]

([~~25~~]26) The agency counts [~~P~~]payments from annuities [~~count~~]as unearned income in the month the payment is received.

([~~26~~]27) If income such as retirement income has been divided between divorced spouses by the divorce decree pursuant to a Qualified Domestic Relations Order, the agency only counts [~~only~~]the amount paid to the individual.

(28) The agency deems both unearned and earned income from an alien's sponsor, and the sponsor's spouse, if any, when the sponsor has signed an Affidavit of Support pursuant to Section 213A of the Immigration and Nationality Act on or after December 19, 1997.

(29) The agency stops deeming income from a sponsor when the alien becomes a naturalized U.S. citizen, or has worked 40 qualifying quarters as defined under Title II of the Social Security Act or can be credited with 40 qualifying work quarters. Beginning after December 31, 1996, a creditable qualifying work quarter is one during which the alien did not receive any federal means-tested public benefit.

(30) Sponsor deeming does not apply to applicants who are eligible for Medicaid for emergency services only.

KEY: financial disclosures, income, budgeting
[~~October 16, 2004~~]2005
Notice of Continuation January 31, 2003
26-18-1

Health, Health Care Financing, Coverage and Reimbursement Policy
R414-305-2
Family Medicaid and Family Institutional Medicaid Resource Provisions

NOTICE OF PROPOSED RULE
(Amendment)
DAR FILE NO.: 27879
FILED: 05/11/2005, 14:00

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: This rulemaking is necessary to add some resource exclusions for Family Medicaid programs to coordinate with changes made for Aged, Blind and Disabled Medicaid programs. Various subsections have been reworded to make them easier to understand.

SUMMARY OF THE RULE OR CHANGE: Some citations have been modified to be more specific, to correct errors and to remove unneeded citations. Various subsections have been reworded for clarity and to make them easier to understand. Subsection R414-305-2(4) adds a specification and reference to another rule about the resource test for poverty level pregnant women. Subsection R414-305-2(8) has been rewritten to clarify that assets of an applicant or recipient that are controlled or managed by another person, even under an informal arrangement, are still treated as assets of that applicant or recipient. Subsection R414-305-2(9) is a clarification about legal impediments to making a resource available. Subsection R414-305-2(11) is a clarification about when household items of high value will be counted. Subsection R414-305-2(12) is an addition about excluding one wedding and engagement ring. Subsection R414-305-2(19) is being changed to extend the exclusion period to nine months for retroactive Social Security and Railroad Retirement funds.

Subsection R414-305-2(20) is a clarification about counting as income any excluded funds held for burial that are used for another purpose. Subsection R414-305-2(27) is a new resource exclusion for funds an individual receives from the Earned Income Tax credit or the Child Tax credit. Such funds will be excluded from resources for nine months.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Title 26, Chapter 18

THIS RULE OR CHANGE INCORPORATES BY REFERENCE THE FOLLOWING MATERIAL: 45 CFR 233.20(a)(3)(i)(B)(1), (2), (3), (4), and (6); 233.20(a)(3)(iv)(A); Section 1917(d) and (e), 404(h) and 1613(a)(13) of the Compilation of the Social Security Laws, in effect January 1, 2003

ANTICIPATED COST OR SAVINGS TO:

❖ THE STATE BUDGET: There should be no cost or savings because of this amendment. This change will allow current eligibles to remain eligible if the amount of Earned Income Tax credit or Child Tax credit happens to exceed the resource limit, by giving them additional time to use the tax credits. It also just extends the exclusion period for retroactive Social Security or Railroad Retirement.

❖ LOCAL GOVERNMENTS: No cost or savings--This does not impact local government as it applies only to eligibility criteria for individuals.

❖ OTHER PERSONS: No cost or savings--This does not take away any benefits or add any costs. There are no compliance costs for affected persons because this does not make eligibility requirements more restrictive nor does it take away any benefits.

COMPLIANCE COSTS FOR AFFECTED PERSONS: There are no compliance costs for affected persons because this does not make eligibility requirements more restrictive nor does it take away any benefits.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: These rule changes add clarity to the rule and maintain the status quo for eligibility in these programs. No fiscal impact is anticipated. A. Richard Melton, Acting Executive Director

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

HEALTH
HEALTH CARE FINANCING,
COVERAGE AND REIMBURSEMENT POLICY
CANNON HEALTH BLDG
288 N 1460 W
SALT LAKE CITY UT 84116-3231, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:

Craig Devashrayee at the above address, by phone at 801-538-6641, by FAX at 801-538-6099, or by Internet E-mail at cdevashrayee@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 07/01/2005.

THIS RULE MAY BECOME EFFECTIVE ON: 07/02/2005

AUTHORIZED BY: Richard Melton, Deputy Director

R414. Health, Health Care Financing, Coverage and Reimbursement Policy.
R414-305. Resources.
R414-305-2. Family Medicaid and Family Institutional Medicaid Resource Provisions.

(1) This section establishes the rules for treatment of resources to determine eligibility for Family Medicaid and Family Institutional Medicaid programs.

([~~1~~]2) The Department adopts 45 CFR [~~206.10(a)(vii),~~]233.20(a)(3)(i)(B)(1), (2), (3), (4) and (6), and 233.20(a)(3)(vi)(A), [~~and 233.51(b)(2), 2001~~]2004 ed., which are incorporated by reference. The Department adopts Subsection 1902(k) of the Compilation of the Social Security Laws, 1993 ed., which is incorporated by reference. The Department adopts 1917(d) and (e), Subsection 404(h) and 1613(a)(13) of the Compilation of the Social Security Laws in effect January 1, [~~1999~~]2003, which are incorporated by reference. The Department [~~shall~~]does not count as an available resource [~~any assets that are prohibited under other~~]retained funds from sources that federal laws specifically prohibit from being counted as a resource to determine eligibility for federally-funded medical assistance programs.

([~~2~~]3) A resource is available when the client owns it or has the legal right to sell or dispose of the resource for the client's own benefit.

([~~3~~]4) Except for pregnant women who meet the criteria under Sections 1902(a)(10)(A)(i)(IV) and 1902(a)(10)(A)(ii)(IX) of the Social Security Act in effect January 1, 2003, [~~T~~]the resource limit is $2,000 for a one person household, $3,000 for a two [~~member~~]person household and $25 for each additional household member. For pregnant women defined above, the resource limit is defined in R414-303-11.

([4]5) Except for the exclusion for a vehicle, the agency uses the same methodology for treatment of resources [~~is the same~~]for all medically needy and categorically needy individuals.

([~~5~~]6) To determine countable resources for Medicaid eligibility, the agency considers [~~is based on~~]all available resources owned by the client. The agency does not consider a resource unavailable [~~Eligibility cannot be granted~~]based upon the client's intent to or action of disposing of non-liquid resources.

([~~6~~]7) The agency counts resources of a sanctioned household member[~~ are counted~~].

([~~7~~]8) [~~The resources of a ward that are controlled by a legal guardian are counted as the ward's resources.~~]If a legal guardian, conservator, authorized representative, or other responsible person controls any resources of an applicant or recipient, the agency counts the resources as the applicant's or recipient's. The arrangement may be formal or informal.

([~~8~~]9) If a resource is potentially available, but a legal impediment to making it available exists, [~~it is not countable~~]the agency does not count the resource until it can be made available. Before an applicant can be made eligible, or to continue eligibility for a recipient, [~~T~~]the applicant or recipient must take appropriate steps to make the resource available unless one of the following conditions exist:

(a) Reasonable action would not be successful in making the resource available.

(b) The probable cost of making the resource available exceeds its value.

([~~9~~]10) Except for determining countable resources for 1931 Family Medicaid, the agency excludes a maximum [~~exemption for the equity~~]of [~~one car is~~]$1,500 in equity value of one vehicle.

([~~10~~]11) The agency does not count as resources the value of [~~Maintenance items~~]household goods and personal belongings that are essential for day-to-day living[~~ are not countable resources~~]. Any single household good or personal belonging with a value that exceeds $1000 must be counted toward the resource limit. The agency does not count as a resource the value of any item that a household member needs because of the household member's medical or physical condition.

(12) The agency does not count the value of one wedding ring and one engagement ring as a resource.

([~~11~~]13) The agency does not count the value of a life[~~Life~~] estate[~~s are not countable~~] as an available resource[~~s~~] if the life estate is the applicant's or recipient's principal residence[~~ of the applicant or recipient~~]. If the life estate is not the principal residence, [~~see~~]the rule in Subsection R414-305-1(25) applies.

([~~12~~]14) The agency does not count the resources of a[~~an ineligible~~] child [~~are not counted~~]who is not counted in the household size to determine eligibility of other household members.

([~~13~~]15) The agency does not count as a resource, the value of the lot on which the excluded home stands [~~is not counted~~]if the lot does not exceed the average size of residential lots for the community in which it is located. The agency counts as a resource the value of the property in excess of an average size lot[~~ is a countable resource~~].

([~~14~~]16) [~~W~~]The agency does not count as a resource the value of water rights attached to an excluded home and lot[~~ are not counted~~].

([~~15~~]17) [~~A~~]The agency does not count any resource, or interest from a resource held within the rules of the Uniform Transfers to Minors Act[~~ is not countable~~]. [~~A~~]The agency counts as a resource any money from such a resource that is given to the child as unearned income and retained beyond the month received[~~ is countable~~].

([~~16~~]18) Lump sum payments received on a sales contract for the sale of an exempt home are not counted if the entire proceeds are committed to replacement of the property sold within 30 days and the purchase is completed within 90 days. The individual shall receive one extension of 90 days, if more than 90 days is needed to complete the actual purchase. Proceeds [~~is~~]are defined as all payments made on the principal of the contract. Proceeds [~~does~~]do not include interest earned on the principal.

([~~17~~]19) Retroactive benefits received from the Social Security Administration and the Railroad Retirement Board are not counted as a resource for the first [~~6~~]9 months after receipt.

([~~18~~]20) The agency excludes from resources, a [~~A $1,500~~]burial and funeral fund or funeral arrangement up to $1500[~~exemption is allowed~~] for each [~~eligible~~]household member who is counted in the household size. Burial and funeral agreements include burial trusts, funeral plans, and funds set aside expressly for the purposes of burial. All such funds must be separated from non-burial funds and clearly designated as burial funds. Interest earned on exempt burial funds and left to accumulate does not count as a resource. If exempt burial funds are used for some other purpose, remaining funds will be counted as an available resource as of the date funds are withdrawn.

([~~19~~]21) Assets shall be deemed from an alien's sponsor, and the sponsor's spouse, if any, when the sponsor has signed an Affidavit of Support pursuant to Section 213A of the Immigration and Nationality Act on or after December 19, 1997. Sponsor deeming will end when the alien becomes a naturalized U.S. citizen, or has worked 40 qualifying quarters as defined under Title II of the Social Security Act or can be credited with 40 qualifying work quarters. Beginning after December 31, 1996, a creditable qualifying work quarter is one during which the alien did not receive any federal means-tested public benefit.

([~~20~~]22) Sponsor deeming does not apply to applicants who are eligible for Medicaid for emergency services only.

([~~21~~]23) Business resources required for employment or self employment are not counted.

([~~22~~]24) For 1931 Family Medicaid households, the [~~state shall either disregard~~]agency will not count as a resource either the equity value of one vehicle that meets the definition of a "passenger vehicle" as defined in 26-18-2(6), or $1,500 of the equity of one vehicle, whichever provides the greatest disregard for the household.

([~~23~~]25) For eligibility under Family-related Medicaid programs, the agency will not count as a resource retirement funds held in an employer or union pension plan, retirement plan or account including 401(k) plans and Individual Retirement Accounts of a disabled parent or disabled spouse who is not included in the coverage[~~ shall be excluded from countable resources~~].

([~~24~~]26) The [~~Department shall exclude from~~]agency will not count as a resource[~~s~~] the contributions made by an individual and the interest accrued on funds held in an Individual Development account as defined in Sections 404-416 of Pub. L. No. 105-285, effective October 27, 1998.

(27) The agency will not count as a resource, funds received from the Child Tax credit or the Earned Income Tax credit for nine months following the month received. Any remaining funds will count as a resource in the 10th month after being received.

KEY: Medicaid
[~~May 7, 2004~~]2005
Notice of Continuation January 31, 2003
26-18

Health, Health Care Financing, Coverage and Reimbursement Policy

R414-309

Medicare Drug Benefit Low-Income Subsidy Determination

NOTICE OF PROPOSED RULE
(New Rule)
DAR FILE NO.: 27901
FILED: 05/13/2005, 16:00

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: This rulemaking is needed to put into place the requirements for the Department of Health to have Medicare Part D Drug Benefit Low-Income Subsidy applications available for individuals to access, and if required, to determine eligibility for the Medicare Part D Drug Benefit Low-Income Subsidies.

SUMMARY OF THE RULE OR CHANGE: This rule establishes that the Department of Health will make applications available at Medicaid offices for individuals who want to apply through Social Security Administration (SSA) for the Medicare Part D Drug Benefit Low-Income Subsidies, and will also complete a determination of eligibility for the Low-Income Subsidies, as required, in accordance with the federal regulations.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Title 26, Chapter 18

ANTICIPATED COST OR SAVINGS TO:
❖ THE STATE BUDGET: The state anticipates only minimal costs, which the Department will absorb, to provide SSA applications, to direct people to mail the applications to SSA, and if necessary, help complete applications for the Medicare Part D low-income subsidy. Other agencies should experience only minimal costs in providing the SSA applications to individuals who inquire about the low-income subsidy.
❖ LOCAL GOVERNMENTS: Local governments are not affected by this rulemaking as this only affects individuals with Medicare.
❖ OTHER PERSONS: This does not affect other persons because it does not impose any costs or fees on others.

COMPLIANCE COSTS FOR AFFECTED PERSONS: There is no compliance cost for affected persons. They will not be charged for applications or assistance in completing applications for the Medicare Part D low-income subsidy.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: This rule facilitates Medicare beneficiaries obtaining lower cost prescription drugs and should have a positive fiscal impact on Utah residents and businesses. A. Richard Melton, Acting Executive Director

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
HEALTH
HEALTH CARE FINANCING,
COVERAGE AND REIMBURSEMENT POLICY
CANNON HEALTH BLDG
288 N 1460 W
SALT LAKE CITY UT 84116-3231, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
Ross Martin at the above address, by phone at 801-538-6592, by FAX at 801-538-6099, or by Internet E-mail at rmartin@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 07/01/2005.

THIS RULE MAY BECOME EFFECTIVE ON: 07/02/2005

AUTHORIZED BY: Richard Melton, Deputy Director

R414. Health, Health Care Financing, Coverage and Reimbursement Policy.
R414-309. Medicare Drug Benefit Low-Income Subsidy Determination.
R414-309-1. Authority and Purpose.
(1) This rule is authorized by Title 26, Chapter18, UCA.
(2) The Medicare Modernization Act requires the state to have the ability, upon request, to determine eligibility for the Medicare drug benefit low-income subsidies as set forth in 42 CFR 423.904. This rule sets forth the requirements for completing eligibility determinations for the Medicare Part D low-income subsidies.

R414-309-2. General Provisions.
(1) The Utah Department of Health shall make Medicare Part D Subsidy applications from the Social Security Administration available at State Medical Assistance Offices to individuals who want to apply for the Medicare drug benefit low-income subsidies, and may help individuals complete and send the form to the Social Security Administration.
(2) The Department shall apply the eligibility criteria for the Medicare drug benefit low-income subsidy programs as defined in 42 CFR 423.904 in making any determinations that the state is required to make and shall notify the applicant of that decision.
(3) If the Department determines that an applicant is not eligible for a Medicare drug benefit low-income subsidy, the applicant may appeal the Department's decision pursuant to the provisions of R410-14.
(4) As required by 42 CFR 423.904, the Department exchanges information on Medicare Part D subsidy applicants and eligible individuals with the Centers for Medicare and Medicaid Services and with the Social Security Administration.

KEY: Medicaid, eligibility
2005
26-18

▼ ▼

Health, Health Systems Improvement, Licensing
R432-150
Nursing Care Facility

NOTICE OF PROPOSED RULE
(Amendment)
DAR FILE NO.: 27884
FILED: 05/13/2005, 09:56

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: Under new federal regulations, nursing homes will be able to hire trained "single task" feeding assistants to help residents who have no complicated feeding problems but need assistance in eating and drinking. The regulations require the feeding assistants to function under nurse supervision and set minimum requirements for a state-approved training course of at least eight hours, but allow states to require additional training. The Center for Medicare and Medicaid Services (CMS) published the final rule on September 26, 2003 which became effective October 27, 2003.

SUMMARY OF THE RULE OR CHANGE: Under the new regulations, CMS requires feeding assistants to successfully complete a state-approved training course that meets the following minimum federal requirements. The rule adds requirements for facilities who wish to utilize dining assistants in their programs. The rule includes proper assessment of patients, specific duties of dining assistants, training requirements to become a dining assistant, credentials of trainers, and Department authority in approving and suspending dining assistant training programs. The minimum requirements are eight hours of training covering relevant items from the nurse aide training curriculum: 1) feeding techniques; 2) assistance with feeding and hydration; 3) communication and interpersonal skills; 4) appropriate responses to residents behavior; 5) safety and emergency procedures including the Heimlich maneuver; 6) infection control; 7) resident rights; and 8) recognizing resident changes inconsistent with their normal behavior and the importance of reporting those changes to the supervising nurse (42 CFR 483.35(h)(3)).

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Title 26, Chapter 21

ANTICIPATED COST OR SAVINGS TO:
❖ THE STATE BUDGET: Costs to the state budget are expected to be minimal. The Department will be responsible for reviewing training proposals for providers. Estimated staff time costs for approval of training courses will be $500 per year for the first year and declining to $100 per year after that.
❖ LOCAL GOVERNMENTS: There are no anticipated costs to local governments. This rule has no effect on local ordinances.
❖ OTHER PERSONS: There are no anticipated costs to other persons. Nursing homes are not required to use dining assistants. Those that do may experience some savings but the amount of the savings are variable, depending on the number of dining assistants employed by nursing homes.

COMPLIANCE COSTS FOR AFFECTED PERSONS: There are no anticipated costs to affected persons. Nursing homes are not required to use dining assistants. Those that do may experience some savings but the amount of the savings are variable, depending on the number of dining assistants employed by nursing homes.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: Participation in this optional method of assisting residents with meal may have some initial costs, but facilities should experience long-term savings. Overall the fiscal impact should be positive. A. Richard Melton, Acting Executive Director

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
HEALTH
HEALTH SYSTEMS IMPROVEMENT, LICENSING
CANNON HEALTH BLDG
288 N 1460 W
SALT LAKE CITY UT 84116-3231, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
Joel Hoffman at the above address, by phone at 801-538-6165, by FAX at 801-538-6163, or by Internet E-mail at jhoffman@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 07/01/2005.

THIS RULE MAY BECOME EFFECTIVE ON: 07/02/2005

AUTHORIZED BY: David N. Sundwall, Executive Director

R432. Health, Health Systems Improvement, Licensing.
R432-150. Nursing Care Facility.
R432-150-4. Definitions.

(1) The definitions found in R432-1-3 apply to this rule.

(2) The following definitions apply to nursing care facilities.

(a) "Skilled Nursing Care" means a level of care that provides 24 hour inpatient care to residents who need licensed nursing supervision. The complexity of the prescribed services must be performed by or under the close supervision of licensed health care personnel.

(b) "Intermediate Care" means a level of care that provides 24-hour inpatient care to residents who need licensed supervision and supportive care, but do not require continuous nursing care.

(c) "Medically-related Social Services" means assistance provided by the facility licensed social worker to maintain or improve each resident's ability to control everyday physical, mental and psycho-social needs.

(d) "Nurse's Aide" means any individual, other than an individual licensed in another category, providing nursing or nurse related services to residents in a facility. This definition does not include an individual who volunteers to provide such services without pay.

(e) "Unnecessary Drug" means any drug when used in excessive dose, for excessive duration, without adequate monitoring, without adequate indications for its use, in the presence of adverse consequences which indicate the dose should be reduced or discontinued, or any combinations of these reasons.

(f) "Chemical Restraint" means any medication administered to a resident to control or restrict the resident's physical, emotional,

or behavioral functioning for the convenience of staff, for punishment or discipline, or as a substitute for direct resident care.

(g) "Physical Restraint" means any physical method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the resident cannot remove easily which restricts the resident's freedom of movement or normal access to his own body.

(h) "Significant Change" means a major change in a resident's status that impacts on more than one area of the resident's health status.

(i) "Therapeutic Leave" means leave pertaining to medical treatment planned and implemented to attain an objective that is specified in the individual plan of care.

(j) "Licensed Practitioner" means a health care practitioner whose license allows assessment, treatment, or prescribing practices within the scope of the license and established protocols.

(k) "Governing Body" means the board of trustees, owner, person or persons designated by the owner with the legal authority and ultimate responsibility for the management, control, conduct and functioning of the health care facility or agency.

(l) "Nursing Staff" means nurses aides that are in the process of becoming certified, certified nurses aides, and those individuals that are licensed (e.g. licensed practical nurses and registered nurses) to provide nursing care in the State of Utah.

(m) "Licensed Practical Nurse" as defined in the Nurse Practice Act, Title 58, Chapter 31, Section 2(11).

(n) "Registered Nurse" as defined in the Nurse Practice Act, Title 58, Chapter 31, Section 2(12).

(o) "Palatable" means food that has a pleasant and agreeable taste and is acceptable to eat.

(p) "Dining Assistant" means an individual unrelated to a resident or patient who meets the training requirements defined in this rule to assist nursing care residents with eating and drinking.

R432-150-24. Food Services.

(1) The facility must provide each resident with a safe, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident.

(2) There must be adequate staff employed by the facility to meet the dietary needs of the residents.

(a) The facility must employ a dietitian either full-time, part-time, or on a consultant basis.

(b) The dietitian must be certified in accordance with Title 58, Chapter 49, Dietitian Certification Act.

(c) If a dietitian is not employed full-time, the administrator must designate a full-time person to serve as the dietetic supervisor.

(d) If the dietetic supervisor is not a certified dietitian, the facility must document at least monthly consulation by a certified dietitian according to the needs of the residents.

(e) The dietetic supervisor shall be available when the consulting dietitian visits the facility.

(3) The facility must develop menus that meet the nutritional needs of residents to the extent medically possible.

(a) Menus shall be:

(i) prepared in advance;

(ii) followed;

(iii) different each day;

(iv) posted for each day of the week;

(v) approved and signed by a certified dietician and;

(vi) cycled no less than every three weeks.

(b) The facility must retain documentation for at least three months of all served substitutions to the menu.

(4) The facility must make available for Department review all food sanitation inspection reports of State or local health department inspections.

(5) The attending physician must prescribe in writing all therapeutic diets.

(6) There must be no more than a 14-hour interval between the evening meal and breakfast, unless a substantial snack is served in the evening.

(7) The facility must provide special eating equipment and assistive devices for residents who need them.

(8) The facility's food service must comply with the Utah Department of Health Food Service Sanitation Regulations R392-100.

(9) The facility must maintain a one-week supply of nonperishable staple foods and a three-day supply of perishable foods to complete the established menu for three meals per day, per resident.

(10) A nursing care facility may use trained dining assistants to aid residents in eating and drinking if:

(a) a licensed practical nurse-geriatric care manager, registered nurse , advance practice registered nurse, speech pathologist, occupational therapist, or dietitian has assessed that the resident does not have complicated feeding problems, such as recurrent lung aspirations, behaviors which interfere with eating, difficulty swallowing, or tube or parenteral feeding; and

(b) The service plan or plan of care documents that the resident needs assistance with eating and drinking and defines who is qualified to offer the assistance.

(11) If the nursing care facility uses a dining assistant, the facility must assure that the dining assistant:

(a) has completed a training course from a Department-approved training program;

(b) has completed a background screening pursuant to R432-35; and

(c) performs duties only for those residents who do not have complicated feeding problems.

(12) A long-term care facility, employee organization, person, governmental entity, or private organization must submit the following to the Department to become Department-approved training program:

(a) a copy of the curriculum to be implemented that meets the requirements of subsection (13); and

(b) the names and credentials of the trainers.

(13) The training course for the dining assistant shall provide eight hours of instruction and one hour of observation by the trainer to ensure competency. The course shall include the following topics:

(a) feeding techniques;

(b) assistance with eating and drinking;

(c) communication and interpersonal skills;

(d) safety and emergency procedures including the Heimlich manuever;

(e) infection control;

(f) resident rights;

(g) recognizing resident changes inconsistent with their normal behavior and the importance in reporting those changes to the supervisory nurse;

(h) special diets;

(i) documentation of type and amount of food and hydration intake;
(j) appropriate response to resident behaviors, and
(k) use of adaptive equipment.
(14) The training program shall issue a certificate of completion and maintain a list of the dining assistants. The certifcate shall include the training program provider and provider's telephone number at which a long-term care facility may verify the training, and the dining assistant's name and address.
(15) To provide dining assistant training in a Department-approved program, a trainer must hold a current valid license to practice as:
(a) a registered nurse, advanced practice registered nurse or licensed practical nurse-geriatric care manager pursuant to Title 58, Chapter 31b;
(b) a registered dietitian, pursuant to Title 58, Chapter 49 ;
(c) a speech-language pathologist, pursuant to Title 58, Chapter 41; or
(d) an occupational therapist, pursuant to Title 58, Chapter 42a .
(16) The Department may suspend a training program if the program's courses do not meet the requirements of this rule.
(17) The Department may suspend a training program operated by a nursing care facility if:
(a) a federal or state survey reveals failure to comply with federal regulations or state rules regarding feeding or dining assistant programs;
(b) the facility fails to provide sufficient, competent staff to respond to emergencies;
(c) the Department sanctions the facility for any reason; or
(d) the Department determines that the facility is in continuous or chronic non-compliance under state rule or that the facility has provided sub-standard quality of care under federal regulation.

KEY: health facilities
[~~November 10, 2004~~]2005
Notice of Continuation October 9, 2002
26-21-5
26-21-16

▼ ▼

Human Resource Management, Administration
R477-2
Administration

NOTICE OF PROPOSED RULE
(Amendment)
DAR FILE NO.: 27885
FILED: 05/13/2005, 11:28

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: Amendments to this rule clarify procedures for filing a discrimination complaint for employees and for the retention of personnel records for human resource professionals and make nonsubstantive changes.

SUMMARY OF THE RULE OR CHANGE: In Subsection R477-2-3(3), the amendments bring the rule more explicitly in line with long standing procedures and options for an employee to file a discrimination claim with the agency head, the Utah Anti-discrimination and Labor Division, or directly with the Equal Employment Opportunity Commission (EEOC). In Subsection R477-2-5(6), this amendment brings rule in line with requirements of the State Record Center for the retention of official records. The retention schedule for these records is more appropriately set by the Department of Human Resource Management (DHRM) under authority of the Government Records Access and Management Act (Subsection 63-2-903(4)), than in rule.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Subsection 63-2-903(4), and Sections 67-19-6 and 67-19-18

ANTICIPATED COST OR SAVINGS TO:
❖ THE STATE BUDGET: Impact on the state budget will be neutral with these amendments. These are just clarifications that will not force agencies to change long standing procedures for dealing with discrimination complaints or records retention.
❖ LOCAL GOVERNMENTS: This rule is only binding on agencies of the executive branch of state government and does not affect local governments.
❖ OTHER PERSONS: This rule is only binding on agencies of the executive branch of state government and does not affect other persons.

COMPLIANCE COSTS FOR AFFECTED PERSONS: No additional resources will be required to comply with this rule amendment. Agencies already have long standing procedures for handling discrimination complaints and records retention issues.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: Rules published by DHRM have no direct effect on businesses or any entity outside state government. DHRM has authority to write rules only to the extent allowed by the Utah Personnel Management Act, Title 67, Chapter 19. Section 67-19-15 limits the provisions of career service and these rules to employees of the executive branch of state government. The only possible impact may be a very slight, indirect effect if an agency passes costs or saving on to businesses through fees. However, no such costs or savings will accrue with this amendment. Jeff Herring, Executive Director

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
HUMAN RESOURCE MANAGEMENT
ADMINISTRATION
Room 2120 STATE OFFICE BLDG
450 N MAIN ST
SALT LAKE CITY UT 84114-1201, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
May Vang or Conroy Whipple at the above address, by phone at 801-537-3081 or 801-538-3067, by FAX at 801-538-3377 or

801-538-3081, or by Internet E-mail at mvang@utah.gov or cwhipple@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 07/01/2005.

THIS RULE MAY BECOME EFFECTIVE ON: 07/02/2005

AUTHORIZED BY: Jeff Herring, Executive Director

R477. Human Resource Management, Administration.
R477-2. Administration.
R477-2-3. Fair Employment Practice.

All state personnel actions must provide equal employment opportunity for all individuals.

(1) Employment actions including appointment, tenure or term, condition or privilege of employment shall be based on the ability to perform the essential duties, functions, and responsibilities assigned to a particular position.

(2) Employment actions shall not be based on race, religion, national origin, color, sex, age, disability, protected activity under the anti-discrimination statutes, political affiliation, military status or affiliation or any other non-job related factor, nor shall any person be subjected to unlawful harassment by a state employee.

(3) [~~Any~~]An employee who alleges [~~that they have been illegally discriminated against,~~]illegal discrimination may submit a claim to the agency head.

(a) [~~If the employee does not agree with the decision of the agency head, the employee may file a complaint with the Utah Anti-Discrimination and Labor Division.~~

~~(b) If the employee does not agree with the decision of the agency head, the employee may also file a complaint with the Equal Employment Opportunity Commission.~~]The employee may file a charge with the Utah Anti-Discrimination and Labor Division within 180 days of the alleged harm, or directly with the EEOC within 300 days of the alleged harm.

([~~e~~]b) No state official shall impede any employee from the timely filing of a discrimination complaint in accordance with state and federal requirements.

R477-2-5. Records.

(1) DHRM shall maintain a computerized file for each employee that contains the following, as appropriate:

(a) performance ratings;

(b) records of actions affecting employee salary, current classification, title and salary range, salary history, and other personal data, status or standing.

(2) Agencies shall maintain the following records in each employee's personnel file:

(a) applications for employment, Employment Eligibility Certification record, Form I-9, and other documents required by Immigration and Naturalization Service (INS) Regulations, under the Immigration Reform and Control Act of 1986, employee signed overtime agreement, personnel action records, notices of corrective or disciplinary actions, new employee orientation form, performance evaluation records, separation and leave without pay records, including employee benefits notification forms for PEHP and URS;

(b) references to or copies of transcripts of academic, professional, or training certification or preparation;

(c) copies of items recorded in the DHRM computerized file and other materials required by agency management to be placed in the personnel file. The agency personnel file shall be considered a supplement to the DHRM computerized file and shall be subject to the rules governing personnel files;

(d) leave and time records; and

(e) [~~Copies~~]copies of any documents affecting the employee's conduct, status or salary. The agency shall inform employees of any changes in their records based on conduct, status or salary no later than when changes are entered into the file.

(3) Agencies shall maintain a separate file from the personnel file if the agency obtains confidential employee medical information.

(a) Information in this file shall include all written and orally obtained information pertaining to medical issues, including Family Medical and Leave Act forms, medical and dental enrollment forms which contain health related information, health statements, applications for additional life insurance, fitness for duty evaluations, drug testing results, and any other medical information.

(b) Information in this file is considered private or controlled information. Communication shall adhere to the Government Records Access and Management Act, Section 63-2-101.

(c) An employee who violates confidentiality is subject to state disciplinary procedures.

(4) An employee has the right to review the employee's personnel file, upon request, in DHRM or the agency, as governed by law and as provided through agency policy.

(a) An employee may correct, amend, or challenge any information in the DHRM computerized or agency personnel file, through the following process:

(i) The employee shall request in writing that changes occur.

(ii) The employing agency shall be given an opportunity to respond.

(iii) Disputes over information that are not resolved between the employing agency and the employee[~~,~~] shall be decided in writing by the Executive Director, DHRM. DHRM shall maintain a record of the employee's letter[~~,~~], the agency's response[~~,~~], and the DHRM Executive Director's decision.

(5) When a disciplinary action is rescinded or disapproved upon appeal, forms, documents and records pertaining to the case shall be removed from the personnel file.

(a) When the record in question is on microfilm, a seal will be placed on the record and a suitable notice placed on the carton or envelope. This notice shall indicate the limits of the sealed section and the authority for the action.

(6) Upon employee separation, DHRM and agencies shall retain computerized records for thirty years. Agency hard copy records shall be retained by the agency for a minimum of two years, then transferred to the State Record Center [~~by State Archives Division~~]to be retained [~~for 65 years~~]according to the record retention schedule.

(7) Information classified as private in both DHRM and agency personnel and payroll files shall be available only to the following people:

(a) the employee;

(b) users authorized by the Executive Director, DHRM, who have a legitimate [~~"need-to-know"~~]need to know;

(c) individuals who have the employee's written consent.

(8) Utah is an open records state, according to Chapter 2, Title 63, the Government Records Access and Management Act. Requests for information shall be in writing. The following information concerning

current or former state employees, volunteers, independent contractors, and members of advisory boards or commissions shall be given to the public upon written request where appropriate with the exception of employees whose records are private or protected:

(a) the employee's name;

(b) gross compensation;

(c) salary range;

(d) contract fees;

(e) the nature of employer[~~-~~] paid benefits;

(f) the basis for and the amount of any compensation in addition to salary, including expense reimbursement;

(g) job title;

(h) performance plan;

(i) education and training background as it relates to qualifying the individual for the position;

(j) previous work experience as it relates to qualifying the individual for the position;

(k) date of first and last employment in state government;

(l) the final disposition of any appeal action by the Career Service Review Board;

(m) the final disposition of any disciplinary action;

(n) work location;

(o) a work telephone number;

(p) city and county of residence, excluding street address;

(q) honors and awards as they relate to state government employment;

(r) number of hours worked per pay period;

(s) gender;

(t) other records as approved by the State Records Committee.

(9) When an employee transfers from one agency to another, the former agency shall transfer the employee's original file to the new agency. The file shall contain a record of all actions that have affected the employee's status and standing.

(10) An employee may request a copy of any documentary evidence used for disciplinary purposes in any formal hearing, regardless of the document's source, prior to such use. This shall not apply to documentary evidence used for rebuttal.

(11) Employee medical information obtained orally or documented in separate confidential files is considered private or controlled information. Communication must adhere to the Government Records Access and Management Act, Section 63-2-101. Employees who violate confidentiality are subject to state disciplinary procedures and may be personally liable for slander or libel.

(12) In compliance with the Government Records Access and Management Act, only information classified as [~~"public" or "private"~~]public or private which can be determined to be related to and necessary for the disposition of a long term disability or unemployment insurance determination shall be approved for release on a need to know basis. The agency human resource manager or authorized manager in DHRM shall make the determination.

(13) An employee may verbally request the release of information for personal use, or authorize in writing the release of personal performance records for use by an outside agent based on a need to know authorization. [~~"Private"~~]Private data shall only be released, except to the employee, after a written request has been evaluated and approved.

R477-2-6. Release of Information in a Reference Inquiry.

Reference checks or inquiries made regarding current or former public employees, volunteers, independent contractors, and members of advisory boards or commissions can be released if the information falls under a category outlined in R477-2-[~~6(7)~~]5(8), or if the subject of the record has signed and provided a reference release form for information authorized under Title 63, Chapter 2.

(1) The employment record is the property of Utah State Government with all rights reserved to utilize, disseminate or dispose of in accordance with the Government Records Access and Management Act.

(2) Additional information may be provided if authorized by law.

KEY: administrative responsibility, confidentiality of information, fair employment practices, public information
[~~July 2, 2004~~]July 2, 2005
Notice of Continuation June 11, 2002
52-3-1
63-2-204(5)
63-2-903(4)
67-19-6
67-19-6.4
67-19-18

Human Resource Management, Administration

R477-4-7

Rehire

NOTICE OF PROPOSED RULE
(Amendment)
DAR FILE NO.: 27886
FILED: 05/13/2005, 11:30

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: This amendment removes from rule a time limitation governing the accrual rate for annual leave. This is no longer appropriate because of a shift in the Department of Human Resource Management(DHRM) policy regarding the calculation of the annual leave accrual rate for rehired state employees and make nonsubstantive changes.

SUMMARY OF THE RULE OR CHANGE: In Subsection R477-4-7(1)(a), the deleted sentence was designed to protect the state from claims of retroactive annual leave accrual from rehired employees. This was deemed necessary when DHRM established a new maximum accrual rate of seven hours per pay period because past rules had recognized a period of time in which all service was not recognized. DHRM had made adjustments in the "years of service" policy in previous rules filings which made this deleted sentence unnecessary but failed to remove it. This filing remedies that oversight.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 67-19-6

ANTICIPATED COST OR SAVINGS TO:
❖ THE STATE BUDGET: No costs or savings will be realized by agency budgets. This amendment simply removes an unnecessary clause from rule.
❖ LOCAL GOVERNMENTS: DHRM rules only affects state government. Local governments will not by affected by this rule.
❖ OTHER PERSONS: DHRM rules only affects state government. No other persons will be affected by this rule.

COMPLIANCE COSTS FOR AFFECTED PERSONS: No additional resource will be required to comply with this rule.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: Rules published by DHRM have no direct effect on businesses or any entity outside state government. DHRM has authority to write rules only to the extent allowed by the Utah Personnel Management Act, Title 67, Chapter 19. Section 67-19-15 limits the provisions of career service and these rules to employees of the executive branch of state government. The only possible impact may be a very slight, indirect effect if an agency passes costs or saving on to businesses through fees. However, no such costs or savings will accrue with this amendment. Jeff Herring, Executive Director

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
HUMAN RESOURCE MANAGEMENT
ADMINISTRATION
Room 2120 STATE OFFICE BLDG
450 N MAIN ST
SALT LAKE CITY UT 84114-1201, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
Conroy Whipple or May Vang at the above address, by phone at 801-538-3067 or 801-537-3081, by FAX at 801-538-3081 or 801-538-3377, or by Internet E-mail at cwhipple@utah.gov or mvang@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 07/01/2005.

THIS RULE MAY BECOME EFFECTIVE ON: 07/02/2005

AUTHORIZED BY: Jeff Herring, Executive Director

R477. Human Resource Management, Administration.
R477-4. Filling Positions.
R477-4-7. Rehire.

(1) A former career service employee may be eligible for rehire to any career service position for which he is qualified.

(a) A rehired employee must compete through the DHRM approved recruitment and selection system and must serve a new probationary period, as designated in the official job description.

(i) The annual leave accrual rate for an employee who is rehired to a position which receives leave benefits shall be based on all state employment in which the employee was eligible to accrue leave.[~~ Any adjustments to the accrual rate shall be prospective from July 1, 2003.~~]

(ii) An employee who is rehired within 12 months of separation to a position which receives sick leave benefits shall have his previously accrued sick leave credit reinstated.

(b) A rehired employee may be offered any salary within the regular salary range for the position.

(2) Career Service exempt employees cannot be rehired to career service positions, except as prescribed by Section 67-19-17.

KEY: employment, fair employment practices, hiring practices
[~~July 2, 2004~~]July 2, 2005
Notice of Continuation June 11, 2002
67-19-6

▼ ▼

Human Resource Management, Administration
R477-6
Compensation

NOTICE OF PROPOSED RULE
(Amendment)
DAR FILE NO.: 27904
FILED: 05/13/2005, 16:50

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The purpose of this amendment is to add clarity that will aid agencies in the administration of the state compensation system and provide a legal basis for the distribution of employee pay raises authorized by the 2005 legislature, provide incentives for employees converting to career service exempt status as provided in H.B. 109, 2005 General Legislative Session, provide schedule AT employees with the same benefits as other career service exempt employees and make nonsubstantive changes. (DAR NOTE: H.B. 109 is found at UT L 2005 Ch 169, and will be effective 07/01/2005.)

SUMMARY OF THE RULE OR CHANGE: In Subsection R477-6-4(1), the amendments clarify which noncareer service (Schedule A) employees are eligible for merit step increases when appropriated by the Legislature. Schedule AM and AS are no longer listed because the Department of Human Resource Management (DHRM) has no control over salary increases for these employees. In Subsection R477-6-4(7), this amendment clarifies management discretion to assign an appropriate salary to an employee who voluntarily transfers to another position. This discretion is provided in other parts of the DHRM rules and is allowed under provisions the Long Term Disability and Americans with Disability laws but is also included here for clarification and the benefit of agency management. Management is limited by the parameters governing assignment of salary contained in the same section. Subsection R477-6-4(12) is a new subsection which is added to provide the legal basis for the distribution of market comparability step increases appropriated by the 2005 legislature. This subsection is necessary this year because of

the lack of specific intent language in the appropriation act that provides the needed details and direction to DHRM. In Subsection R477-6-5(1), the provision for an incentive award to be paid as a contribution to a 401(k) plan is deleted because it proved to be administratively difficult and few employees chose this option. The exception language inserted at Subsection R477-6-5(1)(b) is moved here from Subsection R477-6-5(3)(b) so that it applies to all types of incentive awards and not just awards for cost savings. Section R477-6-7 is amended to make employees on schedule AT eligible for benefits as an incentive to convert to career service service exempt status as provided in H.B. 109, 2005 General Legislative Session. In Section R477-6-8, this amendment provides the same life insurance benefits to schedule AT employees as received by other career service exempt employees. In Subsection R477-6-9(1), this amendment provides the severance benefit to employees who are on schedule AT as provided in H.B. 109. This rule is also clarified and cleaned up with these amendments. It is made clear that eligibility for severance is based on years of service in the executive branch only. The employee will only receive the health care portion of the benefit if eligible under the Consolidated Omnibus Budget Reconciliation Act (COBRA); this is required by the COBRA. The provision for payment of the health care premium in one lump sum is deleted because it is difficult to administer.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Sections 63F-1-106, 67-19-6, and 67-19-12; and Subsection 67-19-15.1(4)

ANTICIPATED COST OR SAVINGS TO:

❖ THE STATE BUDGET: There are costs associated with three provisions in this filing. The most obvious is with the new Subsection R477-6-4(12) concerning implementation of market comparability increases. Although the legislature has appropriated the monies for these increases, this is based on a best educated guess of the actual cost. Things will surely change in the time between the appropriation and the actual implementation of the increases in July 2005. In some cases, agencies will have to use funding from other portions of their budgets to pay for these increases. This has always been the case with salary increases and this situation is not unique to this year or this rule. There is also a potential cost associated with the exception language in the incentive award Subsection R477-6-5(1). Agencies may now request exceptions to the whole variety of incentive awards which may increase costs for the agency but this a discretionary act and is not mandated by this rule. All other changes associated with this rule are clarifications only with no budgetary impact. The third cost will accrue with the granting of the same benefits for schedule AT employees as those received by other career service exempt employees. The immediate cost will be for the life insurance benefit which DHRM estimates to be less than $50,000 in the first year.

❖ LOCAL GOVERNMENTS: This rule only affects the executive branch of state government and has no impact on local governments.

❖ OTHER PERSONS: This rule only affects the executive branch of state government and has no impact on other persons.

COMPLIANCE COSTS FOR AFFECTED PERSONS: No additional resources or procedures will be needed by agencies to implement this rule.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: Rules published by DHRM have no direct effect on businesses or any entity outside state government. DHRM has authority to write rules only to the extent allowed by the Utah Personnel Management Act, Title 67, Chapter 19. Section 67-19-15 limits the provisions of career service and these rules to employees of the executive branch of state government. The only possible impact may be a very slight, indirect effect if an agency passes costs or saving on to businesses through fees. However, the costs associated with these amendments can easily be absorbed by agency budgets and no impact on businesses is anticipated. Jeff Herring, Executive Director

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

HUMAN RESOURCE MANAGEMENT
ADMINISTRATION
Room 2120 STATE OFFICE BLDG
450 N MAIN ST
SALT LAKE CITY UT 84114-1201, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
Conroy Whipple or May Vang at the above address, by phone at 801-538-3067 or 801-537-3081, by FAX at 801-538-3081 or 801-538-3377, or by Internet E-mail at cwhipple@utah.gov or mvang@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 07/01/2005.

THIS RULE MAY BECOME EFFECTIVE ON: 7/2/5005

AUTHORIZED BY: Jeff Herring, Executive Director

R477. Human Resource Management, Administration.
R477-6. Compensation.
R477-6-4. Salary.

(1) Merit increases. The following are applicable if merit increases are authorized and funded by the legislature:

(a) Employees[~~,~~] who are not on a longevity step and who are not at the maximum step of their salary range, who receive a successful or higher rating on their performance evaluations and who have been in a paid status by the state for at least six months shall receive a merit increase of one or more salary steps at the beginning of the new fiscal year.

(b) Employees designated as schedule AE, AI and AL who are receiving benefits are eligible for merit step increases.

([~~b~~]c) Employees designated as schedule AJ are not eligible for [~~a~~]merit step [~~increase~~]increases.[~~—Merit increases for employees in schedule AL, AM, or AS are not mandatory unless they are receiving benefits, and the increase is approved in agency policy.~~]

(2) Highest Level Performer.

(a) Employees designated by the agency as a highest level performer consistent with subsection R477-10-1(2) shall receive, as determined by the agency head, either:

(i) a salary step increase; or

(ii) a bonus; or

(iii) administrative leave; or

(iv) other appropriate recognition as determined by the agency.

(b) An employee who is on a longevity step or at the maximum step of the salary range is not eligible for a salary step increase but may receive a bonus, administrative leave or other appropriate recognition as determined by the agency.

(3) Promotions and Reclassifications.

(a) An employee promoted or reclassified to a job with a salary range exceeding the employee's current salary range maximum by one salary step shall receive a salary increase of a minimum of one salary step and a maximum of four salary steps. An employee who is promoted or reclassified to a job with a salary range exceeding the employee's current salary range maximum by two or more salary steps shall receive a salary increase of a minimum of two salary steps and a maximum of four salary steps.

(i) An employee may not be placed higher than the maximum salary step or lower than the minimum salary step in the new salary range. Placement of an employee in longevity shall be consistent with subsection R477-6-4(4).

(ii) An employee who remains in longevity status after a promotion or reclassification shall retain the same salary by being placed on the corresponding longevity step.

(b) To be eligible for a promotion, an employee shall:

(i) meet the job requirements and skills specified in the job description and position specific criteria as determined by the agency for the position unless the promotion is to a career service exempt position.

(c) An employee whose position is reclassified or changed by administrative adjustment to a job with a lower salary range shall retain the current salary. The employee shall be placed on the corresponding longevity step if the salary exceeds the maximum of the new salary range.

(4) Longevity.

(a) An employee shall receive a longevity increase of 2.75 percent when:

(i) the employee has been in state service for eight years or more. The employee may accrue years of service in more than one agency and such service is not required to be continuous; and

(ii) the employee has been at the maximum salary step in the current salary range for at least one year and received a performance appraisal rating of successful or higher within the 12-month period preceding the longevity increase.

(b) An employee on a longevity step shall be eligible for the same across the board pay plan adjustments authorized for all other employee pay plans.

(c) An employee on a longevity step shall only be eligible for additional step increases every three years. To be eligible, an employee must receive a performance appraisal rating of successful or higher within the 12-month period preceding the longevity increase.

(d) An employee on a longevity step who is reclassified to a lower salary range shall retain the current salary.

(e) An employee on a longevity step who is promoted or reclassified to a higher salary range shall only receive an increase if the current salary step is less than the highest salary step of the new range.

(f) Agency heads or time limited exempt employees identified in R477-4-11 are not eligible for the longevity program.

(5) Administrative Adjustment.

(a) An employee whose position has been allocated by DHRM from one job to another job or salary range for administrative purposes, shall not receive an adjustment in salary.

(b) Implementation of new job descriptions as an administrative adjustment shall not result in a salary increase unless the employee is below the minimum step of the new range.

(6) Reassignment.

When permitted by federal or state law, including but not limited to the Americans with Disabilities Act, management may lower the salary of an employee one or more steps when the employee is reassigned to a [~~job or~~]position with a salary range having a lower maximum step.

(7) Transfer.

[~~An employee who transfers from one job or position to another job or position may be offered a salary increase effective the same date as the transfer.~~]Management may increase or decrease the salary of an employee who initiates a transfer to another position consistent with R477-6-4.

(8) Demotion.

An employee demoted consistent with R477-11-2 shall receive a salary reduction of one or more salary steps as determined by the agency head or designee. The agency head or designee may move an employee to a position with a lower salary range concurrent with the salary reduction.

(9) Productivity step adjustment.

Agency management may establish policies to reward an employee who assumes additional workloads which result from the elimination of a position for at least one year with a salary increase of up to four salary steps. An employee at the maximum step of the salary range or in longevity shall be given a one time lump sum bonus award of 2.75% of their annual salary.

(a) To implement this program, agencies shall apply the following criteria:

(i) either the employee or management can make the suggestion;

(ii) the employee and management agree;

(iii) the agency head approves;

(iv) a written program policy achieves increased productivity through labor[~~/~~] and management collaboration;

(v) the agency human resource representative approves;

(vi) the position will be abolished from the position authorization plan for a minimum of one year;

(vii) staff receive additional duties which are substantially above a normal full workload;

(viii) the same or higher level of service or productivity is achieved without accruing additional overtime hours;

(ix) the total dollar increase, including benefits, awarded to the workgroup as a result of the additional salary steps does not exceed 50 percent of the savings generated by eliminating the position.

(10) Administrative Salary Increase.

The agency head authorizes and approves administrative salary increases under the following parameters:

(a) An employee shall receive one or more steps up to the maximum of the salary range.

(b) Administrative salary increases shall only be granted when the agency has sufficient funding within their annualized base budgets for the fiscal year in which the adjustment is given.

(c) Justifications for Administrative Salary Increases shall be:

(i) in writing;

(ii) approved by the agency head;

(iii) supported by issues such as: special agency conditions or problems or other unique situations or considerations in the agency.

(d) The agency head is the final authority for salary actions authorized within these guidelines. The agency head or designee shall answer any challenge or grievance resulting from an administrative salary increase.

(e) Administrative salary increases may be given during the probationary period. These increases alone do not constitute successful completion of probation or the granting of career service status.

(f) An employee at the maximum step of the range or on a longevity step may not be granted administrative salary increases.

(11) Administrative Salary Decrease.

The agency head authorizes and approves administrative salary decreases for nondisciplinary reasons according to the following:

(a) An employee shall receive a one or more step decrease not to exceed the minimum of the salary range.

(b) Justification for administrative salary decreases shall be:

(i) in writing;

(ii) approved by the agency head; and

(iii) supported by issues such as previous written agreements between the agency and employees to include career mobility; reasonable accommodation, special agency conditions or problems, or other unique situations or considerations in the agency.

(c) The agency head is the final authority for salary actions within these guidelines. The agency head or designee shall answer any challenge or grievance resulting from an administrative salary decrease.

(12) Market comparability adjustments shall be given on July 2, 2005 to all career service employees who qualify. Non career service employees who receive benefits and whose job title is assigned to a benchmark job shall also receive this increase.

(a) A one step increase shall be given to employees whose benchmark job is determined to be 15 percent to 30 percent below the market based on actual average pay.

(b) A two step increase shall be given to employees whose benchmark job is determined to be 30.1 percent or more below the market based on actual average pay.

(c) Employees on the top of the established pay range or in longevity are not eligible for this increase.

R477-6-5. Incentive Awards.

(1) Only agencies with written and published incentive award and bonus policies may reward employees with incentive awards or bonuses. Incentive awards and bonuses are discretionary, not an entitlement, and are subject to the availability of funds in the agency.

(a) Policies shall be approved annually by DHRM and be consistent with standards established in these rules and the Department of Administrative Services, Division of Finance, rules and procedures.[~~(b) Policies may provide for payments to a 401(k) program approved by the Utah Retirement System.~~]

([~~e~~]b) Individual awards shall not exceed $4,000 per occurrence and $8,000 in a fiscal year. In exceptional circumstances, an award may exceed these limits upon application to DHRM and approval by the Governor.

([~~d~~]c) All cash incentive awards and bonuses shall be subject to payroll taxes.

(2) Performance Based Incentive Awards.

(a) Cash Incentive Awards

(i) Agencies may grant a cash incentive award to an employee or group of employees who:

(A) demonstrate exceptional effort or accomplishment beyond what is normally expected on the job for a unique event or over a sustained period of time.

(ii) All cash awards must be approved by the agency head or designee. They must be documented and a copy shall be maintained in the agency's individual employee file.

(b) Noncash Incentive Awards

(i) Agency heads may recognize an employee or group of employees with noncash incentive awards.

(ii) Individual noncash incentive awards shall not exceed a value of $50 per occurrence and $200 for each fiscal year.

(iii) Noncash incentive awards may not include cash equivalents such as gift certificates or tickets for admission.

(3) Cost Savings Bonus

(a) An agency may establish a bonus policy to increase productivity, generate savings within the agency, or reward an employee who submits a cost savings proposal.

(i) The agency shall document the cost savings involved.[~~(b) Amounts awarded are subject to the cost limits of R477-6-5(1)(c). In exceptional circumstances, an award may exceed these limits upon application to DHRM and approval by the Governor.~~]

(4) Market Based Bonuses

Agencies may give a cash bonus to an employee as an incentive to acquire or retain an employee with job skills that are critical to the state and difficult to recruit in the market.

(a) Retention Bonus

An agency may pay a bonus to an employee who has unusually high or unique qualifications that are essential for the agency to retain.

(b) Recruitment or Signing Bonus

An agency may pay a bonus to a qualified job candidate to convince the candidate to work for the state.

(c) Scarce Skills Bonus

An agency may pay a bonus to a qualified job candidate that has the scarce skills required for the job.

(d) Relocation Bonus

An agency may pay a bonus to a current employee who must relocate to accept a position in a different commuting area.

(e) Referral Bonus

An agency may pay a bonus to a current employee who refers a job applicant who is subsequently selected and is successfully employed for at least six months.

R477-6-7. Employee Converting from Career Service to Schedule AD, AR, or AS.

(1) A career service employee in a position meeting the criteria for career service exempt Schedule AD, AR, [~~or~~]AS or AT shall have 60 days to elect to convert from career service to career service exempt. As an incentive to convert, an employee shall be provided the following:

(a) a base salary increase of one to three salary steps, as determined by the agency head. An employee at the maximum of the current salary range or on longevity shall receive, in lieu of the salary step adjustment, a one time bonus of 2.75 percent, 5.5 percent or 8.25 percent to be determined by the agency head;

(b) state paid term life insurance coverage if determined eligible by the Group Insurance Office to participate in the Term Life Program, Public Employees Health Plan:

(i) Salaries less than $50,000 shall receive $125,000 of term life insurance;

(ii) Salaries between $50,000 and $60,000 shall receive $150,000 of term life insurance;

(iii) Salaries more than $60,000 shall receive $200,000 of term life insurance.

(2) An employee electing to convert to career service exempt after the 60 day election period shall not be eligible for the salary increase, but shall be entitled to apply for the insurance coverage through the Group Insurance Office.

(3) An employee electing not to convert to career service exemption shall retain career service status even though the position shall be designated as Schedule AD, AR or AS. When these career service employees vacate these positions, subsequent appointments shall be career service exempt.

(4) An agency head may reorganize so that a current career service exempt position no longer meets the criteria for exemption. In this case, the employee shall be designated as career service if he had previously earned career service. However, the employee shall not be eligible for the severance package or the life insurance. In this situation, the agency and employee shall make arrangements through the Group Insurance Office to discontinue the coverage.

(5) A career service exempt employee without prior career service status shall remain exempt. When the employee leaves the position, subsequent appointments shall be consistent with R477-4.

(6) Agencies shall communicate to all impacted and future eligible employees the conditions and limitations of this incentive program.

R477-6-8. State Paid Life Insurance.

(1) A benefits eligible career service exempt employee on schedule AA, AB, AD, [~~and~~]AR and AT shall be provided the following benefits if the employee is approved through underwriting:

(a) State paid term life insurance coverage if determined eligible by the Group Insurance Office to participate in the Term Life Program Public Employees Health Plan:

(i) Salaries less than $50,000 shall receive $125,000 of term life insurance;

(ii) Salaries between $50,000 and $60,000 shall receive $150,000 of term life insurance;

(iii) Salaries more than $60,000 shall receive $200,000 of term life insurance.

(2) An employee on schedule AC, AK, AM and AS may be provided these benefits at the discretion of the appointing authority.

R477-6-9. Severance Benefit.

(1) A benefits eligible career service exempt employee on schedule AB, AD, [~~or~~]AR or AT who is separated from state service through an action initiated by management, to include resignation in lieu of termination, shall receive at the time of severance a benefit equal to:

(a) one week of pay, up to a maximum of 12 weeks, for each year of consecutive exempt service in the executive branch; and

(b) if eligible for COBRA, one month of health insurance coverage, up to a maximum of six months, for each year of consecutive exempt service, at the level of coverage the employee has at the time of severance, to be paid in a lump sum payment to the state's health care provider.

(2) A severance benefit shall not be paid to an employee:

(a) whose statutory term has expired without reappointment;

(b) who is retiring from state service; or

(c) who is discharged for cause.

(3) A benefits eligible career service exempt employee on schedule AB, AD or AR who accepts reassignment to a position with a lower salary range, without a break in service, shall receive a severance benefit equal to the difference between the current hourly rate of pay and the new hourly rate of pay multiplied by the number of accrued annual leave, converted sick leave, and excess hours on the date of reassignment.

(4) An employee on schedule AC, AK, AM or AS may be provided these same severance benefits at the discretion of the appointing authority.

KEY: salaries, employee benefit plans, insurance, personnel management
[~~July 2, 2004~~]July 2, 2005
Notice of Continuation June 11, 2002
63F-1-106
67-19-6
67-19-12
67-19-12.5
67-19-15.1(4)

Human Resource Management, Administration
R477-7
Leave

NOTICE OF PROPOSED RULE
(Amendment)
DAR FILE NO.: 27896
FILED: 05/13/2005, 12:58

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The purpose of this amendment is to clarify policy and procedure for handling employee leave issues, remove language that is date specific and adjust the Department of Human Resource Management (DHRM) policy governing the return to work of employees from a variety of situations and make nonsubstantive changes.

SUMMARY OF THE RULE OR CHANGE: In Subsection R477-7-2(6), this language is moved unchanged to the section on annual leave at Subsection R477-7-3(4) where it fits more logically since the rule speaks of the use of annual leave in a specific situation. In Subsection R477-7-3(1), the new wording is a clarification of the policy for the governance of annual leave accrual rates. It is made on the recommendation of human resource professionals in the field who needed more clearly written guidelines. In Subsection R477-7-3(6), the added language simply places in rule what is already clear in the code but is placed here for clarity. In Subsection R477-7-3(8), this amendment clarifies the criteria governing who is eligible for the maximum annual leave accrual rate. The previous statement left out some employees in unique situations who should have been included. In Subsection R477-7-5(1), this amendment simply moves existing language to make it clearer

what happens to an employees converted sick leave when the converted sick leave maximum is reached. In Section R477-7-9, this is a complete rewrite of this section designed to accommodate the wide variety of familial relationships in our community. In the new Subsection R477-7-13(1), the new Subsections R477-7-13(1)(a) and (b) are current language moved under this subsection. The new Subsection R477-7-13(1)(c) is new language representing a shift in DHRM policy on the return to work of employees who have been absent from work for a prolonged period. This policy now only requires an agency to offer the employee an immediately available position for which he qualifies and can perform the essential functions without reasonable accommodation. If no position exists, the employee shall be separated from state service. Subsection R477-7-15(1) is deleted because it was only effective up to January 1, 2005. In Subsection R477-7-15(2), this is a technical legal amendment to make the rule consistent with the Fair Labor Standards Act and the Family Medical Leave Act (FMLA). In Subsection R477-7-15(5), sick leave is now required to be used contingent with Family Medical Leave in all instances. This is a shift in DHRM policy; previously, only sick leave that coincided with an FMLA event was used contingent with FMLA. In Subsection R477-7-17(1), this amendment makes DHRM rules concerning long term disability leave consistent with recent changes in how the long term disability (LTD) program is administered by the Public Employees Health Plan. The amendment at Subsection R477-7-17(3) represents a policy shift concerning return to work from LTD leave. This shift is the same as the amendment at Section R477-7-13.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 67-19-6

ANTICIPATED COST OR SAVINGS TO:
❖ THE STATE BUDGET: The provision defining more precisely who is eligible for the maximum annual leave accrual rate (Subsection R477-7-3(8)) may add a few more employees to the list who will now earn more annual leave. This will add indirect cost for the agency as this additional leave is used and direct cost when the leave is cashed out at termination. It is impossible to predict with precision how much this will be but it is not anticipated to be more than $10,000 to $20,000 for the entire state. All other amendments are clarification of procedures already in place.
❖ LOCAL GOVERNMENTS: This rule only affects the executive branch of state government and will have no impact on local governments.
❖ OTHER PERSONS: This rule only affects the executive branch of state government and will have no impact on other persons.

COMPLIANCE COSTS FOR AFFECTED PERSONS: Changes mandated by these amendments can be easily handled by the HR system and will have little if any impact on agency resources or procedures.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: Rules published by DHRM have no direct effect on businesses or any entity outside state government. DHRM has authority to write rules only to the extent allowed by the Utah Personnel Management Act, Title 67, Chapter 19. Section 67-19-15 limits the provisions of career service and these rules to employees of the executive branch of state government. The only possible impact may be a very slight, indirect effect if an agency passes costs or saving on to businesses through fees. However, it is anticipated that the minimal costs associated with these changes will be absorbed by agency budgets and will not have any affect on businesses. Jeff Herring, Executive Director

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
HUMAN RESOURCE MANAGEMENT
ADMINISTRATION
Room 2120 STATE OFFICE BLDG
450 N MAIN ST
SALT LAKE CITY UT 84114-1201, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
May Vang or Conroy Whipple at the above address, by phone at 801-537-3081 or 801-538-3067, by FAX at 801-538-3377 or 801-538-3081, or by Internet E-mail at mvang@utah.gov or cwhipple@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 07/01/2005.

THIS RULE MAY BECOME EFFECTIVE ON: 07/02/2005

AUTHORIZED BY: Jeff Herring, Executive Director

R477. Human Resource Management, Administration.
R477-7. Leave.
R477-7-2. Holiday Leave.

(1) The following dates are designated legal holidays:
(a) New Years Day -- January 1
(b) Dr. Martin Luther King Jr. Day -- third Monday of January
(c) Washington and Lincoln Day -- third Monday of February
(d) Memorial Day -- last Monday of May
(e) Independence Day -- July 4
(f) Pioneer Day -- July 24
(g) Labor Day -- first Monday of September
(h) Columbus Day -- second Monday of October
(i) Veterans' Day -- November 11
(j) Thanksgiving Day -- fourth Thursday of November
(k) Christmas Day -- December 25
(l) The Governor may also designate any other day a legal holiday.

(2) If a holiday falls on a Sunday, the following Monday shall be observed as a holiday. If a holiday falls on a Saturday, the preceding Friday shall be observed as a holiday.

(3) If an employee is required to work on an observed holiday, the employee shall receive appropriate holiday leave, or shall receive compensation for the excess hours worked.

(4) The following employees are eligible to receive holiday leave:

(a) A full-time employee shall accrue eight hours of paid holiday leave on holidays.

(b) A part-time career service employee and a partner in a shared position who works 40 hours or more per pay period shall receive holiday leave in proportion to the hours paid in the pay period in which the holiday falls.

(c) An employee working flex time, as defined in R477-8-2, shall receive a maximum of 88 hours of holiday leave in each calendar year. If the holiday falls on a regularly scheduled day off, a flex time employee shall receive an equivalent workday off, not to exceed eight hours, or shall receive compensation for the excess hours at the later date.

(5) An employee receives holiday leave in proportion to the number of hours paid during the pay period in which the holiday falls.

(a) A new hire shall be in a paid status on or before the holiday in order to receive holiday leave.

(b) A separating employee shall be in a paid status on or after the holiday in order to receive holiday leave.

(c) An employee in a leave without pay status shall receive holiday leave in proportion to the time paid in the pay period in which the holiday falls.[

~~(6) The first eight hours of annual leave used by an employee in the calendar leave year shall be the employee's personal preference day.~~]

R477-7-3. Annual Leave.

(1) An employee eligible for annual leave shall accrue leave based on the following years of state service:

(a) [~~zero through five years~~]less than 5 years -- four hours per pay period;

(b) [~~beginning of sixth year through ten years~~]at least 5 and less than 10 years -- five hours per pay period;

(c) [~~beginning of eleventh year through twenty years~~]at least 10 and less than 20 years --six hours per pay period;

(d) [~~beginning of the twenty-first year or more~~]20 years or more -- seven hours per pay period.

(2) The accrual rate for an employee rehired to a position which receives leave benefits shall be based on all state employment in which the employee was eligible to accrue leave.

(3) An eligible employee may begin to use annual leave after completing the equivalent of two full pay periods of employment.

(4) The first eight hours of annual leave used by an employee in the calendar leave year shall be the employee's personal preference day.

([~~4~~]5) Agency management shall allow every employee the option to use annual leave each year for at least the amount accrued in the year.

([~~5~~]6) An employee may elect to convert unused annual leave to a 401(k) or 457 deferred compensation program sponsored by the Utah State Retirement Board when funded by the legislature.

(a) Only hours accrued in excess of 320 hours after the end of the last pay period of the leave year are eligible for conversion.

(b) The election to convert may only be made after the end of the last pay period of the leave year as determined by the Division of Finance.

(c) The conversion shall be in whole hour increments.

(d) An employee may convert up to 20 hours or $250 in value, whichever is less.

(e) The value of the converted leave may not cause the contribution to the 401(k) or 457 account to exceed the maximum authorized by the Internal Revenue Code.

([~~6~~]7) After the conversion in R477-7-3(5), unused accrued annual leave time in excess of 320 hours shall be forfeited at the beginning of the first full pay period of each calendar year.

([~~7~~]8) The maximum annual leave accrual rate shall be granted to a certain employee under the following conditions:

(a) an employee on the Executive Pay Plan, as described in 67-22-2, an employee in schedule AB, and agency deputy directors and division directors appointed to career service exempt positions.

(b) an employee who is schedule A, FLSA exempt and who has a direct reporting relationship to an elected official, executive director, [~~or~~]deputy director, commissioner or board[~~who is schedule A and FLSA exempt~~].

(c) The maximum accrual rate shall be effective from the day the employee is appointed through the duration of the appointment. Employees in these positions on July 1, 2003, shall have the leave accrual rate adjusted prospectively.

(d) The employee may not be eligible for any transfer of leave from other jurisdictions.

(e) Other provisions of leave shall apply as defined in R477-7-1.

R477-7-5. Converted Sick Leave.

As an incentive to reduce sick leave abuse, an employee may convert sick leave hours to converted sick leave after the end of the last pay period of the calendar year in which the employee is eligible.

(1) To be eligible, an employee's sick leave account must have accrued a minimum total of 144 hours at the beginning of the first pay period of the calendar year.

(a) At the end of the last pay period of a calendar year in which an employee is eligible, all unused hours accrued that year in excess of 64 shall be converted to converted sick leave. In the event the employee has the maximum accrued in converted sick, these hours will be added to the annual leave account balance. An employee who does not wish to have the sick leave converted shall notify agency management no later than the end of February. The converted sick leave hours will then be returned to the sick leave account.

(b) Upon separation, an eligible employee may convert any unused hours accrued in the current calendar leave year in excess of 64 to converted sick.[~~In the event the employee has the maximum accrued in converted sick these hours will be added to the annual leave account balance.~~]

(c) The maximum hours of converted sick leave an employee may accrue is 320.

(2) Converted sick leave may be used as annual leave, regular sick leave, or as paid health and life insurance at the time of retirement for employees under age 65. If an employee is 65 years of age or older at the time of retirement, converted sick leave may be used to purchase a Medicare supplement.

(a) Payment for health and life insurance is the responsibility of the employing agency.

(b) The purchase rate shall be eight hours of converted sick leave for the state paid portion of the premium for one month's coverage for health and life insurance.

(c) The retiree shall pay the same percentage of the premium as a current employee on the same plan.

R477-7-9. Funeral Leave.

An employee may receive a maximum of 24 hours funeral leave per occurrence with pay, at management's discretion, to attend the funeral of a member of the employee's immediate family. Funeral leave may not be charged against accrued sick or annual leave.

(1) The [~~"immediate family"~~]immediate family means relatives of the employee or spouse including in-laws, step-relatives, or equivalent relationship of the same degree as follows:[~~wife, husband, children, daughter-in-law, son-in-law, parents, grandchildren, mother-in-law,~~

~~father-in-law, brother-in-law, sister-in-law, grandparents, step-grandparents, spouse's grandparents, spouse's step-grandparents, step-children, step-parents, brothers and sisters, and step-brothers and step-sisters of the employee~~]

(a) spouse;

(b) parents;

(c) siblings;

(d) children;

(e) all levels of grandparents; or

(f) all levels of grandchildren.

R477-7-13. Leave of Absence Without Pay.

(1) An employee shall apply in writing to agency management for approval of a leave of absence without pay. Approval may be granted for continuous leave for up to 12 months from the last day worked.[~~If unable to return to work within the time period granted, the employee shall be separated from state employment.~~]

(a) The employee shall be entitled to previously accrued annual and sick leave.

(b) If unable to return to work within the time period granted, the employee shall be separated from state employment.

(c) If an employee returns to work on or before the expiration of leave without pay and is unable to perform the essential functions of the position because of a permanent disability that qualifies as a disability under the ADA, the agency shall offer the employee a reassignment to one or more immediately available vacant positions, for which the employee qualifies, and whose essential functions the employee is able to perform without a reasonable accommodation. If no position is immediately available the employee shall be separated from state employment.

([~~1~~]2) Nonmedical Reasons

(a) Leave without pay may be granted only when there is an expectation that the employee will return to work. This section does not apply for military leave.

(b) Agency management may approve leave without pay for an employee even though annual or sick leave balances exist. An employee may take up to ten consecutive working days of leave without pay without affecting the leave accrual rate.

(c) An employee who receives no compensation for a complete pay period shall be responsible for payment of the full premium of state provided benefits.

(d) An employee who returns to work on or before the expiration of leave without pay shall be placed in a position with comparable pay and seniority to the previously held position.[~~The employee shall also be entitled to previously accrued annual and sick leave.~~]

([~~2~~]3) Medical Reasons

(a) An employee who is ineligible for FMLA, Workers Compensation, or Long Term Disability may be granted leave without pay for medical reasons.

(b) Medical leave without pay may be granted for no more than 12 months. Medical leave may be approved if a registered health practitioner certifies that an employee is temporarily disabled.

(c) An employee who is granted this leave shall provide a monthly status update to the employee's supervisor.

R477-7-15. Family and Medical Leave.

[~~(1) This section, R477-7-15(1), is effective until January 1, 2005. This rule conforms to the federal Family and Medical Leave Act, 29 USC 2601. Employees eligible under this rule shall continue to receive medical insurance benefits provided the employee was entitled to medical insurance benefits prior to the commencement of FMLA leave.~~

~~(a) Agency management shall authorize up to 12 weeks of leave each calendar year to employees for any of the following reasons:~~

~~(i) birth of a child;~~

~~(ii) adoption of a child;~~

~~(iii) placement of a foster child;~~

~~(iv) a serious health condition of the employee; or~~

~~(v) care of a spouse, dependent child, or parent with a serious medical condition.~~

~~This paragraph and section, R477-7-15(1), are effective on January 1, 2005. This rule parallels the federal Family and Medical Leave Act, 29 USC 2601. Family and medical leave (FMLA) may be authorized when appropriate. This provision does not authorize FMLA leave in excess of that provided for by federal statutes and regulations.~~]

(1) An employee is entitled to 12 weeks of family and medical leave in a 12 month period.

(a) The amount of FMLA leave available to an employee shall be 12 weeks minus any FMLA leave used in the immediately preceding 12 month period.

(b) Agency management shall approve FMLA leave for any of the following reasons:

(i) birth of a child;

(ii) adoption of a child;

(iii) placement of a foster child;

(iv) a serious health condition of the employee; or

(v) care of a spouse, dependent child, or parent with a serious medical condition.

(c) An employee on FMLA leave shall continue to receive the same health insurance benefits the employee was receiving prior to the commencement of FMLA leave.

(2) To be eligible for family medical leave, the employee must:

(a) be employed by the state for at least 12 months;

(b) be employed by the state for a minimum of 1250 [~~compensable work~~]hours worked as determined under FMLA during the 12 month period immediately preceding the commencement of leave; and

(c) apply in writing to the agency when the reason for requesting family medical leave changes in the course of a year.

(3) An employee, or an appropriate spokesperson, shall submit a leave request:

(a) thirty days in advance for foreseeable needs; or

(b) as soon as possible in emergencies.

(4) Agency Responsibility

(a) Agency management shall be responsible for:

(i) documenting employee leave requests which qualify as FMLA leave; and

(ii) designating any qualifying leave taken by an employee as FMLA leave. All leave requests which qualify as FMLA leave shall be designated as such and shall be subject to all provisions of this rule; and

(iii) notifying an employee orally or in writing of the designation within two business days, or as soon as a determination can be made that the leave request qualifies as FMLA leave if the agency does not initially have sufficient information to make a determination.

(A) An oral notice must be confirmed in writing no later than the following payday.

(B) If the payday is less than one week after the oral notice, then written notice must be issued by the subsequent payday.

(b) Written notification to an employee shall include the following information:

(i) that the leave will be counted against the employee's annual FMLA entitlement;

(ii) any requirements for the employee to furnish medical certification of a serious health condition and the consequences of failing to do so;

(iii) a statement explaining which types of leave the employee will be required to exhaust before going into a LWOP status;

(iv) the requirement for the employee to make premium payments to maintain health benefits, the arrangements for making such payments, and the possible consequences of failure to make such payments on a timely basis;

(v) the employee's potential liability for payment of health insurance premiums paid by the employer during the employee's unpaid FMLA leave if the employee fails to return to work after taking FMLA leave;

(vi) any requirement for the employee to present a fitness for duty certificate to be restored to employment; and

(vii) the employee's rights to restoration to the same or an equivalent job upon return from leave.

(c) Agencies may designate FMLA leave after the fact only:

(i) if the reason for leave was previously unknown, provided the reason for leave is made known within two business days after the employee's return to work; or

(ii) the agency has preliminarily designated the leave as FMLA leave and is awaiting medical certification.

(d) Agencies shall allow the employee at least 15 calendar days to provide medical certification if FMLA leave is not foreseeable.

(e) Agencies shall inform Group Insurance that an employee is approved for FMLA leave.

(5) An employee shall be required to [~~use~~]exhaust accrued annual leave, sick leave, [~~and~~]converted sick leave and excess hours prior [~~to the use of~~]to going into leave without pay status for the family and medical leave period. [~~An employee shall be required to use accrued sick leave only in situations considered eligible under R477-7-4(3).~~]An employee who takes family and medical leave in a leave without pay status must comply with R477-7-13.

(a) An employee may choose to use compensatory time for an FMLA reason. Any period of leave paid from the employee's accrued compensatory time account may not be counted against the employee's FMLA leave entitlement.

(6) An employee shall be eligible to return to work under R477-7-13.

(a) If an employee has gone into leave without pay status and fails to return to work after FMLA leave has ended, an agency may recover, with certain exceptions, the health insurance premiums paid by the agency on the employee's behalf. An employee is considered to have returned to work if the employee returns for at least 30 calendar days.

(b) Exceptions to this provision include:

(i) an FLSA exempt and schedule AB, AD and AR employee who has been denied restoration upon expiration of their leave time;

(ii) an employee whose circumstances change unexpectedly beyond the employee's control during the leave period preventing the return to work at the end of 12 weeks.

(7) Leave taken for purposes of childbirth, adoption, placement for adoption or foster care shall not be taken intermittently or on a reduced leave schedule unless the employee and employer mutually agree.

(8) Leave required for certified medical reasons may be taken intermittently.

(9) Leave taken for a serious health condition covered under workers' compensation may be counted towards an employee's FMLA entitlement. Use of accrued paid leave shall not be required for FMLA leave at the same time the employee is collecting a workers' compensation benefit.

(10) Medical records created for purposes of FMLA and the Americans with Disabilities Act must be maintained in accordance with confidentiality requirements of R477-2-5(6).

R477-7-17. Long Term Disability Leave.

(1) An employee who is determined eligible for the Long Term Disability Program (LTD) shall be granted up to one year of medical leave, if warranted by a medical condition.

(a) The medical leave begins on the last day the employee worked. LTD requires a three month waiting period before benefit payments begin. During this period, an employee may use available sick and converted sick leave. When those balances are exhausted, an employee may use other leave balances available.

(b) [~~An employee determined eligible for Long Term Disability benefits, after the three month waiting period, shall be eligible for health insurance benefits beginning two months after the last day worked. The employee is responsible for the employee share of the premium during the two months following the last day worked. The health insurance benefit shall continue without premium payment for up to 22 months or until eligibility for Medicare or Medicaid, whichever occurs first. After 22 months, the health insurance may be continued with premiums being paid in accordance with LTD policy and practice.~~]An employee determined eligible for Long Term Disability benefits shall be eligible for health insurance benefits the day after the last day worked. The employee is responsible for 10% of the health insurance premium during the first year of disability, 20% during the second year of disability, and 30% thereafter until the employee is no longer covered by the long term disability program.

Upon approval of the LTD claim:

(i) Biweekly salary payments that the employee may be receiving shall cease. If the employee received any salary payments after the three month waiting period, the LTD benefit shall be offset by the amount received.

(ii) The employee shall be paid for remaining balances of annual leave, compensatory hours and excess hours in a lump sum payment. This payment shall be made at the time LTD is approved unless the employee requests in writing to receive it upon separation from state employment. No reduction of the LTD payment shall be made to offset this payment. If the employee returns to work prior to one year after the last day worked, the employee has the option of buying back annual leave at the current hourly rate.

(iii) An employee with a converted sick leave balance at the time of LTD eligibility shall have the option to receive a lump sum payout of all or part of the balance or to keep the balance intact to pay for health and life insurance upon retirement. The payout shall be at the rate at the time of LTD eligibility.

(iv) An employee who retires from state government directly from LTD may be eligible for up to five years health and life insurance as provided in Subsection 67-19-14(2)(b)(ii).

(v) Unused sick leave balance shall remain intact until the employee retires. At retirement, the employee shall be eligible for the cash payout and the purchase of health and life insurance as provided in Subsection 67-19-14(2)(c)(i).

(2) An employee shall continue to accrue service credit for retirement purposes while receiving long term disability benefits.

(3) Conditions for return from leave without pay shall include:

(a) If an employee is able to return to work within one year of the last day worked, the agency shall place the employee in the previously held position or similar position in a comparable salary range provided the employee is able to perform the essential functions of the job with or without a reasonable accommodation.

(b) If an employee is unable to perform the essential functions of the position because of a permanent disability that qualifies as a disability under the ADA, the agency shall [~~place the employee in the best available, vacant position for which the employee qualifies and is able to perform the essential functions of the position with or without reasonable accommodation~~]offer the employee a reassignment to one or more immediately available vacant positions, for which the employee qualifies, and whose essential functions the employee is able to perform without a reasonable accommodation.

(c) If an employee is unable to return to work within one year after the last day worked, the employee shall be separated from state employment.

(4) An employee who files a fraudulent long term disability claim shall be disciplined according to the provisions of R477-11.

KEY: holidays, leave benefits, vacations
[~~July 2, 2004~~]July 2, 2005
49-9-203
63-13-2
67-19-6
67-19-12.9
67-19-14.5

Human Resource Management, Administration
R477-8
Working Conditions

NOTICE OF PROPOSED RULE
(Amendment)
DAR FILE NO.: 27889
FILED: 05/13/2005, 11:32

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: Amendments to this rule give voting rights to employees and clarify restrictions on the pay out of compensatory hours and make nonsubstantive changes.

SUMMARY OF THE RULE OR CHANGE: In Subsection R477-8-2(1), new language places in rule the right to vote given all employees by Section 20A-3-103. Very few state employees will need to invoke this rule in order to vote because almost all work shifts in the state provide the necessary time to vote. In Subsection R477-8-6(4), amendments to this subsection clarify that pay down of compensatory hours earned in excess of 80 is not mandatory for certain employees and is prohibited for schedule AB employees (agency heads). Pay down to 80 hours is optional for schedule AD deputy and division directors and equivalents and those on schedule AQ (members of full time boards and councils). Pay down is mandatory for all other Fair Labor Standards Act (FLSA) nonexempt employees. In Subsection R477-8-6(6), this amendment clarifies that the compensatory time of an employee is paid down to zero when the employee is impacted by certain personnel actions defined in rule.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Sections 20A-3-103, 67-19-6, and 67-19-6.7

ANTICIPATED COST OR SAVINGS TO:
❖ THE STATE BUDGET: With the exception of the voting rights amendment, these changes are clarifications that will not increase the costs agencies already incur with these policies. The voting rights amendment will affect very few state employees and at most will result in minor indirect costs when the employee has to be absent from work to vote.
❖ LOCAL GOVERNMENTS: This rule only affects the executive branch of state government and will have no effect on local governments.
❖ OTHER PERSONS: This rule only effects the executive branch of state government and will have no effect on other persons.

COMPLIANCE COSTS FOR AFFECTED PERSONS: Agency policies and procedures affected by these amendments have been in place for a long time and will not have to be adjusted.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: Rules published by the Department of Human Resource Management (DHRM) have no direct effect on businesses or any entity outside state government. DHRM has authority to write rules only to the extent allowed by the Utah Personnel Management Act, Title 67, Chapter 19. Section 67-19-15 limits the provisions of career service and these rules to employees of the executive branch of state government. The only possible impact may be a very slight, indirect effect if an agency passes costs or saving on to businesses through fees. However, the small indirect costs which will accrue to agencies with this amendment will be easily absorbed and have no impact on businesses. Jeff Herring, Executive Director

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
HUMAN RESOURCE MANAGEMENT
ADMINISTRATION
Room 2120 STATE OFFICE BLDG
450 N MAIN ST
SALT LAKE CITY UT 84114-1201, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
May Vang or Conroy Whipple at the above address, by phone at 801-537-3081 or 801-538-3067, by FAX at 801-538-3377 or 801-538-3081, or by Internet E-mail at mvang@utah.gov or cwhipple@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 07/01/2005.

THIS RULE MAY BECOME EFFECTIVE ON: 07/02/2005

AUTHORIZED BY: Jeff Herring, Executive Director

R477. Human Resource Management, Administration.
R477-8. Working Conditions.
R477-8-2. Work Period.

(1) Tasks shall be assigned and wages paid in return for work completed. During the state's standard work week, each employee is responsible for fulfilling the essential functions of his job.

(a) The state's standard work week begins Saturday and ends the following Friday.

(b) State offices are typically open Monday through Friday from 8 a.m. to 5 p.m. Agencies may adopt extended business hours to enhance service to the public, consistent with overtime provisions of R477-8-6.

(c) An employee may negotiate for flexible starting and quitting times with the immediate supervisor as long as scheduling is consistent with overtime provisions of the rules R477-8-6.

(d) Agencies may implement alternative work schedules approved by the Director.

(e) An employee is required to be at work on time. An employee who is late, regardless of the reason including inclement weather, shall make up the lost time by using accrued leave, leave without pay or, with management approval, adjust their work schedule.

(f) An employee must work in increments of 15 minutes or more to receive pay for hours worked and overtime hours worked. This rule incorporates by reference 29 CFR 785.48 for rounding practices when calculating time worked.

(g) An employee who satisfies the criteria in this subsection shall be granted up to two hours of administrative leave to vote in an official election.

(i) The employee must:

(A) have fewer than three total hours off the job between the time the polls open and close, and;

(B) apply for the time in the previous 24 hours.

(ii) Management may specify the hours when the employee may be absent.

R477-8-6. Overtime.

The state's policy for overtime is adopted and incorporated from the Fair Labor Standards Act, 29 CFR Parts 500 to 899(2002) and Utah Code Section 67-19-6.7.

(1) Management may direct an employee to work overtime. Each agency shall develop internal rules and procedures to ensure overtime usage is efficient and economical. These policies and procedures shall include:

(a) prior supervisory approval for all overtime worked;

(b) recordkeeping guidelines for all overtime worked;

(c) verification that there are sufficient funds in the budget to compensate for overtime worked.

(2) Overtime compensation standards are identified for each job title in HRE as either FLSA nonexempt, or FLSA exempt.

(a) An employee may appeal the FLSA designation to the agency human resource office and DHRM concurrently. Further appeals must be filed directly with the United States Department of Labor, Wage and Hour Division. The provisions of Sections 67-19-31 and 67-19a-301 and Title 63, Chapter 46b shall not apply for FLSA appeals purposes.

(3) An FLSA nonexempt employee may not work more than 40 hours a week without management approval. Overtime shall accrue when the employee actually works more than 40 hours a week. Leave and holiday time taken within the work period shall not count as hours worked when calculating overtime accrual. Hours worked over two or more weeks shall not be averaged with the exception of certain types of law enforcement, fire protection, and correctional employees.

(a) An FLSA nonexempt employee shall sign a prior overtime agreement authorizing management to compensate the employee for overtime worked by actual payment or time off at time and one half.

(b) An FLSA nonexempt employee may receive compensatory time for overtime up to a maximum of 80 hours. Only with prior approval of the Executive Director, DHRM, may compensatory time accrue up to 240 hours for regular employees or up to 480 hours for peace or correctional officers, emergency or seasonal employees. Once an employee reaches the maximum, additional overtime shall be paid on the payday for the period in which it was earned.

(4) An FLSA exempt employee may not work more than 80 hours in a pay period without management approval. Compensatory time shall accrue when the employee actually works more than 80 hours in a work period. Leave and holiday time taken within the work period may not count as hours worked when calculating compensatory time. Each agency shall compensate an FLSA exempt employee who works overtime by granting time off. For each hour of overtime worked, an FLSA exempt employee shall accrue an hour of compensatory time. Except for Schedule AB, Schedule AD Deputy and Division Directors and equivalents, and Schedule AQ, [~~Compensatory~~]compensatory hours earned in excess of a base of 80 shall be paid down to 80.

(a) Agencies shall establish in written policy a uniform overtime year and communicate it to employees. If an agency fails to establish a uniform overtime year, the Executive Director, DHRM, and the Director of Finance, Department of Administrative Services, will determine the date for the agency at the end of one of the following pay periods: Five, Ten, Fifteen, Twenty, or the last pay period of the calendar year.

(b) Any compensatory time earned by an FLSA exempt employee is not an entitlement, a benefit, nor a vested right.

(c) Any compensatory time earned by an FLSA exempt employee shall lapse upon occurrence of any one of the following events: when an employee transfers to another agency, terminates, retires, or otherwise does not return to work before the end of the overtime year.

(i) If an FLSA exempt employee's status changes to nonexempt, that employee's compensatory time earned while in exempt status shall lapse if not used by the end of the current overtime year.

(d) The agency head may approve overtime for career service exempt deputy and division directors, but overtime shall not be compensated with actual payment. Schedule AB employees shall not be compensated for compensatory time except with time off.

(5) Law enforcement, correctional and fire protection employees

(a) To be considered for overtime compensation under this rule, a law enforcement or correctional officer must meet the following criteria:

(i) be a uniformed or plainclothes sworn officer;

(ii) be empowered by statute or local ordinance to enforce laws designed to maintain public peace and order, to protect life and property from accident or willful injury, and to prevent and detect crimes;

(iii) have the power to arrest;

(iv) be POST certified or scheduled for POST training; and

(v) perform over 80 percent law enforcement duties.

(b) Agencies shall select one of the following maximum work hour thresholds to determine when overtime compensation is granted to

law enforcement or correctional officers designated FLSA nonexempt and covered under this rule.

(i) 171 hours in a work period of 28 consecutive days; or

(ii) 86 hours in a work period of 14 consecutive days.

(c) Agencies shall select one of the following maximum work hour thresholds to determine when overtime compensation is granted to fire protection employees.

(i) 212 hours in a work period of 28 consecutive days; or

(ii) 106 hours in a work period of 14 consecutive days.

(d) Agencies may designate a lesser threshold in a 14 day or 28 day consecutive work period as long as it conforms to the following:

(i) the Fair Labor Standards Act, Section 207(k);

(ii) 29 CFR 553.230;

(iii) the state's payroll period;

(iv) the approval of the Executive Director, DHRM.

(6) Compensatory Time

(a) Agency management shall arrange for an employee's use of compensatory time as soon as possible without unduly disrupting agency operations or endangering public health, safety or property.

(b) Compensatory time balances for an FLSA nonexempt employee shall be paid down to zero [~~when transferring~~]in the same pay period that the employee is transferred from one agency to a different agency, [~~or when~~]promoted, reclassified, reassigned, or transferred to an FLSA exempt position. The pay down for unused compensatory time balances shall be based on the employee's hourly rate of pay in the old position.

(7) Time Reporting

(a) An FLSA nonexempt employee must complete and sign a state approved biweekly time sheet. Time sheets developed by the agency shall have the same elements of the state approved time sheet and be approved by the Department of Administrative Services, Division of Finance.

(b) An FLSA exempt employee who works more than 80 hours in a work period must record the total hours worked and the compensatory time used on a biweekly time sheet. All hours must be recorded in order to claim overtime. Completion of the time sheet is at agency discretion when no overtime is worked during the work period.

(8) Hours Worked: An FLSA nonexempt employee shall be compensated for all hours worked. An employee who works unauthorized overtime may be subject to disciplinary action.

(a) All time that an FLSA nonexempt employee is required to wait for an assignment while on duty, before reporting to duty, or before performing activities is counted towards hours worked.

(b) Time spent waiting after being relieved from duty is not counted as hours worked if one or more of the following conditions apply:

(i) the employee arrives voluntarily before their scheduled shift and waits before starting duties;

(ii) the employee is completely relieved from duty and allowed to leave the job;

(iii) the employee is relieved until a definite specified time;

(iv) the relief period is long enough for the employee to use as the employee sees fit.

(c) On-call time: An employee required by agency management to be available for on-call work shall be compensated for on-call time at a rate of one hour for every 12 hours the employee is on-call.

(i) Time is considered [~~"on-call time"~~]on-call time when the employee has freedom of movement in personal matters as long as the employee is available for call to duty.

(ii) An employee must be directed by his supervisor, either verbally or in writing, that he is on call for a specified time period. Carrying a beeper or cell phone shall not constitute on-call time without a specific directive from a supervisor.

(iii) The employee shall record the hours spent in on-call status on his time sheet in order to be paid.

(d) Stand-by time: An employee restricted to [~~"stand-by"~~]stand-by at a specified location ready for work must be paid full-time or overtime, as appropriate. An employee must be paid for stand-by time if required to stand by the post ready for duty, even during lunch periods, equipment breakdowns, or other temporary work shutdowns.

(e) The meal periods of guards, police, and other public safety or correctional officers and firefighters who are on duty more than 24 consecutive hours must be counted as working time, unless an express agreement excludes the time.

(f) Commuting and Travel Time:

(i) Normal commuting time from home to work and back shall not count towards hours worked.

(ii) Time an employee spends traveling from one job site to another during the normal work schedule shall count towards hours worked.

(iii) Time an employee spends traveling on a special one day assignment shall count towards hours worked except meal time and ordinary home to work travel.

(iv) Travel that keeps an employee away from home overnight does not count towards hours worked if it is time spent outside of regular working hours as a passenger on an airplane, train, boat, bus, or automobile.

(v) Travel as a passenger counts toward hours worked if it is time spent during regular working hours. This applies to nonworking days, as well as regular working days. However, regular meal period time is not counted.

(g) Excess Hours: An employee may use excess hours the same way as annual leave.

(i) Agency management shall approve excess hours before the work is performed.

(ii) Agency management may deny the use of any leave time, other than holiday leave, that results in an employee accruing excess hours.

(iii) An employee on schedule AB may not accumulate more than 80 excess hours.

(iv) Agency management may pay out excess hours under one of the following:

(A) paid off automatically in the same pay period accrued;

(B) all hours accrued above 80; or

(C) an employee on schedule AB shall only be paid for excess hours at separation.

KEY: breaks, telecommuting, overtime, dual employment
[~~July 2, 2004~~]July 2, 2005
Notice of Continuation June 11, 2002
67-19-6
67-19-6.7
20A-3-103

Human Resource Management, Administration
R477-10
Employee Development

NOTICE OF PROPOSED RULE
(Amendment)
DAR FILE NO.: 27887
FILED: 05/13/2005, 11:31

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The purpose of this amendment is to remove an employee requirement from the performance management program, implement a shift in policy on corrective action and close a potential loophole in the education assistance program.

SUMMARY OF THE RULE OR CHANGE: In Subsection R477-10-1(4), the sentence deleted by this amendment is done so on the urging of legal counsel who advise that this clause is almost impossible to enforce and may place the state in a difficult legal situation if challenged. In Subsections R477-10-2(3) and (4), this amendment is a policy shift for the Department of Human Resource Management (DHRM) on corrective action. It will now be mandatory that the corrective plan be documented in the official personnel record and that the plan be completed prior to any disciplinary action. Prior policy left this for agencies to control through agency policy. This should help eliminate some troublesome disciplinary situations for the state. In Subsection R477-10-5(1), the additional language places the requirement on the employee to disclose all sources of funding for an educational program he is pursuing. This closes a potential loophole that could allow an employee to receive more than 100% reimbursement from a variety of sources.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 67-19-6

ANTICIPATED COST OR SAVINGS TO:
❖ THE STATE BUDGET: There is potential for some savings in agency budgets resulting from the amendment to the educational assistance program. In FY 2004, the state recorded expenditures of $60,647 for educational assistance. If 5% of those receiving this assistance were taking advantage of this loophole, the savings to the state would be less than $3,000.
❖ LOCAL GOVERNMENTS: This rule only applies to the executive branch of state government and will have no affect on local governments.
❖ OTHER PERSONS: This rule applies only to the executive branch of state government and will hove no affect on other persons.

COMPLIANCE COSTS FOR AFFECTED PERSONS: No additional resources will be required to comply with these amendments.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: Rules published by DHRM have no direct effect on businesses or any entity outside state government. DHRM has authority to write rules only to the extent allowed by the Utah Personnel Management Act, Title 67, Chapter 19. Section 67-19-15 limits the provisions of career service and these rules to employees of the executive branch of state government. The only possible impact may be a very slight, indirect effect if an agency passes costs or saving on to businesses through fees. However, the possible minuscule savings that may accrue with this amendment will stay with the agency. Jeff Herring, Executive Director

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
HUMAN RESOURCE MANAGEMENT
ADMINISTRATION
Room 2120 STATE OFFICE BLDG
450 N MAIN ST
SALT LAKE CITY UT 84114-1201, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
May Vang or Conroy Whipple at the above address, by phone at 801-537-3081 or 801-538-3067, by FAX at 801-538-3377 or 801-538-3081, or by Internet E-mail at mvang@utah.gov or cwhipple@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 07/01/2005.

THIS RULE MAY BECOME EFFECTIVE ON: 07/02/2005

AUTHORIZED BY: Jeff Herring, Executive Director

R477. Human Resource Management, Administration.
R477-10. Employee Development.
R477-10-1. Performance Evaluation.

Agency management shall develop an employee performance management system consistent with these rules and subject to approval by the Executive Director, DHRM. The Executive Director, DHRM, may authorize exceptions to provisions of this rule consistent with R477-2-2. For this rule, the word employee refers to a career service employee, unless otherwise indicated.

(1) An acceptable performance management system shall satisfy the following criteria:

(a) Performance standards and expectations for each employee shall be specifically written in a performance plan by August 30 of each fiscal year.

(b) Managers or supervisors provide employees with regular verbal and written feedback based on the standards of performance and conduct outlined in the performance plan.

(c) Each employee shall be informed concerning the actions to be taken, time frames, and the supervisor's role in providing assistance to improve performance and increase the value of service.

(d) Each employee shall have the right to include written comment with his performance evaluation.

(e) Agency management shall select a performance management rating system or a combination of systems by August 30 to be effective for the entire fiscal year. The rating system shall be one or more of the following:

TABLE

SYSTEM #	RATING	POINTS
1	Pass	2
	Fail	0
2	Exceptional	3
	Successful	2
	Unsuccessful	0
3	Exceptional	3
	Highly Successful	2.5
	Successful	2
	Unsuccessful	0
4	Exceptional	3
	Highly Successful	2.5
	Successful	2
	Marginal	1
	Unsuccessful	0

(2) In addition to the above ratings, agency management may establish a rating category for highest level performers under the following conditions:

(a) Each employee who receives this rating shall receive a performance rating of 4.

(b) Agencies shall devise and publish the criteria they will use to select the highest level performers by August 30 of each year. Selection criteria for non-supervisory employees shall be comparable to the Utah Code 67-19c-101(3)(c). Selection criteria for supervisory or management employees shall be comparable to "The Manager of the Year Award."

(3) Each state employee shall receive a performance evaluation effective on or before the beginning of the first pay period of each fiscal year.

(a) A probationary employee shall receive a performance evaluation at the end of the probationary period and again prior to the beginning of the first pay period of the fiscal year.

(4) The employee shall sign the evaluation. Signing the evaluation only means that the employee has reviewed the evaluation. Refusal to sign the evaluation shall constitute insubordination, subject to discipline.

(a) The evaluation form shall include a space for the employee's comments. [~~The employee shall check a space indicating either agreement or disagreement with the evaluation.~~]The employee may comment in writing, either in the space provided or on a separate attachment.

R477-10-2. Corrective Action.

When an employee's performance does not meet established standards due to failure to maintain skills, incompetence, or inefficiency, agency management shall take appropriate, documented, and clearly labeled corrective action in accordance with the following rules:

(1) The supervisor shall discuss the substandard performance with the employee to discover the reasons and to develop an appropriate written corrective action plan. The employee shall sign the written corrective action plan to certify that it has been reviewed. Refusal to sign the corrective action shall constitute insubordination subject to discipline. An employee shall have the right to submit written comment to accompany the corrective action plan.

(a) Corrective actions shall include one or more of the following:

(i) closer supervision;

(ii) training;

(iii) referral for personal counseling by an agency head's approved designee;

(iv) reassignment;

(v) use of appropriate leave;

(vi) career counseling and outplacement;

(vii) period of constant review;

(viii) opportunity for remediation;

(ix) written warnings.

(2) The supervisor shall designate an appropriate corrective action period and shall provide periodic evaluation of the employee's progress.

(3) At the conclusion of corrective action, a formal performance evaluation shall be written and documented in the personnel record.

(4) [~~If, after reasonable effort, the corrective action taken does not result in~~]When the corrective action plan is completed and the employee has not demonstrated improved performance that is satisfactory, the employee shall be disciplined according to R477-11. The written record of the corrective action shall satisfy the requirement of Section 67-19-18(1).

(5) DHRM shall provide assistance to agency management upon request.

R477-10-5. Education Assistance.

State agencies may assist an employee in the pursuit of educational goals by granting administrative leave to attend classes, a subsidy of educational expenses, or both.

(1) Prior to granting education assistance, agencies shall establish policies which shall include the following conditions:

(a) The educational program will provide a benefit to the state.

(b) The employee shall successfully complete the required course work or the educational requirements of a program.

(c) The employee shall agree to repay any assistance received if the employee resigns from state employment within 12 months of completing educational work.

(d) Education assistance shall not exceed $5,250 per employee in any one calendar year unless approved in advance by the agency head.

(e) The employee shall disclose all sources of funding being received for the educational program.

(i) Except for funding that must be repaid by the employee, the amount reimbursed by the State may not include funding received from other sources.

(2) Agency management shall be responsible for determining the taxable or nontaxable status of educational assistance reimbursements.

(3) Agencies may offer educational assistance to law enforcement and correctional officers consistent with section 67-19-12.2 and with these criteria:

(a) The program shall comply with R477-10-5(1) and R477-10-5(2).

(b) The program shall be published and available to all qualified employees. To qualify:

(i) The employee's job duties shall satisfy the conditions of subsection 67-19-12.2 (1).

(ii) The employee shall have completed probation.

(iii) The employee shall maintain a grade point average of at least 3.0 or equivalent from an accredited college or university.

(c) The program may provide additional compensation for an employee who completes a higher degree on or after April 30, 2001, in a subject area directly related to the employee's duties. If this policy is adopted, then:

(i) Two steps shall be given for an associate's degree.
(ii) Two steps shall be given for a bachelor's degree.
(iii) Two steps shall be given for a master's degree.

KEY: educational tuition, employee performance evaluations, employee productivity, training programs
[~~July 1, 2003~~|July 2, 2005
Notice of Continuation June 11, 2002
67-19-6
67-19-12.4

Human Resource Management, Administration
R477-11-2
Dismissal or Demotion

NOTICE OF PROPOSED RULE
(Amendment)
DAR FILE NO.: 27888
FILED: 05/13/2005, 11:32

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: This is a technical legal amendment that will provide more precise direction for state officials in disciplinary situations involving non career service employees.

SUMMARY OF THE RULE OR CHANGE: In Subsections R477-11-2(1) and (2), the amendments to these two subsections clearly distinguish between the dismissal or demotion for a career service employee, a career service exempt, and a probationary employee. It is made clear that probationary employees, i.e., an employee who has not achieved career service status, is treated the same as a career service exempt employee.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Sections 67-19-6 and 67-19-18

ANTICIPATED COST OR SAVINGS TO:
❖ THE STATE BUDGET: These are technical legal definitional adjustments that will have no impact on procedures and thus will be cost neutral to the state.
❖ LOCAL GOVERNMENTS: This rule only impacts the executive branch of state government and will not affect local governments.
❖ OTHER PERSONS: This rule only impacts the executive branch of state government and will not affect other persons.

COMPLIANCE COSTS FOR AFFECTED PERSONS: No additional resources will be required by agencies to implement these provisions.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: Rules published by the Department of Human Resource Management (DHRM) have no direct effect on businesses or any entity outside state government. DHRM has authority to write rules only to the extent allowed by the Utah Personnel Management Act, Title 67, Chapter 19. Section 67-19-15 limits the provisions of career service and these rules to employees of the executive branch of state government. The only possible impact may be a very slight, indirect effect if an agency passes costs or saving on to businesses through fees. However, no such costs or savings will accrue with this amendment. Jeff Herring, Executive Director

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
HUMAN RESOURCE MANAGEMENT
ADMINISTRATION
Room 2120 STATE OFFICE BLDG
450 N MAIN ST
SALT LAKE CITY UT 84114-1201, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
May Vang or Conroy Whipple at the above address, by phone at 801-537-3081 or 801-538-3067, by FAX at 801-538-3377 or 801-538-3081, or by Internet E-mail at mvang@utah.gov or cwhipple@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 07/01/2005.

THIS RULE MAY BECOME EFFECTIVE ON: 07/02/2005

AUTHORIZED BY: Jeff Herring, Executive Director

R477. Human Resource Management, Administration.
R477-11. Discipline.
R477-11-2. Dismissal or Demotion.

An employee may be dismissed or demoted for cause as explained under R477-10-2 and R477-11-1, and through the process outlined in this rule.

(1) An agency head or appointing officer may dismiss or demote a probationary employee or career service exempt employee without right of appeal. Such dismissal or demotion may be for any reason or for no reason.

(2) No career service employee shall be dismissed or demoted from a career service position unless the agency head or designee has observed the Grievance Procedure Rules and law cited in R137-1-13 and Title 67, Chapter 19a, and the following procedures:

(a) The agency head or designee shall notify the employee in writing of the specific reasons for the proposed dismissal or demotion.

(b) The employee shall have up to five working days to reply. The employee must reply within five working days for the agency head or designee to consider the reply before discipline is imposed.

(c) The employee shall have an opportunity to be heard by the agency head or designee. The hearing before the department head or designee shall be strictly limited to the specific reasons raised in the notice of intent to demote or dismiss.

(i) At the hearing the employee may present, either in person, in writing, or with a representative, comments or reasons as to why the proposed disciplinary action should not be taken. The agency head or

designee is not required to receive or allow other witnesses on behalf of the employee.

(ii) The employee may present documents, affidavits or other written materials at the hearing. However, the employee is not entitled to present or discover documents within the possession or control of the department or agency that are private, protected or controlled under Chapter 63-2, the Governmental Access and Records Management Act.

(d) Following the hearing, the employee may be dismissed or demoted if the agency head finds adequate cause or reason.

(e) The employee shall be notified in writing of the agency head's decision. Specific reasons shall be provided if the decision is a demotion or dismissal.

(3) Agency management may suspend an employee with pay pending the administrative appeal to the agency head.

KEY: discipline of employees, dismissal of employees, grievances, government hearings
[~~July 2, 2004~~]July 2, 2005
Notice of Continuation June 11, 2002
67-19-6
67-19-18
63-2

Human Resource Management, Administration
R477-12-3
Reduction in Force

NOTICE OF PROPOSED RULE
(Amendment)
DAR FILE NO.: 27890
FILED: 05/13/2005, 11:33

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The purpose of this amendment is to implement two adjustments in policy on the placement of employees on the reduction in force (RIF) list and the hiring of former employees from that list and make nonsubstantive changes.

SUMMARY OF THE RULE OR CHANGE: In Subsection R477-12-3(7)(c), these amendments give a former employee on the RIF list rehire rights to any vacant position for which he qualifies at a salary range equal to or less than the salary range of the employees last career service position. If the salary range of the previous career service position has moved upward than this will be the new range to which the rehired employee is entitled. In Subsection R477-12-3(9), the new language permits management to place a former career service employee currently serving in a career service exempt position into a vacant career service position for which he qualifies as an alternative to being placed on the RIF list if the employee agrees to waive all reappointment rights. Without this adjustment, the employee would automatically be placed on the RIF list. By law (Section 67-19-18), the employee would then be appointed to the next available position for which he qualifies.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Sections 67-19-6, 67-19-17, and 67-19-18

ANTICIPATED COST OR SAVINGS TO:
❖ THE STATE BUDGET: These policy adjustments will be cost neutral. Vacant positions are filled by a former employee on the RIF list or with a new recruitment. In neither case will the person be given a salary outside the approved range and beyond what the agency can pay.
❖ LOCAL GOVERNMENTS: This rule only impacts the executive branch of state government and will not affect local governments.
❖ OTHER PERSONS: This rule only impacts the executive branch of state government and will not affect other persons.

COMPLIANCE COSTS FOR AFFECTED PERSONS: No new resources are required to implement this policy change.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: Rules published by the Department of Human Resource Management (DHRM) have no direct effect on businesses or any entity outside state government. DHRM has authority to write rules only to the extent allowed by the Utah Personnel Management Act, Title 67, Chapter 19. Section 67-19-15 limits the provisions of career service and these rules to employees of the executive branch of state government. The only possible impact may be a very slight, indirect effect if an agency passes costs or saving on to businesses through fees. However, no such costs or savings will accrue with this amendment. Jeff Herring, Executive Director

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HUMAN RESOURCE MANAGEMENT
ADMINISTRATION
Room 2120 STATE OFFICE BLDG
450 N MAIN ST
SALT LAKE CITY UT 84114-1201, or
at the Division of Administrative Rules.

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INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 07/01/2005.

THIS RULE MAY BECOME EFFECTIVE ON: 07/02/2005

AUTHORIZED BY: Jeff Herring, Executive Director

R477. Human Resource Management, Administration.
R477-12. Separations.
R477-12-3. Reduction in Force.

Reductions in force shall be required when there are inadequate funds, a change of workload, or lack of work. Reductions in force shall be governed by DHRM business practices, standards and the following rules:

(1) When staff will be reduced in one or more categories of work, agency management shall develop a work force adjustment plan (WFAP). A career service employee shall only be given formal written notification of separation after a WFAP has been reviewed and approved by the Executive Director, DHRM, or designee. The following items shall be considered in developing the work force adjustment plan:

(a) the categories of work to be eliminated, including positions impacted through bumping, as determined by management;

(b) a decision by agency management allowing or disallowing bumping;

(c) specifications of measures taken to facilitate the placement of affected employees through normal attrition, retirement, reassignment, relocation, and movement to vacant positions for which the employee qualifies;

(d) a list of all affected employees showing the retention points for each employee.

(2) Eligibility for RIF.

(a) Only career service employees who have been identified in an approved WFAP and given an opportunity for a hearing with the agency head may be RIF'd.

(b) An employee covered by USERRA and in a leave without pay status must be identified, assigned retention points, and notified of the RIF of the previous position in the same manner as a career service employee.

(3) Retention points shall be calculated for all affected employees within a category of work as follows:

(a) Seniority shall be determined by the length of total state career service, which commenced in a competitive career service position for which the probationary period was successfully completed.

(i) For part-time work, length of service shall be determined in proportion to hours actually worked.

(ii) Exempt service time subsequent to attaining career service tenure with no break in service shall also be counted for purposes of seniority.

(iii) In the event of ties in retention points, the amount of time employed in the affected agency or department serves as the tie breaker.

(b) Length of state service shall be measured in years and additional days shown as a fraction of a year.

(c) Time spent in a leave without pay status for service in the uniformed services covered under USERRA shall be counted for purposes of seniority.

(d) Any time spent in leave without pay status, to include worker's compensation leave, may not be counted for purposes of seniority.

(e) An employee within a category of work, including employees covered under USERRA in a leave without pay status, shall be assigned a job proficiency rating. The job proficiency rating shall be an average of the last three annual performance evaluation ratings as described in R477-10-1(1)(e). If employees have had fewer than three annual performance evaluations, the proficiency ratings shall be an average of all ratings received as of that time.

(f) The numeric values of each employee's job proficiency rating and that employee's actual length of service shall be added together to produce the retention points.

(g) Retention points shall be calculated for an employee covered under USERRA and in a leave without pay status in the same manner as for current employees in the affected class. If there are no performance evaluation ratings for an employee covered under USERRA, no proficiency rating shall be included in the retention points.

(4) The order of separation shall be:

(a) career service exempt employees;

(b) probationary employees;

(c) career service employees [~~in the order of their retention points~~]with the lowest retention points are released first. In the event of ties in retention points, the amount of seniority in the affected agency serves as the tie breaker.

(5) An employee, including one covered under USERRA in a leave without pay status, who is separated due to a reduction in force shall be given formal written notification of separation, allowing for a minimum of 20 working days prior to the effective date of the RIF.

(6) Appeals.

(a) An employee notified of separation due to a reduction in force may appeal to the agency head for an administrative review by submitting a written notice of appeal within 20 working days after the receipt of written notification of separation.

(b) The employee may appeal the decision of the agency head according to the appeals procedure of the Career Service Review Board.

(7) Reappointment of RIF'd individual.

(a) A RIF'd individual is eligible for reappointment into a half time or greater career service position for which he qualifies in a salary range comparable to or less than the last career service position held, for a period of one year following the date of separation. R477-4-4 applies for selection of individuals from the reappointment register.

(i) The Executive Director, DHRM, shall maintain a reappointment register and shall make the final determination on whether an eligible RIF'd individual meets the job requirements for position vacancies.

(ii) A RIF'd individual shall remain on the state reappointment register for [~~twelve~~]12 months from the date of separation, unless reappointed sooner.

(b) During a statewide mandated freeze on hiring wherein the Governor disallows increases in each agency's FTEs, eligibility for the reappointment register shall be extended for the entire length of time covered by a freeze.

(c) When determining comparable salary ranges in cases of RIF eligibility, a comparison of the previous career service salary range to the [~~new~~]current career service salary range maximum step is required. A RIF'd individual shall have RIF rights to any vacant position for which he qualifies. The basis for comparison shall be:

(i) [~~The previous salary range shall be considered comparable if the maximum step is equal to or greater than the maximum step of the new salary range.~~]The current salary range of a vacant position if it is equal to or lesser than the individual's previous salary range, or;

(ii) If the maximum step of the [~~job or~~]position previously held by the RIF'd individual has moved upward, [~~the RIF'd individual shall be eligible to exercise RIF rights for vacancies with that job or position as long as the duties remain essentially the same as when the RIF'd individual held the job or position~~]the new range shall be used.

(d) A RIF'd individual who is reappointed to a career service position shall not be required to serve a probationary period. The RIF'd individual shall enjoy all the rights and privileges of a regular career service employee.

(e) At agency discretion, an individual reappointed from a reappointment register may buy back part or all accumulated annual and converted sick leave that was cashed out when RIF'd.

(8) Appeal rights of RIF'd individual. An individual whose name is on the reappointment register as a result of a reduction in force may use the grievance procedure regarding their reappointment rights.

(9) A career service employee in an exempt position. Any career service employee accepting an exempt position without a break in service, who is later not retained by the appointing officer, unless discharged for cause as provided for by these rules, shall be placed on [~~a~~]the reappointment register.

(a) The Executive Director, DHRM, shall maintain a reappointment register for this purpose. An individual on this register shall:

(i) be appointed to any half time or greater career service position for which the individual qualifies in a pay range comparable to the individual's last position in the career service, provided an opening exists; or

(ii) be appointed to any lesser career service position for which the individual qualifies, pending the opening of a position at the last career service salary range held.

(b) The Executive Director, DHRM, shall make the final determination on whether an eligible individual meets the job requirements for position vacancies.

(c) The individual shall declare a desire to remain on the reappointment register upon inquiry by DHRM.

(d) In lieu of placement on the reappointment register, management may place an employee in a vacant career service position consistent with R477-12-3(7)(c) for which he qualifies. A memorandum of understanding waiving all appeal rights concerning the reassignment shall be signed by the employee.

KEY: administrative procedures, employees' rights, grievances, retirement
[~~July 2, 2004~~]July 2, 2005
Notice of Continuation June 11, 2002
67-19-6
69-19-17
69-19-18

▼ ▼

Labor Commission, Industrial Accidents
R612-1-3
Official Forms

NOTICE OF PROPOSED RULE
(Amendment)
DAR FILE NO.: 27892
FILED: 05/13/2005, 11:48

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The purpose of this rule is to define the circumstances in which employers must file Form 122, "Employer's First Report of Injury", and the circumstance in which health care providers must file Form 123, "Physician's Initial Report."

SUMMARY OF THE RULE OR CHANGE: The proposed amendment clarifies that employers are not required to report first aid treatments administered at the work site or at an employer-sponsored free clinic. The proposed amendment also defines "first aid." The proposed rule also clarifies that physicians must report treatment of injured workers if the treatment results in a bill for medical services or exceeds the limits of first aid.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Sections 34A-2-101 et seq., 34A-3-101 et seq., 34A-1-104 et seq., and 63-46b-1 et seq.

ANTICIPATED COST OR SAVINGS TO:
❖ THE STATE BUDGET: This rule amendment will not impose any costs or savings to the State budget, either in administration costs or in the State's capacity as an employer as it is just a clarification.
❖ LOCAL GOVERNMENTS: This rule amendment will not result in costs or savings to local governments as it is just a clarification.
❖ OTHER PERSONS: This rule amendment will not result in costs or savings as it is just a clarification.

COMPLIANCE COSTS FOR AFFECTED PERSONS: This rule amendment clarifies existing reporting requirements rather than imposing any new requirements. Consequently, no compliance costs are associated with the rule.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: Because this rule is primarily a clarification of existing standards, the effect on business will be negligible. R. Lee Ellertson, Commissioner

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
LABOR COMMISSION
INDUSTRIAL ACCIDENTS
HEBER M WELLS BLDG
160 E 300 S
SALT LAKE CITY UT 84111-2316, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
Joyce Sewell at the above address, by phone at 801-530-6988, by FAX at 801-530-6804, or by Internet E-mail at jsewell@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 07/01/2005.

THIS RULE MAY BECOME EFFECTIVE ON: 07/02/2005

AUTHORIZED BY: R Lee Ellertson, Commissioner

R612. Labor Commission, Industrial Accidents.
R612-1. Workers' Compensation Rules - Procedures.
R612-1-3. Official Forms.

A. "Employer's First Report of Injury - Form 122" - This form is used for reporting accidents, injuries, or occupational diseases as per Section 34A-2-407. This form must be filed within seven days of the occurrence of the alleged industrial accident or the employer's first knowledge or notification of the same. This form also serves as OSHA Form [+]301. The employer must report all injuries, other than first aid administered on site or at an employer sponsored free clinic, to the Industrial Accident Division and to the insurance carrier. First aid treatment is defined as:

a. non-prescription medications at non-prescription strength;
b. administering tetanus immunizations;
c. cleaning, flushing, or soaking wounds on the skin surface;
d. using wound coverings, such as bandages, Band Aid (TM), gauze pads, etc., or using SteriStrips (TM) or butterfly bandages;
e. using hot or cold therapy (limited to hot or cold packs, contrast baths and paraffin;
f. using any totally non-rigid means of support, such as elastic bandages, wraps, non-rigid back belts, etc.;
g. using temporary immobilization devices while transporting an accident victim (splints, slings, neck collars, or back boards);
h. drilling a fingernail or toenail to relieve pressure, or draining fluids from blisters;
i. using eye patches; using simple irrigation or a cotton swab to remove foreign bodies not embedded in or adhered to the eye;
j. using irrigation, tweezers, cotton swab or other simple means to remove splinters or foreign material from areas other than the eye;
k. using finger guards;
l. using massages;
m. drinking fluids to relieve heat stress;

First aid, as defined above, is limited to a one-time visit and one subsequent follow up visit within a 7 day tiem period. (This does not apply to reporting it on OSHA's 300 log). However, if first aid treatment is given by a licensed health professional in an employer sponsored free clinic then two subsequent visits within a 14 consecutive day time period are allowed. The employer must maintain the employer's injury report (Form 122) and health records on site for first aid treatment.

First aid, as defined in a through m, does not include any work injuries resulting in:

i) loss of consciousness;
ii) loss of work;
iii) restriction of work; or
iv) transfer to another job.

B. "Physician's Initial Report of Work Injury or Occupational Disease - Form 123" - This form is used by physicians and chiropractors to report their initial treatment of an injured employee. This form must be completed when a bill is generated for treatment administered by a licensed health care provider, as defined in 34A-2-11. This form is also to be completed by the health care provider if treatment, beyond first aid, is given at an employer sponsored free clinic. The form must be cosigned by the supervising physician, unless the form is completed by a nurse practitioner.

C. "Restorative Services Authorization - Form 221" - This form is to be used by any medical provider billing under the restorative services section of the Commission's adopted Resource-Based Relative Value Scale and the Medical Fee Guidelines. The medical provider shall file this form with the insurance carrier or self-insured employer and the division within ten days of the initial evaluation. After the initial filing, an updated Restorative Services Authorization form must be filed for approval or denial at least every six visits until a fixed state of recovery has been reached.

D. "Statement of Insurance Carrier or Self-Insurer with Respect to Payment of Benefits - Form 141" - This form is used for reporting the initial benefits paid to an injured employee. This form must be filed with or mailed to the division on the same date the first payment of compensation is mailed to the employee. A copy of this form must accompany the first payment.

E. "Employee Notification of Denial of Claim - Form 089" - This form is used by insurance carriers or self-insured employers to notify the claimant that his or her claim, in whole or part, is denied and the reason(s) why the claim is being denied. An insurance carrier or self-insured employer shall complete its investigation within 45 days of receipt of the claim and shall commence the payment of benefits or notify the claimant and the division in writing that the claim, in whole or part, is denied.

F. "Insurance Carriers/ Self-Insurer's Notice of Further Investigation of a Workers' Compensation Claim - Form 441" - This form is used by insurance carriers or self-insured employers to notify the claimant and the commission that further investigation is needed and the reasons for further investigation. This form or letter containing similar information is to be filed within 21 days of notification of claim that further investigation is needed.

G. "Statement of Insurance Carrier or Self-Insurer with Respect to Suspension of Benefits - Form 142" - This form is to be used by insurance carriers or self-insured employers to notify an employee of the suspension of weekly compensation benefits. The form must be mailed to the employee and filed with the division five days before the date compensation is suspended. The insurance carrier or self-insured employer must specify the reason for the suspension of beneftis.

H. "Application for Hearing - Form 001" - Used by an applicant for instituting an industrial claim against an insurance carrier, self-insured employer, or uninsured employer. This form, obtainable from the division, must be filed and signed by the injured employee or his/her agent. All blanks must be completed to the best knowledge, belief, or information of the injured employee.

I. "Claim for Dependents' Benefits and/or Burial Benefits - Form 025" - This form is used by the dependent(s) of a deceased employee to seek benefits as a result of a fatal accident or occupational disease occurring in the course of employment.

1. This form must be filed before a hearing or an award is made, and pleadings will not be accepted in lieu thereof. If pleadings are submitted, the attorney so filing will be supplied the form for filing before any proceedings are initiated.

2. The filing of this form by the surviving spouse on behalf of the surviving spouse and the surviving spouse's dependent minor children is sufficient for all dependents.

3. Unless otherwise directed by an Administrative Law Judge, the following information shall be supplied before an Order or an Award is made:

(a) A certified copy of the marriage license and birth certificates of dependent minor children. If such evidence is not readily available, the Administrative Law Judge will determine the adequacy of substitute evidence.

(b) Adoption papers or other decrees of courts of record establishing legal responsibility for support of dependent children.

(c) If either the deceased employee or surviving spouse has been involved in divorce proceedings, copies of decrees and orders of the court should be supplied.

J. "Insurance Company's and Self-Insurer's Final Report of Injury and Statement of Total Losses - Form 130" - This form is used by insurance carriers and self-insurers to report the total losses occurring in a claim for any benefits. This form must be filed with the division as soon as final settlement is made but in no event more than 30 days from such settlement. This form shall be filed for all losses including medical only, compensation, survivor benefits, or any combination of all so as to provide complete loss information for each claim.

K. "Dependents' Benefit Order - Form 151" - This form is used by the division in all accidental death cases where no issue of liability for the death or establishment of dependency is raised and only one household of dependents is involved. The carrier indicates acceptance of liability by completing the top half of the form and filing it with the division.

L. "Medical Information Authorization - Form 046" - This form is used to release the applicant's medical records to the Commission or the chairman of a medical panel appointed by an Administrative Law Judge.

M. "Application to Change Doctors - Form 102" - This form must be used by the employee pursuant to the provisions of Rule R612-2-9 as contained herein.

N. "Employee's Notification of Intent to Leave Locality or State, and to Change Doctor or Hospital - Form 044" - As per Section 34A-2-604, this form is used by the employee and must be accompanied by the "Attending Physician's Statement - Form 043" before Commission approval can be granted. Otherwise, compensation may not be allowed.

O. "Attending Physician's Statement - Form 043" - This form must be completed by employee and his last attending physician in the state to establish the medical condition of the employee. It must be accompanied by Form 044.

P. "Compensation Agreement - Form 219" - This form is used by the parties to a workers' compensation claim to enter into an agreement as to a permanent partial impairment award, and must be submitted to the Division of Industrial Accidents for approval.

Q. "Application for Lump Sum or Advance Payment - Form 134" - This form is used by an employee to apply for a lump sum or advance payment for a permanent partial impairment award.

R. "Release to Return to Work - Form 110" - This form may be used to meet the requirements of Rule R612-2-3(D), as contained herein.

S. "Request for Copies From Claimant's File - Form 205" - This form is used to request copies from a claimant's file in the Commission with the appropriate authorized release.

T. Reemployment Program Forms

1. "Initial Assessment Report - Form 206" - This form is completed either by the self-insured employer, the workers' compensation insurance provider, or by a rehabilitation agency contracted by the employer/carrier. The report contains claimant demographics and insurance coverage details, and addresses the issue of need for vocational assistance.

2. "Request for Decision of Administrative Review - Form 207" - This form is completed when the employee wishes to contest the information/decision made by the carrier or rehabilitation agency.

3. "U.S.O.R. Rehabilitation Progress Report - Form 208A" - This form shall be requested from the Utah State Office of Rehabilitation at each stage of the reemployment process (eligibility determination, reemployment plan development/implementation and case closure) or at any interruption of the process. An Individualized Written Rehabilitation Program (USOR 5 IWRP) shall also be requested when a plan is developed. All other private rehabilitation providers shall submit a Form 206 for any plan progress, postponement, or interruption in the plan.

4. "Reemployment Plan - Form 209" - This form is used for either an original or amended work plan. The form contains the details and estimated costs in returning the injured worker to the work force.

5. "Reemployment Plan Closure Report - Form 210" - This form is submitted to the division upon completion of the reemployment plan. The closure report shall detail costs by category either by dollar amounts or time expended (only in the categories of evaluation and counseling). The report shall also contain all the details on the return to work.

6. "Application for Certification as a Reemployment Provider - Form 212" - This form is completed by rehabilitation providers who wish to be certified by the division. It contains provider demographics, Utah staff credentials, services/fees, and references.

7. "Administrative Review Determination - Form 213" - This form is used by the division to summarize the outcome of the administrative review.

U. "Medical Records - Copies - Form 302" - This form is used by a claimant to request a free copy of his/her medical records from a medical provider. This form must be signed by a staff member of the division.

V. The division may approve change of any of the above forms upon public notice. Carriers may print these forms or approved versions.

KEY: workers' compensation, time, administrative procedures, filing deadlines
[~~December 17, 2002~~|2005
Notice of Continuation September 5, 2002
34A-2-101 et seq.
34A-3-101 et seq.
34A-1-104 et seq.
63-46b-1 et seq.

Labor Commission, Industrial Accidents
R612-2-1
Definitions

NOTICE OF PROPOSED RULE
(Amendment)
DAR FILE NO.: 27894
FILED: 05/13/2005, 11:54

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The purpose of this amendment is to add a definition for "Usual and Customary Rate (UCR)" and specify what the term "insurer" means.

SUMMARY OF THE RULE OR CHANGE: This amendment defines "Usual and Customary Rate (UCR)" as the rate of payment to a dental provider using Ingenix, or a similar service, for charges for services for a particular zip code. It also specifies that the term "insurer" includes workers' compensation insurance carriers and self-insured employers, unless otherwise specified.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Sections 34A-2-101 et seq., 34A-3-101 et seq., and 34A-1-104

ANTICIPATED COST OR SAVINGS TO:
❖ THE STATE BUDGET: There should be no cost or savings to the state budget, as this rule only adds definitions.
❖ LOCAL GOVERNMENTS: There should be no cost or savings to local government, as this rule only adds definitions.
❖ OTHER PERSONS: There should be no cost or savings to other persons, as this rule only adds definitions.

COMPLIANCE COSTS FOR AFFECTED PERSONS: There should be no compliance costs for affected persons, as this rule only adds definitions.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: There should be no fiscal impact on businesses because of this amendment, as the amendment only adds definitions. R. Lee Ellertson, Commissioner

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
LABOR COMMISSION
INDUSTRIAL ACCIDENTS
HEBER M WELLS BLDG
160 E 300 S
SALT LAKE CITY UT 84111-2316, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
Joyce Sewell at the above address, by phone at 801-530-6988, by FAX at 801-530-6804, or by Internet E-mail at jsewell@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 07/01/2005.

THIS RULE MAY BECOME EFFECTIVE ON: 07/02/2005

AUTHORIZED BY: R Lee Ellertson, Commissioner

R612. Labor Commission, Industrial Accidents.
R612-2. Workers' Compensation Rules-Health Care Providers.
R612-2-1. Definitions.

A. All definitions in Rule R612-1 apply to this section.

B. "Medical Practitioner" - means any person trained in the healing arts and licensed by the State in which such person practices.

C. "Global Fee Cases" - are those flat fee cases where fees include pre-operative and follow-up or aftercare.

D. "Usual and Customary Rate (UCR)" is the rate of payment to a dental provider using Ingenix, or a similar service, for charges for services for a particular zip code.

E. Unless otherwise specified, the term "insurer" includes workers' compensation insurance carriers and self-insured employers.

KEY: workers' compensation, fees, medical practitioner
[~~July 2, 2003~~]2005
Notice of Continuation May 28, 2003
34A-2-101 et seq.
34A-3-101 et seq.
34A-1-104

▼ ▼

Labor Commission, Industrial Accidents
R612-2-2
Authority

NOTICE OF PROPOSED RULE
(Amendment)
DAR FILE NO.: 27895
FILED: 05/13/2005, 11:57

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The purpose of this amendment is to add Section 34A-2-407 as a basis for authorizing the rules governing workers' compensation and health care providers.

SUMMARY OF THE RULE OR CHANGE: This amendment adds Section 34A-2-407 as a basis for authorizing the rules governing Workers' Compensation and Health Care Providers.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Sections 34A-2-101 et seq., 34A-3-101 et seq., and 34A-1-104

ANTICIPATED COST OR SAVINGS TO:
❖ THE STATE BUDGET: There should be no cost or savings to the state budget, as this amendment does not add any new requirements.
❖ LOCAL GOVERNMENTS: There should be no cost or savings to local government, as this amendment does not add any new requirements.
❖ OTHER PERSONS: There should be no cost or savings to other persons, as this amendment does not add any new requirements.

COMPLIANCE COSTS FOR AFFECTED PERSONS: There should be no compliance costs for affected person with this amendment, as there are no new requirements because of this change.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: There should be no fiscal impact on businesses because this amendment does not add any additional requirements in compliance with workers' compensation matters. R. Lee Ellertson, Commissioner

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LABOR COMMISSION
INDUSTRIAL ACCIDENTS
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160 E 300 S
SALT LAKE CITY UT 84111-2316, or
at the Division of Administrative Rules.

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THIS RULE MAY BECOME EFFECTIVE ON: 07/02/2005

AUTHORIZED BY: R Lee Ellertson, Commissioner

R612. Labor Commission, Industrial Accidents.
R612-2. Workers' Compensation Rules-Health Care Providers.
R612-2-2. Authority.

This rule is enacted under the authority of Section 34A-1-104 and Section 34A-2-407.

KEY: workers' compensation, fees, medical practitioner
[~~July 2, 2003~~]2005
Notice of Continuation May 28, 2003
34A-2-101 et seq.
34A-3-101 et seq.
34A-1-104

Labor Commission, Industrial Accidents
R612-2-3
Filings

NOTICE OF PROPOSED RULE
(Amendment)
DAR FILE NO.: 27900
FILED: 05/13/2005, 15:58

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The reason for the change is to clarify reporting requirements for first aid and other initial treatment of work-related injuries.

SUMMARY OF THE RULE OR CHANGE: The proposed amendment requires health care providers to file the Commission's form 123 after providing initial treatment for any injury or illness reported to be work related. The amendment also requires the signature of a physician, chiropractor, or nurse practitioner on form 123.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Sections 34A-2-101 et seq., 34A-3-101 et seq., and 34A-1-104

ANTICIPATED COST OR SAVINGS TO:
❖ THE STATE BUDGET: This rule amendment will not impose any costs or savings to the state budget, either in administration costs or in the State's capacity as an employer because it is a clarification.
❖ LOCAL GOVERNMENTS: This rule amendment will not result in costs or savings to local governments because it is a clarification.
❖ OTHER PERSONS: This rule amendment will not result in costs or savings to other persons because it is a clarification.

COMPLIANCE COSTS FOR AFFECTED PERSONS: This rule amendment clarifies existing reporting requirements rather than imposing any new requirements. Consequently, no compliance costs are associated with the rule.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: This rule will primarily affect medical providers, who are already generally aware of Commission reporting requirements. The effect on business will therefore be negligible. R. Lee Ellertson, Commissioner

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160 E 300 S
SALT LAKE CITY UT 84111-2316, or
at the Division of Administrative Rules.

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THIS RULE MAY BECOME EFFECTIVE ON: 07/02/2005

AUTHORIZED BY: R Lee Ellertson, Commissioner

R612. Labor Commission, Industrial Accidents.
R612-2. Workers' Compensation Rules-Health Care Providers.
R612-2-3. Filings.

A. Within one week following the initial examination of an industrial patient, nurse practicioners, physicians and chiropractors[~~,~~] shall file "Form 123 - Physicians' Initial Report" with the carrier/self-insured employer, employee, and the division. This form is to be completed in as much detail as feasible. Special care should be used to make sure that the employee's account of how the accident occurred is completely and accurately reported. All questions are to be answered or marked "N/A" if not applicable in each particular instance. All addresses must include city, state, and zip code. If modified employment in #29 is marked "yes," the remarks in #29 must reflect the particular restrictions or limitations that apply, whether as to activity or time per day or both. Estimated time loss must also be given in #29. If

"Findings of Examination" (#17) do not correctly reflect the coding used in billing, a reduction of payment may be made to reflect the proper coding. A physician, chiropractor, or nurse practitioner is to report every initial visit for which a bill is generated, including first aid, when a worker reports that an injury or illness is work related. All initial treatment, beyond first aid, that is provided by any health care provider other than a physician, chiropractor, or nurse practictioner must be countersigned by the supervising physician and reported on Form 123 to the Industrial Accidents Division and the insurance carrier or self-insured employer.

B. 1. Any medical provider billing under the restorative services section of the Labor Commission's adopted Resource-Based Relative Value Scale (RBRVS) or the Medical Fee Guidelines shall file the Restorative Services Authorization (RSA) form with the insurance carrier or self-insured employer (payor) and the division within ten days of the initial evaluation.

2. Upon receipt of the provider's RSA form, the payor has ten days to respond, either authorizing a specified number of visits or denying the request. No more than eight visits may be incurred during the authorization process.

3. After the initial RSA form is filed with the payor and the division, an updated RSA form must be filed for approval or denial at least every six visits until a fixed state of recovery has been achieved as evidenced by either subjective or objective findings. If the medical provider has filed the RSA form per this rule, the payor is responsible for payment, unless compensability is denied by the payor. In the event the payor denies the entire compensability of a claim, the payor shall so notify the claimant, provider, and the division, after which the provider may then bill the claimant.

4. Any denial of payment for treatment must be based on a written medical opinion or medical information. The denial notification shall include a copy of the written medical opinion or information from which the denial was based. The payor is not liable for payment of treatment after the provider, claimant, and division have been notified in writing of the denial for authorization to pay for treatment. The claimant may then become responsible for payment.

5. Any dispute regarding authorization or denial for treatment will be determined from the date the division received the RSA form or notification of denial for payment of treatment.

6. The claimant may request a hearing before the Division of Adjudication to resolve compensability or treatment issues.

7. Subjective objective assessment plan/procedure (SOAP notes) or progress notes are to be sent to the payor in addition to the RSA form.

8. Any medical provider billing under the Restorative Services Section of the RBRVS or the Commission's Medical Fee Guidelines who fails to submit the required RSA form shall be limited to payment of up to eight visits for a compensable claim. The medical provider may not bill the patient or employer for any remaining balances.

C. S.O.A.P. notes or progress reports of each visit are to be sent to the payor by all medical practitioners substantiating the care given, the need for further treatment, the date of the next treatment, the progress of the patient, and the expected return-to-work date. These reports must be sent with each bill for the examination and treatment given to receive payment. S.O.A.P. notes are not to be sent to the division unless specifically requested.

D. "Form 110 - Release to Return to Work" must be mailed by either the medical practitioner or carrier/employer to the employee and the division within five calendar days of release.

E. The carrier/employer may request medical reports in addition to regular progress reports. A charge may be made for such additional reports, which charge should accurately reflect the time and effort expended by the physician.

KEY: workers' compensation, fees, medical practitioner
[~~July 2, 2003~~]2005
Notice of Continuation May 28, 2003
34A-2-101 et seq.
34A-3-101 et seq.
34A-1-104

Labor Commission, Industrial Accidents
R612-2-5
Regulation of Medical Practitioner Fees

NOTICE OF PROPOSED RULE
(Amendment)
DAR FILE NO.: 27899
FILED: 05/13/2005, 14:52

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: This amendment updates standards for determining fees for medical practitioners treating work-related injuries and illnesses. The amendment also increases the fees allowed for categories of medical care described as "medicine" and "restorative medicine."

SUMMARY OF THE RULE OR CHANGE: This amendment incorporates by reference the 2005 version of the "Resource Based Relative Value Scale" which is used in establishing fees for medical practitioners in workers' compensation cases. The amendment increases from $42 to $44 the unit value for medicine and restorative medicine services. The amendment also increase the relative values of four restorative medicine treatment codes. The amendment also provides a reference to the Labor Commission's web site.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Sections 34A-2-101 et seq., 34A-3-101 et seq., and 34A-1-104

THIS RULE OR CHANGE INCORPORATES BY REFERENCE THE FOLLOWING MATERIAL: National Centers for Medicare and Medicaid Services (CMS) for the Medicare Physician Fee Schedule (MPFS) "Resource-Based Relative Value Scale", 2005 edition, and the American Medical Association's CPT-4, 2005 edition.

ANTICIPATED COST OR SAVINGS TO:
❖ THE STATE BUDGET: This amendment imposes no additional costs of administration. Regarding cost to the State in its capacity as an employer, the aggregate cost to all Utah employers is estimated at $2,000,000. This represents an increase of 1% in workers' compensation medical costs, which will be factored into workers' compensation insurance premiums over time.

❖ LOCAL GOVERNMENTS: The aggregate cost of this amendment to all Utah employers is estimated at $2,000,000. This represents an increase of 1% in workers' compensation medical costs, which will be factored into workers' compensation insurance premiums over time.
❖ OTHER PERSONS: Health care providers providing "medical" and "restorative medical" services to injured workers will receive increased fees totaling $2,000,000. This represents an increase of 1% in workers' compensation medical costs, which will be factored into workers' compensation insurance premiums over time.

COMPLIANCE COSTS FOR AFFECTED PERSONS: Compliance costs are limited to possible minor increases in overall workers' compensation rates resulting from the increase in workers' compensation medical payments.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: This small increase in payments to medical providers under the workers' compensation system is approximately 1% of current medical costs. This amount will be factored into future workers' compensation premiums, but is expected to have a negligible impact on businesses that purchase workers' compensation insurance. R. Lee Ellertson, Commissioner

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LABOR COMMISSION
INDUSTRIAL ACCIDENTS
HEBER M WELLS BLDG
160 E 300 S
SALT LAKE CITY UT 84111-2316, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
Joyce Sewell at the above address, by phone at 801-530-6988, by FAX at 801-530-6804, or by Internet E-mail at jsewell@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 07/01/2005.

THIS RULE MAY BECOME EFFECTIVE ON: 07/02/2005

AUTHORIZED BY: R Lee Ellertson, Commissioner

R612. Labor Commission, Industrial Accidents.
R612-2. Workers' Compensation Rules-Health Care Providers.
R612-2-5. Regulation of Medical Practitioner Fees.

Pursuant to Section 34A-2-407:

A. The Labor Commission of Utah:

1. Establishes and regulates fees and other charges for medical, surgical, nursing, physical and occupational therapy, mental health, chiropractic, naturopathic, and osteopathic services, or any other area of the healing arts as required for the treatment of a work-related injury or illness.

2. Adopts and by this reference incorporates the National [~~Health Care Financing Administration's (HCFA)~~]Centers for Medicare and Medicaid Services (CMS) for the Medicare Physician Fee Schedule (MPFS) "Resource-Based Relative Value Scale" (RBRVS), 200[~~3~~]5 edition, as the method for calculating reimbursement and the American Medical Association's CPT-4, 200[~~3~~]5 edition, coding guidelines. The non-facility total unit value will apply in calculating the reimbursement, except that procedures provided in a facility setting shall be reimbursed at the facility total unit value and the facility may bill a separate facility charge. The CPT-4 coding guidelines and RBRVS are subject to the Utah Labor Commission's Medical Fee Guidelines and Codes and the following Labor Commission conversion factors for medical care rendered for a work-related injury or illness, effective July [~~2, 2003~~]1, 2005:

Anesthesiology $41.00 (1 unit per 15 minutes of anesthesia);

Medicine $[~~42.00~~]44.00;

Pathology and Laboratory 150% of Utah's published Medicare carrier;

Radiology $53.00;

Restorative Medicine $[~~42.00~~]44.00, with Utah code 97001 and 97003 at a [~~0.8~~]1.5 relative value unit and Utah code 97002 and 97004 at a [~~0.5~~]1.0 of relative value unit.

Surgery $37.00;

All 20000 codes, codes 49505 thru 49525 and all 60000 codes of the CPT-4 coding guidelines $58.00.

3. Adopts and incorporates by this reference the Utah Labor Commission's Medical Fee Guidelines and Codes, as of [~~June 1, 2002~~]July 1, 2005. The Utah Medical Fee Guidelines and Codes can be obtained from the division for a fee sufficient to recover costs of development, printing, and mailing or can be downloaded at the Labor Commission's website at www.laborcommission.utah.gov/indacc/indacc.htm.

4. Decides appropriate billing procedure codes when disputes arise between the medical practitioner and the employer or its insurance carrier. In no instance will the medical practitioner bill both the employer and the insurance carrier.

B. Employees cannot be billed for treatment of their work-related injuries or illnesses.

C. Discounting from the fees established by the Labor Commission is allowed only through specific contracts between a medical provider and a payor for treatment of work-related injury or illness.

D. Restocking fee 15%. Rule R612-2-16 covers the restocking fee.

E. Dental fees are not published. Rule R612-2-18 covers dental injuries.

F. Ambulance fees are not published. Rule R612-2-19 covers ambulance charges.

KEY: workers' compensation, fees, medical practitioner
[~~July 2, 2003~~]2005
Notice of Continuation May 28, 2003
34A-2-101 et seq.
34A-3-101 et seq.
34A-1-104

Labor Commission, Industrial Accidents
R612-2-18
Dental Injuries

NOTICE OF PROPOSED RULE
(Amendment)
DAR FILE NO.: 27893
FILED: 05/13/2005, 11:52

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: This amendment sets fees for treatment of work-related dental injuries. It also establishes procedures by which insurance carriers can manage expenses of dental treatment.

SUMMARY OF THE RULE OR CHANGE: This amendment completely removes this section of the Commission's rule. The amendment establishes a benchmark for determining the "usual and customary rate" for dental services. The amendment authorizes workers to make their own initial selection of dentist for emergency dental care. Thereafter, the employer is authorized to negotiate for additional dental care. The amendment also establishes procedures and time limits for this process.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Sections 34A-2-101 et seq., 34A-3-101 et seq., and 34A-1-104

ANTICIPATED COST OR SAVINGS TO:

❖ THE STATE BUDGET: The Commission does not anticipate any appreciable cost or savings to the state in administering this rule. Because the amendment increases employers/ insurance carriers' ability to limit the cost of work-related dental treatment, the state may experience some small reduction in its workers' compensation expenses.

❖ LOCAL GOVERNMENTS: This rule only affects local government in their capacity as employers. Because the amendment increases employers/insurance carriers' ability to limit the cost of work-related dental treatment, local governments may experience some small reduction in their workers' compensation expenses.

❖ OTHER PERSONS: Workers' compensation insurance companies should realize some small savings from their increased ability under the amendment to limit the cost of work-related dental treatment. This reduction in dental expenses will, over time, be factored into workers' compensation premiums, to the benefit of employers.

COMPLIANCE COSTS FOR AFFECTED PERSONS: Affected persons (primarily workers' compensation insurance carriers, self-insured employers and dental care providers) already have management systems that can be adapted to the requirements of this rule. The Commission anticipates no significant costs to such person as a result of adoption of this rule.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: This proposal allows workers' compensation insurance carriers and self-insured employers to more closely manage the cost of dental treatment for injured workers. Insurance carriers and self-insured employers already have case management capabilities, so the addition of dental management responsibilities should not result in any additional costs. The result of this increased control over dental care will, over time, tend to reduce workers' compensation costs by a relatively small amount. R. Lee Ellertson, Commissioner

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Joyce Sewell at the above address, by phone at 801-530-6988, by FAX at 801-530-6804, or by Internet E-mail at jsewell@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 07/01/2005.

THIS RULE MAY BECOME EFFECTIVE ON: 07/02/2005

AUTHORIZED BY: R Lee Ellertson, Commissioner

R612. Labor Commission, Industrial Accidents.
R612-2. Workers' Compensation Rules-Health Care Providers.
R612-2-18. Dental Injuries.

[~~Where a worker sustains an accident in the course of his employment resulting in the loss of or injury to teeth, making dental work necessary, the injured worker shall consult a dental surgeon and receive such first aid as may be necessary to preserve, if possible, the normal function of the injured teeth. The dental surgeon shall then file with the insurance carrier a report setting forth the nature of the injury together with an estimate of the cost of restoration. The dental surgeon shall not proceed with the restoration until authority has been granted by the insurance carrier, provided, however, that if an employer maintains a medical staff or designates a company doctor, the employee shall first report to that medical staff or medical officer and be guided by directions then given. If the carrier refuses payment at the level estimated by the dental surgeon, the employee may choose to pay the difference and seek adjudication by Application for Hearing. A dental surgeon may choose to settle for the payment allowed, or the carrier shall direct the employee to a dental surgeon who will provide his services at the payment level specified by the carrier.~~]A. This rule establishes procedures to obtain dental care for work-related dental injuries and sets fees for such dental care.

B. Initial Treatment.

1. If an employer maintains a medical staff or designates a company doctor, an injured worker seeking dental treatment for work-related injuries shall report to such medical staff or doctor and follow their instructions.

2. If an employer does not maintain a medical staff or designate a company doctor, or if such staff or doctor are not available, an injured worker may consult a dentist to obtain immediate care dental for injuries caused by a work-related accident. The insurer shall pay the dentist providing this initial treatment at 70% of UCR for the services rendered.

C. Subsequent care by initial treatment provider.

1. If additional treatment is necessary, the dentist who provided initial treatment may submit to the insurer a request for authorization to continue treatment. The transmission date of the request must be verifiable. The request itself must include a description of the injury, the additional treatment required, and the cost of the additional treatment. If the dentist proceeds with treatment without authorization, the dentist must accept 70% of UCR as payment in full and may not charge any additional sum to the injured worker.

2. The insurer shall respond to the request for authorization within 10 working days of the request's transmission. This 10-day period can be extended only with written approval of the Industrial Accidents Division. If the insurer does not respond to the dentist's request for authorization within 10 working days, the insurer shall pay the cost of treatment as contained in the request for authorization.

3. If the insurer approves the proposed treatment, the insurer shall send written authorization to the dentist and injured worker. This authorization shall include the anticipated payment amount.

4. On receipt of the insurer's written authorization, and if the dentist accepts the payment provisions therein, the dentist may proceed to provide the approved services. The dentist must accept the amount to be paid by the insurer as full payment for those services and may not bill the injured worker for any additional amount.

D. Subsequent care by other providers.

1. If the dentist who provided initial treatment does not agree to the payment offered by the insurer, the insurer shall within 20 calendar days direct the injured worker to a dentist located within a reasonable travel distance who will accept the insurer's payment offer.

2. If the insurer cannot locate another dentist to provide the necessary services, the insurer shall attempt to negotiate a satisfactory reimbursement with the dentist who provided initial treatment. The negotiated reimbursement may not include any balance billing to the claimant.

3. If the insurer is successful in arranging treatment with another dentist, the insurer shall notify the injured worker.

4. If, after having received notice that the insurer has arranged the services of another dentist, the injured worker chooses to obtain treatment from a different dentist, the insurer shall only be responsible for payment at 70% of UCR. Under the circumstances of this subsection (4), the treating dentist may bill the injured worker for the difference between the dentist's charges and the amount paid by the insurer.

E. Payment or treatment disputes that cannot be resolved by the parties may be submitted to the Labor Commission's Adjudication Division for decision, pursuant to the Adjudication Division's established forms and procedures.

KEY: workers' compensation, fees, medical practitioner
[~~July 2, 2003~~]2005
Notice of Continuation May 28, 2003
34A-2-101 et seq.
34A-3-101 et seq.
34A-1-104

▼ ▼

Labor Commission, Industrial Accidents
R612-2-22
Medical Records

NOTICE OF PROPOSED RULE
(Amendment)
DAR FILE NO.: 27891
FILED: 05/13/2005, 11:46

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: In response to changes in medical record access established by the federal government under HIPAA (Health Insurance Portability and Accountability Act of 1996), this rule completely rewrites the Commission's existing rule governing access to injured workers' medical records for workers' compensation purposes. Under HIPAA, an individual's medical information can be released in accordance with standards established by states to administer workers' compensation systems. This rule establishes such standards for Utah.

SUMMARY OF THE RULE OR CHANGE: The rule recognizes the needs of insurers, employers and the Labor Commission to obtain a workers' compensation applicant's medical records. The rule identifies those circumstances where a medical provider can release such information without the claimant's consent. The rule also sets out other circumstances in which the claimant's permission is required for release of medical information. The rule defines the types of records that are considered relevant for workers' compensation purposes. It also addresses subsequent use of such information, sets fees that may be charged for providing information, and establishes a procedure to resolve disputes.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Sections 34A-2-101 et seq., 34A-3-101 et seq., and 34A-1-104

ANTICIPATED COST OR SAVINGS TO:

❖ THE STATE BUDGET: The Commission does not anticipate any appreciable costs or savings to the State in administering this rule or in its capacity as an employer.

❖ LOCAL GOVERNMENTS: This rule only affects local government in their capacity as employers. The Commission does not anticipate any appreciable costs or savings to local governments.

❖ OTHER PERSONS: This rule primarily affects insurance adjusting functions. The Commission anticipates that the definitions and procedures established by this rule will not require any appreciable additional expense or result in any appreciable savings ti other persons.

COMPLIANCE COSTS FOR AFFECTED PERSONS: Federal HIPAA regulations already impose record keeping standards on medical providers. This rule will not add any additional requirements of that nature. Insurers' adjusting functions will be somewhat affected by new definitions and procedures, but the Labor Commission is unaware of any information indicating that compliance with these standards will impose any significant compliance costs.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: The requirements of this rule are less onerous than would otherwise be applied under federal HIPAA. Although the rule contains new safeguards to limit disclosure of medical records to only those records that are relevant to workers' compensation claims, the rule also establishes definitions and procedures to facilitate the identification of records as relevant or nonrelevant. On balance, the rule will have no negative impact on business. R. Lee Ellertson, Commissioner

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

LABOR COMMISSION
INDUSTRIAL ACCIDENTS
HEBER M WELLS BLDG
160 E 300 S
SALT LAKE CITY UT 84111-2316, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
Joyce Sewell at the above address, by phone at 801-530-6988, by FAX at 801-530-6804, or by Internet E-mail at jsewell@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 07/01/2005.

THIS RULE MAY BECOME EFFECTIVE ON: 07/02/2005

AUTHORIZED BY: R Lee Ellertson, Commissioner

R612. Labor Commission, Industrial Accidents.
R612-2. Workers' Compensation Rules-Health Care Providers.
R612-2-22. Medical Records.

[~~A. When any medical practitioner provides copies of medical records to the parties of an industrial case, the following charges are presumed reasonable:~~

~~1. A search fee of $15 payable in advance of the search,~~

~~2. Copies at $0.50 per page including copies of microfilm payable after the records have been prepared, and~~

~~3. Actual costs of postage payable after the records have been prepared. Actual costs of postage are deemed to be the cost of regular mail unless the requesting party has requested the delivery of the records by special mail or method.~~

~~B. Those persons or entities who are entitled to copies of medical records involving an industrial case are:~~

~~1. The injured employee or his/her dependents,~~

~~2. The employer of the injured worker,~~

~~3. The employer's workers' compensation insurance carrier,~~

~~4. The Uninsured Employers' Fund,~~

~~5. The Employers' Reinsurance Fund,~~

~~6. The Commission, and~~

~~7. Any attorney representing any of the above in an industrial injury or occupational disease claim.~~

~~C. No other person or entity is entitled to medical records unless ordered by a Court or provided with a notarized release executed by the injured worker.~~

~~D. The Commission will operate in the release of its records to the parties/entities as specified above unless the information is classified as confidential under the Government Records Access and Management Act (GRAMA).~~

~~E. No fee shall be charged when the RBRVS requires specific documentation for a procedure or when physicians and surgeons are required to report by statute or rule.~~

~~F. An injured worker may obtain one of each of the following records related to the industrial injury or occupational disease, at no cost, when the injured worker or his/her dependents have a signed form by the division to substantiate his/her industrial injury/illness claim:~~

~~1. History and physical,~~

~~2. Operative reports of surgeries,~~

~~3. Discharge summary, and~~

~~4. Emergency room records,~~

~~5. Radiological reports,~~

~~6. Specialized testing results,~~

~~7. Physician SOAP notes, progress notes or specialized reports.~~

~~(a) Alternatively, a summary of the patient's record may be made available to the claimant at the discretion of the physician.~~

~~8. And such other records as may be requested by the Commission in order to make a determination of liability.~~]A. Workers' compensation insurers, employers and the Utah Labor Commission need access to health information of individuals who are injured on the job or who have a work-related illness in order to process or adjudicate claims, or to coordinate care under Utah's workers' compensation system. Generally, this health information is obtained from health care providers who treat these individuals and who may be covered by federal "HIPAA" privacy rules.

The HIPAA Privacy Rule specifically recognizes the legitimate need of the workers' compensation system to have access to individuals' health information to the extend authorized by State law. See 45 CFR 164.512(1). The Privacy Rule also recognizes the importance of permitting disclosures required by other laws. See 45 CFR 164.512(a). Therefore, disclosures permitted by this rule for workers' compensation purposes or otherwise required by this rule do not conflict with and are not prohibited by the HIPAA Privacy Rule.

B. A medical provider, without authorization from the injured workers, shall:

1. For purposes of substantiating a bill submitted for payment or filing required Labor Commission forms, such as the "Physician's Initial Report of Injury/Illness" or the "Restorative Services Authorization," disclose medical records necessary to substantiate the billing, including drug and alcohol testing, to:

a. An employer's workers' compensation insurance carrier or third party administrator;

b. A self-insured employer who administers its own workers' compensation claims;

c. The Uninsured Employers' Fund;

d. The Employers' Reinsurance Fund; or

e. The Labor Commission as required by Labor Commission rules.

2. Disclose medical records pertaining to treatment of an injured worker, who makes a claim for workers' compensation benefits, to another physician for specialized treatment, to a new treating physician chosen by the claimant, or for a consultation regarding the claimed work related injury or illness.

C. 1. Except as limited in C(3), a medical provider, whose medical records are relevant to a workers' compensation claim shall, upon receipt of a Labor Commission medical records release form, or an authorization form that conforms to HIPAA requirements, disclose his/her medical records to:

a. An employer's insurance carrier or third party administrator;

b. A self-insured employer who administers its own workers' compensation claims;

c. An agent of an entity listed in B(1)(a through e), which includes, but is not limited to a case manager or reviewing physician;

d. The Uninsured Employers Fund;

e. The Employers' Reinsurance Fund;

f. The Labor Commission;

g. The injured worker;

h. An injured workers' personal representative;

i. An attorney representing any of the entities listed above in an industrial injury or occupational disease claim.

2. Medical records are relevant to a workers' compensation claim if:

a. The records were created after the reported date of the accident or onset of the illness for which workers' compensation benefits have been claimed; or

b. The records were created in the past ten years (15 years if permanent total disability is claimed) and;

i. There is a specific reason to suspect that the medical condition existed prior to the reported date of the claimed work related injury or illness or

ii. The claim is being adjudicated by the Labor Commission.

3. Medical records related to care provided by a psychiatrist, psychologist, obstetrician, or care related to the reproductive organs may not be disclosed by a medical provider unless a claim has been made for a mental condition, a condition related to the reproductive organs, or the claimant has signed a separate, specific release for these records.

D. A medical provider, who has treated an injured worker for a work related injury or illness, shall disclose information to an injured workers' employer as to when and what restrictions an injured worker may return to work.

E. Requests for medical records beyond what sections B, C, and D permit require a signed approval by the director, the medical director, or a designated person(s) within the Industrial Accidents Division.

F. A party affected by the decision made by a person in section E may appeal that decision to the Adjudication Division of the Labor Commission.

G. Upon receipt and within the scope of this rule, an injured worker shall provide those entities or person listed in C(1) the names, address, and dates of medical treatment (if known) of the medical providers who have provided medical care within the past 10 years (15 years for permanent total disability claim) except for those medical providers names in C(3). Labor Commission form number 307 "Medical Treatment Provider List" must be used for this purpose. Parties listed in C(1) of this rule must provide each medical provider identified on form 307 with a signed authorization for access to medical records. A copy of the signed authorization may be sent to the medical providers listed on form 307.

H. An injured worker may contest, for good reason, a request for medical records created prior to the reported date of the accident or illness for which the injured worker has made a claim for benefits by filing a complaint with the Labor Commission. Good reason is defined as the request has gone beyond the scope of this rule or sensitive medical information is contained in a particular medical record.

I. 1. Any party obtaining medical records under authority of this rule may not disclose those medical records, without a valid authorization, except as required by law.

2. An employer may only use medical records obtained under the authority of this rule to:

a. Pay or adjudicate workers' compensation claims if the employer is self-insured;

b. To assess and facilitate an injured workers' return to work;

c. As otherwise authorized by the injured worker.

3. An employer obtaining medical records under authority of this rule must maintain the medical records separately from the employee's personnel file.

J. Any medical records obtained under the authority of this rule to make a determination regarding the acceptance of liability or for treatment of a condition related to a workers' compensation claim shall only be used for workers' compensation purposes and shall not be released, without a signed release by the injured worker or his/her personal representative, to any other party. An employer shall make decisions related only to the workers' compensation claim based on any medical information received under this rule.

K. When any medical provider provides copies of medical records, other than the records required when submitting a bill for payment or as required by the Labor commission rules, the following charges are presumed reasonable:

1. A search fee of $15 payable in advance of the search;

2. Copies at $.50 per page, including copies of microfilm, payable after the records have been prepared and

3. Actual costs of postage payable after the records have been prepared an sent. Actual cost of postage are deemed to be the cost of regular mail unless the requesting party has requested the delivery of the records by special mail or method.

4. The Labor Commission will release its records per the above charges to parties/entities with a signed and notarized release from the injured worker unless the information is classified and controlled under the Government Records Access and Management Act (GRAMA).

L. No fee shall be charged when the RBRVS or the Commission's Medical Fee Guidelines require specific documentation for a procedure or when medical providers are required to report by statute or rule.

M. An injured worker or his/her personal representative may obtain one copy of each of the following records related to the industrial injury or occupational disease claim, at no cost, when the injured worker or his/her personal representative have signed a form by the Industrial Accidents Division to substantiate his/her industrial injury/illness claim;

1. History and physical;

2. Operative reports of surgery;

3. Hospital discharge summary;

4. Emergency room records;

5. Radiological reports;

6. Specialized test results; and

7. Physician SOAP notes, progress notes, or specialized reports.

(a) Alternatively, a summary of the patients records may be made available to the injured worker or his/her personal representative at the discretion of the physician.

KEY: workers' compensation, fees, medical practitioner
[~~July 2, 2003~~]2005
Notice of Continuation May 28, 2003
34A-2-101 et seq.
34A-3-101 et seq.
34A-1-104

Labor Commission, Occupational Safety and Health
R614-7-4
Residential-Type Construction, Raising Framed Walls

NOTICE OF PROPOSED RULE
(Amendment)
DAR FILE NO.: 27903
FILED: 05/13/2005, 16:36

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The purpose of this new section is to prevent the increasing number of injuries that result from manual attempts to raise framed walls.

SUMMARY OF THE RULE OR CHANGE: The proposed amendment applies to "residential-type construction" and establishes safety standards for raising framed walls in such construction. For framed walls between 10 and 18 feet high, cleats, straps or other restraining devices are required. For framed walls greater than 18 feet high, mechanical lifting devices are required. The proposed rule also requires employee training on the hazards of raising framed walls and the use of protective measures.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Title 34A, Chapter 6

ANTICIPATED COST OR SAVINGS TO:
❖ THE STATE BUDGET: The State is not generally involved in the types of construction subject to this rule. Furthermore, the restraining devices and other safety measures required by this rule require minimal cost. The Commission anticipates no aggregate cost to the State budget.
❖ LOCAL GOVERNMENTS: Local governments are not generally involved in the types of construction subject to this rule. Furthermore, the restraining devices and other safety measures required by this rule require minimal cost and will result in no cost to local government.
❖ OTHER PERSONS: Construction companies that perform the type of construction subject to this rule will be required to use simple restraining devices or mechanical lifting devices. These devices will cost, on average, $75.

COMPLIANCE COSTS FOR AFFECTED PERSONS: The estimated cost of a strap or cleat is less than $5. The estimated cost of a mechanical lift will vary depending on the type of lift, but is estimated in the range of $75.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: The cost of injuries that result from accidents in lifting framed walls can easily run to thousands of dollars. The cost of preventing such accidents, through the simple and inexpensive methods required by the proposed rule, is less than $100 per construction project. Consequently, this rule should have a positive fiscal impact on business. R. Lee Ellertson, Commissioner

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
LABOR COMMISSION
OCCUPATIONAL SAFETY AND HEALTH
HEBER M WELLS BLDG
160 E 300 S
SALT LAKE CITY UT 84111-2316, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
William Adams at the above address, by phone at 801-530-6897, by FAX at 801-530-7606, or by Internet E-mail at wadams@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 07/01/2005.

THIS RULE MAY BECOME EFFECTIVE ON: 07/02/2005

AUTHORIZED BY: R Lee Ellertson, Commissioner

R614. Labor Commission, Occupational Safety and Health.
R614-7. Construction Standards.
R614-7-4. Residential-Type Construction, Raising Framed Walls.

A. Scope and Application

This section applies to work directly associated with the raising of framed walls in new buildings or structures in residential-type construction.

B. Definitions

1. "Residential-type Construction" means construction using the operations, methods, and procedures associated with residential and light commercial construction characterized by joists or trusses resting on stud walls and using wood and/or light gage steel frame construction.

2. "Bottom Plate" means the bottom horizontal member of a frame wall.

C. Standards For Raising Walls.

1. At no time during the raising of the framed wall shall an employee who is not performing the actual lift be allowed under the wall system unless a mechanical bracing system is in place to arrest the fall of a wall.

2. Before manually raising framed walls that are 10 feet or more in height, temporary restraints such as cleats on the foundation/floor system or straps on the wall bottom plate shall be installed to prevent inadvertent horizontal sliding or uplift of the framed wall bottom plate. Anchor bolts and/or toe nails, are not sufficient for use in blocking or bracing the framed wall.

3. Framed walls 18 feet or more in height shall be raised using mechanical lifting devices.

D. Standards For Training.

1. The employer shall provide a training program to employees engaged in raising framed walls. The program shall enable employees to recognize the hazards associated with raising framed walls and shall include procedures to minimize those hazards, including:

a. Where required by the standard, the use of and limitations to temporary restraints used to prevent inadvertent sliding and uplift on the bottom plate;

b. the use of mechanical lifting devises;

c. the use of mechanical bracing systems; and

d. the role of each employee involved in the raising of a framed wall.

KEY: safety
[~~December 4, 1998~~]2005
Notice of Continuation November 25, 2002
34A-6

▼ ▼

Natural Resources, Wildlife Resources
R657-5
Taking Big Game

NOTICE OF PROPOSED RULE
(Amendment)
DAR FILE NO.: 27865
FILED: 05/05/2005, 10:50

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: This rule is being amended pursuant to Regional Advisory Council meetings and the Wildlife Board meeting conducted for taking public input and reviewing the big game antlerless and doe limited entry hunts and drawing as approved by the Wildlife Board.

SUMMARY OF THE RULE OR CHANGE: Provisions are being amended to allow 20% of the antlerless deer, elk, and doe pronghorn permits to be reserved for youth hunters who wish to participate in a youth drawing. Other changes are being made for consistency.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Sections 23-14-18 and 23-14-19

ANTICIPATED COST OR SAVINGS TO:

❖ THE STATE BUDGET: These amendments allow for 20% of youth permits to be reserved for youth in the antlerless drawing. Therefore, the Division of Wildlife Resources (DWR) determines that these amendments do not create a cost or savings impact to the state budget or DWR's budget.

❖ LOCAL GOVERNMENTS: None--This filing does not create any direct cost or savings impact to local governments because they are not directly affected by the rule. Nor are local governments indirectly impacted because the rule does not create a situation requiring services from local governments.

❖ OTHER PERSONS: These amendments allow for 20% of youth permits to be reserved for youth in the antlerless drawing. Therefore, the amendments do not impose any additional requirements on other persons, nor generate a cost or savings impact to other persons.

COMPLIANCE COSTS FOR AFFECTED PERSONS: These amendments allow for 20% of youth permits to be reserved for youth in the antlerless drawing. DWR determines that there are no additional compliance costs associated with these amendments.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: The amendments to this rule do not create an impact on businesses. Michael R. Styler, Executive Director

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

NATURAL RESOURCES
WILDLIFE RESOURCES
1594 W NORTH TEMPLE
SALT LAKE CITY UT 84116-3154, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
Debbie Merrill at the above address, by phone at 801-538-4707, by FAX at 801-538-4745, or by Internet E-mail at debbiemerrill@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 07/01/2005.

THIS RULE MAY BECOME EFFECTIVE ON: 07/02/2005

AUTHORIZED BY: James F Karpowitz, Director

R657. Natural Resources, Wildlife Resources.
R657-5. Taking Big Game.
R657-5-24. Application Process for Premium Limited Entry, Limited Entry, Cooperative Wildlife Management Unit and Once-In-A-Lifetime Permits, and Application Process for General Buck Deer, General Muzzleloader Elk, and Youth General Any Bull Elk Permits.

(1)(a) A person may obtain only one permit per species of big game, including premium limited entry, limited entry, cooperative wildlife management unit, once-in-a-lifetime, conservation, sportsman, landowner and general permits, except antlerless permits as provided in the Antlerless Addendum and permits as provided in Rule R657-42.

(b) Hunting with a permit where payment has not been received for that permit constitutes a violation of hunting without a valid permit.

(c) A person must notify the division of any change of mailing address, residency, telephone number, and physical description.

(2) Applications are available from license agents, division offices, and through the division's Internet address.

(3) A resident may apply in the big game drawing for the following permits:

(a) only one of the following:

(i) buck deer - premium limited entry, limited entry and cooperative wildlife management unit;

(ii) bull elk - premium limited entry, limited entry and cooperative wildlife management unit; or

(iii) buck pronghorn - limited entry and cooperative wildlife management unit; and

(b) only one once-in-a-lifetime permit, including once-in-a-lifetime cooperative wildlife management unit permits, except as provided in Section R657-5-64(2)(b).

(4) A nonresident may apply in the big game drawing for the following permits:

(a) only one of the following:

(i) buck deer - premium limited entry and limited entry;

(ii) bull elk - premium limited entry and limited entry; or

(iii) buck pronghorn - limited entry; and

(b) only one once-in-a-lifetime permit.

(5) A resident or nonresident may apply in the big game drawing for:

(a)(i) a statewide general archery buck deer permit;

(ii) by region for general season buck deer; or

(iii) by region for general muzzleloader buck deer.

(b) A youth may apply in the drawing as provided in Subsection (a) or Subsection R657-5-27(4), and for youth general any bull elk pursuant to Section R657-5-46.

(6) A person may not submit more than one application per species as provided in Subsections (3) and (4), and Subsection (5) in the big game drawing.

(7)(a) Applications must be mailed by the date prescribed in the Bucks, Bulls and Once-In-A-Lifetime Proclamation of the Wildlife Board for taking big game. Applications filled out incorrectly or received later than the date prescribed in the Bucks, Bulls and Once-In-A-Lifetime Proclamation may be rejected.

(b) If an error is found on an application, the applicant may be contacted for correction.

(8)(a) Late applications, received by the date published in the Bucks, Bulls and Once-In-A-Lifetime Proclamation, will not be considered in the drawing, but will be processed, for the purpose of entering data into the division's draw database to provide:

(i) future preprinted applications;

(ii) notification by mail of late application and other draw opportunities; and

(iii) re-evaluation of division or third-party errors.

(b) The nonrefundable handling fee will be used to process the late application. Any permit fees submitted with the application will be refunded.

(c) Late applications received after the date published in the Bucks, Bulls and Once-In-A-Lifetime Proclamation shall not be processed and shall be returned to the applicant.

(9) Any person who applies for a hunt that occurs on private land is responsible for obtaining written permission from the landowner to access the property. To avoid disappointment and wasting the permit and fee if access is not obtained, hunters should get permission before applying. The division does not guarantee access and does not have the names of landowners where hunts occur.

(10) Only a resident may apply for or obtain a resident permit and only a nonresident may apply for or obtain a nonresident permit, except as provided in Subsections R657-5-27(4).

(12) To apply for a resident permit, a person must be a resident at the time of purchase.

(13) The posting date of the drawing shall be considered the purchase date of a permit.

R657-5-26. Applying as a Group for Premium Limited Entry, Limited Entry, Cooperative Wildlife Management Unit and Once-In-A-Lifetime Permits, and for General Buck Deer, General Muzzleloader Elk and Youth General Any Bull Elk Permits.

(1)(a) Up to four people may apply together for premium limited entry, limited entry, and resident cooperative wildlife management unit deer, elk or pronghorn permits in the big game drawing and in the antlerless drawing.

(b) Up to two youth may apply together for youth general any bull elk permits in the big game drawing.

(c) Up to ten people may apply together for general deer permits in the big game drawing.

(d) Youth applicants who wish to participate in the [~~Youth General Buck Deer Drawing Process~~]youth general buck deer drawing process as provided in Subsection R657-5-[~~27(3)~~]27(4), or the youth antlerless drawing process as provided in Subsection R657-5-59(3), must not apply as part of a group.

(2)(a) Applicants must indicate the number of hunters in the group by filling in the appropriate box on each application form.

(b) If the appropriate box is not filled out with the number of hunters in the group, each hunter in that group shall be entered into the drawing as individual hunters, and not as a group.

(3) Group applicants must submit their applications together in the same envelope.

(4) Residents and nonresidents may apply together.

(5)(a) Group applications shall be processed as one single application.

(b) Any bonus points used for a group application, shall be averaged and rounded down.

(6) When applying as a group:

(a) if the group is successful in the drawing, then all applicants with valid applications in that group shall receive a permit;

(b) if the group is rejected due to an error in fees and only one species is applied for, then the entire group is rejected;

(c) if the group is rejected due to an error in fees and more than one species is applied for, the group will be kept in the drawing for any species with sufficient fees, using the draw order; or

(d) if one or more members of the group are rejected due to an error other than fees, the members with valid applications will be kept in the drawing, unless the group indicates on the application that all members are to be rejected.

(i) The applicant whose application is on the top of all the applications for that group, will be designated the group leader.

(ii) If any group member has an error on their application that is not corrected during the correction process, the reject box on the group leader's application will determine whether the entire group is rejected.

R657-5-57. Antlerless Application - Deadlines.

(1) Applications are available from license agents, division offices, and through the division's Internet address.

(2) Residents may apply for, and draw the following permits, except as provided in Subsection [~~(4)~~](5):

(a) antlerless deer;

(b) antlerless elk;

(c) doe pronghorn; and
(d) antlerless moose.
(3) Nonresidents may apply in the drawing for, and draw the following permits, except as provided in Subsection [~~(4)~~](5):
(a) antlerless deer;
(b) antlerless elk;
(c) doe pronghorn; and
(d) antlerless moose, if permits are available during the current year.
(4) A youth may apply in the antlerless drawing as provided in Subsection (3) or Subsection R657-5-59(3).
(5) Any person who has obtained a pronghorn permit, or a moose permit may not apply for a doe pronghorn permit or antlerless moose permit, respectively, except as provided in Section R657-5-61.
[~~(5)~~](6) A person may not submit more than one application in the antlerless drawing per each species as provided in Subsections (2) and (3).
[~~(6)~~](7) Only a resident may apply for or obtain a resident permit and only a nonresident may apply for or obtain a nonresident permit, except as provided in Subsection R657-5-[~~59(3)~~] 59(4) and Section R657-5-61.
[~~(7)(a)~~](8)(a) Applications must be mailed by the date prescribed in the Antlerless Addendum to the Bucks, Bulls and Once-In-A-Lifetime Proclamation of the Wildlife Board for taking big game. Applications filled out incorrectly or received later than the date prescribed in the Antlerless Addendum to the Bucks, Bulls and Once-In-A-Lifetime Proclamation of the Wildlife Board for taking big game may be rejected.
(b) If an error is found on an application, the applicant may be contacted for correction.
[~~(8)(a)~~](9)(a) Late applications, received by the date published in the Antlerless Addendum to the Bucks, Bulls and Once-In-A-Lifetime Proclamation, will not be considered in the drawing, but will be processed for the purpose of entering data into the division's draw data base to provide:
(i) future preprinted applications;
(ii) notification by mail of late application and other draw opportunities; and
(iii) re-evaluation of division or third-party errors.
(b) The nonrefundable handling fee will be used to process the late application. Any permit fees submitted with the application will be refunded.
(c) Late applications received after the date published in the Antlerless Addendum to the Bucks, Bulls and Once-In-A-Lifetime Proclamation shall not be processed and shall be returned to the applicant.
[~~(9)~~](10) Any person who applies for a hunt that occurs on private land is responsible for obtaining written permission from the landowner to access the property. To avoid disappointment and wasting the permit and fee if access is not obtained, hunters should get written permission before applying. The division does not guarantee access and does not have the names of landowners where hunts occur.
[~~(10)~~](11) To apply for a resident permit, a person must establish residency at the time of purchase.
[~~(11)~~](12) The posting date of the drawing shall be considered the purchase date of a permit.

R657-5-59. Antlerless Big Game Drawing.
(1) The antlerless drawing results may be posted at the Lee Kay Center, Cache Valley Hunter Education Center, division offices and on the division Internet address on the date published in the Antlerless Addendum to the Bucks, Bulls and Once-In-A-Lifetime Proclamation of the Wildlife Board for taking big game.
(2) Permits are drawn in the order listed in the Antlerless Addendum to the Bucks, Bulls and Once-In-A-Lifetime Proclamation of the Wildlife Board for taking big game.
(3)(a) Twenty percent of the antlerless deer, elk and doe pronghorn permits are reserved for youth hunters.
(b) For purposes of this section, "youth" means any person 18 years of age or younger on the opening day of the general archery buck deer season.
(c) Youth hunters who wish to participate in the youth drawing must:
(i) submit an application in accordance with Section R657-5-57; and
(ii) not apply as a group.
(d) Youth applicants who apply for an antlerless deer, elk, or doe pronghorn permit as provided in Subsection (c), will automatically be considered in the youth drawing based upon their birth date.
(e) Any reserved permits remaining and any youth applicants who were not selected for reserved permits shall be returned to the antlerless drawing.
(4) If permits remain after all choices have been evaluated separately for residents and nonresidents, a second evaluation will be done allowing cross-over usage of remaining resident and nonresident permit quotas.

KEY: wildlife, game laws, big game seasons
[~~January 15,~~] 2005
Notice of Continuation November 30, 2000
23-14-18
23-14-19
23-16-5
23-16-6

▼ ▼

Natural Resources, Wildlife Resources
R657-15
Closure of Gunnison, Cub and Hat Islands

NOTICE OF PROPOSED RULE
(Amendment)
DAR FILE NO.: 27862
FILED: 05/05/2005, 09:49

RULE ANALYSIS
PURPOSE OF THE RULE OR REASON FOR THE CHANGE: This rule is being amended pursuant to Regional Advisory Council meetings and the Wildlife Board meeting conducted for taking public input and reviewing this rule.

SUMMARY OF THE RULE OR CHANGE: This rule is being amended to clarify the closure encompassing Gunnison, Cub, and Hat islands to include the surrounding beaches of the Great Salt Lake 1 mile in every direction from the 4200-foot mean sea level elevation due to the low water levels in the Great Salt Lake.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Sections 23-14-18 and 23-14-19

ANTICIPATED COST OR SAVINGS TO:
❖ THE STATE BUDGET: This rule is being amended to clarify the closure encompassing Gunnison, Cub, and Hat islands. The Division of Wildlife Resources (DWR) determines that these amendments do not create a cost or savings impact to the state budget or DWR's budget.
❖ LOCAL GOVERNMENTS: None--This filing does not create any direct cost or savings impact to local governments because they are not directly affected by the rule. Nor are local governments indirectly impacted because the rule does not create a situation requiring services from local governments.
❖ OTHER PERSONS: This rule is being amended to clarify the closure encompassing Gunnison, Cub, and Hat islands. The amendments do not impose any additional requirements on other persons, nor generate a cost or savings impact to other persons.

COMPLIANCE COSTS FOR AFFECTED PERSONS: This rule is being amended to clarify the closure encompassing Gunnison, Cub, and Hat islands. DWR determines that there are no additional compliance costs associated with these amendments.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: The amendments to this rule do not create an impact on businesses. Michael R. Styler, Executive Director

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
NATURAL RESOURCES
WILDLIFE RESOURCES
1594 W NORTH TEMPLE
SALT LAKE CITY UT 84116-3154, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
Debbie Merrill at the above address, by phone at 801-538-4707, by FAX at 801-538-4745, or by Internet E-mail at debbiemerrill@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 07/01/2005.

THIS RULE MAY BECOME EFFECTIVE ON: 07/02/2005

AUTHORIZED BY: James F Karpowitz, Director

R657. Natural Resources, Wildlife Resources.
R657-15. Closure of Gunnison, Cub and Hat Islands.
R657-15-1. Purpose and Authority.

Under authority of Section 23-21a-3, this rule provides for the management of Gunnison, Cub, and Hat islands for the protection and perpetuation of the American white pelican, [~~Pelecanus erythrorhychos~~]Pelacanus erythrorhynchos, and other avian species.

R657-15-2. Closed Areas.

(1) The following areas are closed to air, water, and land trespass as a conservation measure to protect colonial bird nesting areas:

(a) Gunnison and Cub islands, located in Sections 9, 10, 15 and 16, Township 7 North, Range 9 West, Salt Lake Base and Meridian; and

(b) Hat Island, located in Section 24, Township 4 North, Range 7 West, Salt Lake Base and Meridian.

(2) This closure encompasses all of Gunnison, Cub, and Hat islands and the surrounding waters and beaches of the Great Salt Lake one mile in every direction from the 4200-foot mean sea level elevation shoreline of Gunnison, Cub, and Hat islands.

(3) The provisions of this rule do not apply to division personnel while performing their official duties, or to certified peace officers and emergency personnel acting under their direction when engaged in exigent law enforcement activities or emergency rescue operations.

KEY: wildlife, birds, conservation, wildlife management
[~~1990~~]2005
Notice of Continuation May 22, 2000
23-21a-3

Tax Commission, Auditing
R865-19S-6
Tax Collection Pursuant to Utah Code Ann. Section 59-12-107

NOTICE OF PROPOSED RULE
(Amendment)
DAR FILE NO.: 27868
FILED: 05/06/2005, 15:39

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: S.B. 147 from the 2003 Legislative session made changes to Section 59-12-107 which eliminates the need for this section. (DAR NOTE: S.B. 147 is found at UT L 2003 Ch 312, and was effective 07/01/2004.)

SUMMARY OF THE RULE OR CHANGE: This section is being removed because it is no longer necessary.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 59-12-107

ANTICIPATED COST OR SAVINGS TO:
❖ THE STATE BUDGET: None--Language removed is currently reflected in statute.
❖ LOCAL GOVERNMENTS: None--Language removed is currently reflected in statute.
❖ OTHER PERSONS: None--Language removed is currently reflected in statute.

COMPLIANCE COSTS FOR AFFECTED PERSONS: None--The concepts in the removed section are embodied in statute.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: Removing this section will have no fiscal impact on businesses. Pam Hendrickson, Tax Commission Chair

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
TAX COMMISSION
AUDITING
210 N 1950 W
SALT LAKE CITY UT 84134, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
Cheryl Lee at the above address, by phone at 801-297-3900, by FAX at 801-297-3919, or by Internet E-mail at clee@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 07/01/2005.

THIS RULE MAY BECOME EFFECTIVE ON: 07/02/2005

AUTHORIZED BY: Pam Hendrickson, Commissioner

R865. Tax Commission, Auditing.
R865-19S. Sales and Use Tax.
[~~R865-19S-6. Tax Collection Pursuant to Utah Code Ann. Section 59-12-107.~~
~~A. The vendor shall collect sales or use tax at the rate set by law. Rule R865-19S-30 defines sales price.~~
~~B. The Tax Commission furnishes tables that may be used to determine the proper amount of tax on each transaction. These tables reflect the appropriate amount, including applicable local taxes, for the various taxing jurisdictions.~~

]KEY: charities, tax exemptions, religious activities, sales tax
[~~December 21, 2004~~]2005
Notice of Continuation April 5, 2002
59-12-107

▼ ▼

Tax Commission, Auditing
R865-19S-78
Charges for Labor to Repair, Renovate and Install Tangible Personal Property Pursuant to Utah Code Ann. Section 59-12-103

NOTICE OF PROPOSED RULE
(Amendment)
DAR FILE NO.: 27870
FILED: 05/09/2005, 12:12

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: Section 59-12-103 has been significantly updated by recent legislation, most notably S.B. 127 (2005), so as to eliminate the need for the deleted language. The language added in this amendment is necessary to clarify a term recently added in Section 59-12-102. (DAR NOTE: S.B. 127 is found at UT L 2005 Ch 158, and will be effective 07/01/2005.)

SUMMARY OF THE RULE OR CHANGE: The proposed amendment deletes language that now appears in statute, and provides guidance for when an item of tangible personal property is permanently attached to real property.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 59-12-103

ANTICIPATED COST OR SAVINGS TO:
❖ THE STATE BUDGET: None--The substance of the law remains the same as does the practice.
❖ LOCAL GOVERNMENTS: None--The substance of the law remains the same as does the practice.
❖ OTHER PERSONS: None--The substance of the law remains the same as does the practice.

COMPLIANCE COSTS FOR AFFECTED PERSONS: None--Recent statutory changes and this proposed amendment continue the current practice.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: There will be no fiscal impact as a result of this clarifying amendment. Pam Hendrickson, Tax Commission Chair

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
TAX COMMISSION
AUDITING
210 N 1950 W
SALT LAKE CITY UT 84134, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
Cheryl Lee at the above address, by phone at 801-297-3900, by FAX at 801-297-3919, or by Internet E-mail at clee@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 07/01/2005.

THIS RULE MAY BECOME EFFECTIVE ON: 07/02/2005

AUTHORIZED BY: Pam Hendrickson, Commissioner

R865. Tax Commission, Auditing.
R865-19S. Sales and Use Tax.
R865-19S-78. Charges for Labor to Repair[~~,~~] or Renovate[~~,~~] [~~and Install~~]Tangible Personal Property Pursuant to Utah Code Ann. Section 59-12-103.

[~~A. Charges for installation labor.~~

~~1. Amounts paid or charged for labor for installing tangible personal property in connection with other tangible personal property are subject to tax.~~

~~2. Separately stated charges for labor to install personal property to real property are not subject to tax, regardless of whether the personal property becomes part of the real property. On-site assembly that does not involve affixing the tangible personal property to real property is not installation within the meaning of this rule.~~

~~B. Charges for labor to repair, renovate, wash, or clean.~~

~~1. Charges for labor to repair, renovate, wash, or clean tangible personal property are subject to sales tax. Parts or materials used to repair, renovate, wash, or clean tangible personal property that are exempt from sales tax pursuant to Section 59-12-104 must be separately stated on the invoice or the entire charge for labor and parts is taxable.~~

~~a) Labor for cleaning and blocking hats is taxable under the provisions of the act imposing a tax on dry cleaning services.~~

~~b) Motor vehicles, trailers, contractors' equipment, drilling equipment, commercial equipment, railroad cars and engines, radio and television sets, watches, jewelry, clothing and accessories, shoes, tires and tubes, office equipment, furniture, bicycles, sporting equipment, boats and household appliances not permanently attached to a house or building are examples of tangible personal property upon which the sales or use tax applies when repaired, washed, cleaned, renovated, or installed in connection with other tangible personal property.~~

~~c) Labor charges for cleaning and washing tangible personal property held in resale inventory are not taxable. An example is the cleaning, washing, or detailing of a new or used car in a dealer's inventory.~~

~~2. Charges for labor to service, repair or renovate real property, improvements, or items of personal property that are attached to real property so as to be considered real property are not subject to sales tax. The determination of whether parts, materials or other items are sold or used in the service, repair, or renovation of real property shall be made in accordance with R865-19S-58. Exempt labor charges must be separately stated on the invoice or the entire charge for labor and parts is taxable.~~

~~a) For purposes of B., fixtures, trade fixtures, equipment, or machinery permanently attached to real property shall be treated as real property while so attached, but shall revert to personal property when severed from the real property.~~

~~b) Mere physical attachment is not enough to indicate permanent attachment. Portable or movable items that are attached merely for convenience, stability or for an obvious temporary purpose are considered personal property, even when attached to real property.~~

~~c) An item is considered permanently attached if:~~

~~(i) attachment is essential to the operation or use of the item and the manner of attachment suggests that the item will remain affixed in the same place over the useful life of the item; or~~

~~(ii) removal would cause substantial damage to the item itself or require substantial alteration or repair of the structure to which it is affixed.~~

~~d) If an item is attached to real property so that it is treated as real property for purposes of this rule, its accessories are also treated as real property if the accessories are essential to the operation of the item and installed solely to serve the operation of the item.~~

~~e) An item or part of an item may be temporarily detached from real property for on-site repairs without losing its real property status, but an item that is detached from the premises and removed from the site temporarily or permanently reverts to personal property.~~

~~C. Charges made for lubrication of motor vehicles are taxable as sales of tangible personal property.~~]A. For purposes of applying the definition of "permanently attached to real property" under Section 59-12-102, the determination of whether the attachment of an item of tangible personal property to real property suggests that the tangible personal property will remain attached to the real property in the same place over the useful life of the tangible personal property shall be made without regard to the tangible personal property's attachment to a line that supplies water, electricity, gas, telephone, cable, or other similar services.

[~~D.~~]B. Sales of extended warranty agreements.

1. Sales of extended warranty agreements or service plans are taxable, and tax must be collected at the time of the sale of the agreement. The payment is considered to be for future repair, which would be taxable. If the extended warranty agreement covers parts as well as labor, any parts that are exempt from sales tax pursuant to Section 59-12-104 must be separately stated on the invoice or the entire charge under the extended warranty agreement is taxable. Repairs made under an extended warranty plan are exempt from tax, even if the plan was sold in another state.

a) Repair parts provided and services rendered under the warranty agreements or service plans are not taxable because the tax is considered prepaid as a result of taxing the sale of the warranty or service plan when it was sold.

b) If the customer is required to pay for any parts or labor at the time of warranty service, sales tax must be collected on the amount charged to the customer. Sales tax must also be collected on any deductibles charged to customers for their share of the repair work done under the warranty agreement. Parts or materials that are exempt from sales tax pursuant to Section 59-12-104 must be separately stated on the invoice or the entire charge for labor and parts is taxable.

2. Extended warranties on items of tangible personal property that are converted to real property are not taxable. However, the taxable nature of parts and other items of tangible personal property provided in conjunction with labor under an extended warranty service shall be determined in accordance with R865-19S-58.

KEY: charities, tax exemptions, religious activities, sales tax [~~December 21, 2004~~]2005
Notice of Continuation April 5, 2002
59-12-103

▼ ▼

Tax Commission, Auditing
R865-19S-112
Confirmation of Purchase of Admission or User Fee Relating to the Olympic Winter Games of 2002 Pursuant to Utah Code Ann. Sections 59-12-103 and 59-12-104

NOTICE OF PROPOSED RULE
(Amendment)
DAR FILE NO.: 27867
FILED: 05/06/2005, 11:16

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: Because the statutory sales tax exemption for certain purchases of tickets to the Olympic Winter Games of 2002 is no longer relevant, the section clarifying the statute is unnecessary.

SUMMARY OF THE RULE OR CHANGE: The section is being removed because it is no longer necessary.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Sections 59-12-103 and 59-12-104

ANTICIPATED COST OR SAVINGS TO:
❖ THE STATE BUDGET: None--The sales tax exemption for certain purchases of 2002 Olympic tickets is irrelevant.
❖ LOCAL GOVERNMENTS: None--The sales tax exemption for certain purchases of 2002 Olympic tickets is irrelevant.
❖ OTHER PERSONS: None--The sales tax exemption for certain purchases of 2002 Olympic tickets is irrelevant.

COMPLIANCE COSTS FOR AFFECTED PERSONS: None--The sales tax exemption for certain purchases of 2002 Olympic tickets is irrelevant.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: There is no fiscal impact. Pam Hendrickson, Tax Commission Chair

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
TAX COMMISSION
AUDITING
210 N 1950 W
SALT LAKE CITY UT 84134, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
Cheryl Lee at the above address, by phone at 801-297-3900, by FAX at 801-297-3919, or by Internet E-mail at clee@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 07/01/2005.

THIS RULE MAY BECOME EFFECTIVE ON: 07/02/2005

AUTHORIZED BY: Pam Hendrickson, Commissioner

R865. Tax Commission, Auditing.
R865-19S. Sales and Use Tax.
[~~R865-19S-112. Confirmation of Purchase of Admission or User Fee Relating to the Olympic Winter Games of 2002 Pursuant to Utah Code Ann. Sections 59-12-103 and 59-12-104.~~
~~A. For purposes of the sales and use tax exemption for amounts paid or charged as admission or user fees relating to the Olympic Winter Games of 2002:~~
~~1. Except as provided in 2., the Salt Lake Organizing Committee (SLOC), or a person designated by SLOC, is deemed to have sent a purchaser confirmation of the purchase of an admission or user fee relating to the Olympic Winter Games of 2002 at the time SLOC or its designee receives a payment for the purchase.~~
~~2. In the case of a purchase of tickets designated as lottery tickets by SLOC, SLOC or its designee are deemed to have sent confirmation of the purchase at the time the purchaser accepts the tickets available to him or her through that process.~~

]**KEY: charities, tax exemptions, religious activities, sales tax [~~December 21, 2004~~]2005**
Notice of Continuation April 5, 2002
59-12-103
59-12-104

▼ ▼

Tax Commission, Auditing
R865-19S-120
Sales and Use Tax Exemption Relating to Film, Television, and Video Pursuant to Utah Code Ann. Section 59-12-104

NOTICE OF PROPOSED RULE
(Amendment)
DAR FILE NO.: 27871
FILED: 05/09/2005, 13:32

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: Section 59-12-104 provides a sales tax exemption for the purchase, lease, or rental of machinery or equipment by certain establishments, if used primarily in the production or post production of film, television, video, or similar media for

commercial distribution. This proposed section defines machinery and equipment for purposes of the exemption.

SUMMARY OF THE RULE OR CHANGE: This proposed section defines terms for purposes of the sales tax exemption for the purchase, lease, or rental of machinery or equipment primarily used in the production or post production of film, television, and video for commercial distribution; indicates transactions that do not qualify for the exemption.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 59-12-104

ANTICIPATED COST OR SAVINGS TO:
❖ THE STATE BUDGET: None--Any impact was taken into account in S.B. 190 (2004). (DAR NOTE: S.B. 190 is found at UT L 2004 Ch 298, and was effective 07/01/2004.)
❖ LOCAL GOVERNMENTS: None--Any impact was taken into account in S.B. 190 (2004).
❖ OTHER PERSONS: None--Any impact was taken into account in S.B. 190 (2004).

COMPLIANCE COSTS FOR AFFECTED PERSONS: Entities that meet the criteria for the sales tax exemption will be able to make certain purchases tax exempt.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: This rule has no fiscal impact since the sales tax exemption was accounted for in the fiscal note for S.B. 190 when it passed in the 2004 Legislative Session. Pam Hendrickson, Tax Commission Chair

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
TAX COMMISSION
AUDITING
210 N 1950 W
SALT LAKE CITY UT 84134, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
Cheryl Lee at the above address, by phone at 801-297-3900, by FAX at 801-297-3919, or by Internet E-mail at clee@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 07/01/2005.

THIS RULE MAY BECOME EFFECTIVE ON: 07/02/2005

AUTHORIZED BY: Pam Hendrickson, Commissioner

R865. Tax Commission, Auditing.
R865-19S. Sales and Use Tax.
R865-19S-120. Sales and Use Tax Exemption Relating to Film, Television, and Video Pursuant to Utah Code Ann. Section 59-12-104.

(1) The provisions of this rule apply to the sales and use tax exemption authorized under Section 59-12-104 for the purchase, lease, or rental of machinery or equipment by certain establishments related to film, television, and video if those purchases, leases, or rentals are primarily used in the production or postproduction of film, television, video, or similar media for commercial distribution.

(2) "Machinery or equipment" means tangible personal property eligible for depreciation under accounting standards.

(3)(a) "Tangible personal property eligible for depreciation under accounting standards" means tangible personal property with an economic life greater than one year.

(b) "Tangible personal property eligible for depreciation under accounting standards" includes tangible personal property that is not eligible for depreciation if that tangible personal property:

(i) is an incidental component of a transaction that is a purchase, lease, or rental of machinery or equipment; and

(ii) is not billed as a separate component of the transaction.

(c) "Tangible personal property eligible for depreciation under accounting standards" does not include tangible personal property with an economic life of less than one year and depreciated on the establishment's financial records.

(d) There is a rebuttable presumption that an item of tangible personal property not shown as a depreciable asset on the financial records of the establishment is not eligible for depreciation.

(4) Transactions that do not qualify for the sales tax exemption referred to in Subsection (1) include purchases, leases, or rentals of:

(a) land;
(b) buildings;
(c) raw materials;
(d) inventory;
(e) supplies;
(f) film;
(g) repair or replacement parts;
(h) services;
(i) transportation;
(j) gas, electricity, and other fuels;
(k) admissions or user fees; and
(l) accommodations.

(5)(a) Except as provided in Subsection (5)(b), an item used for administrative purposes does not qualify for the exemption.

(b) Notwithstanding Subsection (5)(a), if an item is used both in the production or postproduction process and for administrative purposes, the item qualifies for the exemption if the primary use of the item is in the production or postproduction process.

KEY: charities, tax exemptions, religious activities, sales tax
[~~December 21, 2004~~]2005
Notice of Continuation April 5, 2002
59-12-104

Transportation, Operations, Traffic and Safety
R920-50
Ropeway Operation Safety Rules

NOTICE OF PROPOSED RULE
(Amendment)
DAR FILE NO.: 27876
FILED: 05/10/2005, 15:55

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The purpose of this change is to: 1) require notification to committee when permittee's insurance lapses; and 2) require departmental evaluation of design drawings.

SUMMARY OF THE RULE OR CHANGE: This amendment makes nonsubstantive wording changes, requires notification of insurance lapses, and evaluation of proposed drawings.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Sections 72-2-201 and 72-11-210

ANTICIPATED COST OR SAVINGS TO:
❖ THE STATE BUDGET: There will be additional cost from mail delivery of notifications of insurances lapses, which currently is not required, and from evaluation of design drawings and specifications. Since this has not occurred before, it is impossible to say what those costs might be.
❖ LOCAL GOVERNMENTS: Local governments do not apply for ropeway permits so this rule does not apply to them.
❖ OTHER PERSONS: There might be additional costs to the industry from having to send notification of insurance lapses and from carrying out any changes to plans, or designs that result from the department's evaluation. Because this has never occurred in the past, the precise costs cannot be estimated.

COMPLIANCE COSTS FOR AFFECTED PERSONS: It is impossible to calculate how much compliance with this amendment will cost the industry. There will be increased costs from additional correspondence and possibly from needing to make changes to submitted drawings.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: The fiscal impact, though not fully known, should not be significant. Requiring notification of insurance and evaluation of plans, however, is necessary to ensure the safe operation of ropeways. Therefore, the probable costs would more than likely not exceed the benefit to the public. John R. Njord, Executive Director

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
TRANSPORTATION
OPERATIONS, TRAFFIC AND SAFETY
CALVIN L RAMPTON COMPLEX
4501 S 2700 W
SALT LAKE CITY UT 84119-5998, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
James Beadles at the above address, by phone at 801-965-4168, by FAX at 801-965-4796, or by Internet E-mail at jbeadles@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 07/01/2005.

THIS RULE MAY BECOME EFFECTIVE ON: 07/02/2005

AUTHORIZED BY: John R. Njord, Executive Director

R920. Transportation, Operations, Traffic and Safety.
R920-50. Ropeway Operation Safety Rules.
R920-50-3. Registration of Ropeways.

A. General

1. Purpose - In order to ensure that all passenger Ropeways conform with the requirements set forth by the Passenger Ropeway Act and these rules, all passenger Ropeways operating in the state of Utah shall be registered annually with the committee, and no passenger Ropeway shall be operated for passengers without a valid certificate of registration[~~:~~].

2. Term - Passenger Ropeways shall be registered annually starting November 1st of each year, and each registration expires on October 31st next following date of issue[~~:~~].

3. New ropeways - Any passenger ropeway which shall be opened for the first time for passenger operation shall, during its first calendar year of operation, be construed to be a new ropeway for purposes stated in these rules[~~:~~].

4. Existing ropeways - Any passenger ropeway which shall have been operated for passengers in excess of one calendar year, shall be construed to be an existing ropeway for purposes stated in these rules[~~:~~].

5. Relocated ropeways - Any passenger ropeway moved to a new location shall be construed to be a new ropeway for purposes stipulated in these rules, with the exception that ropeways expressly designed to be portable, operated without a permanent foundation, and that have a design range of maximum grade, shall not be considered new ropeways when moved to different locations but remaining under the jurisdiction of the same operator[~~:~~].

6. Identification number - For each ropeway, upon receipt of the first application for a certificate of registration, the committee shall assign an identification number to the ropeway, which shall remain as a permanent identification number for the life of the ropeway[~~:~~]. [~~a~~] All correspondence with the committee pertaining to any ropeway shall refer to the identification number assigned to that ropeway[~~:~~].

7. All ropeway operators shall be covered by a liability insurance of a minimum of $300,000[~~:~~]. The Utah Passenger Ropeway Safety Committee shall be notified of a lapse or termination of insurance coverage pursuant to the terms of the policy.

8. Submittal of application for registration of ropeways - All applications for registration of new or existing ropeways shall be submitted in accordance with requirements of these rules and shall be made in writing and addressed to:

Utah Department of Transportation
Passenger Ropeway Safety Committee
Division of Safety
4501 South 2700 West
Salt Lake City, Utah 84119-5998[~~:~~]

9. "As Built" drawings for each passenger ropeway shall be submitted no later than 60 days after the project is completed and the Acceptance Test and Inspection is finished.

B. Attachments

In addition to supporting documents indicated in R920-50-4 or R920-50-7, each application is to include as attachments:

1. Certificate of insurance
2. Annual registration fee.

R920-50-4. Registration of New Ropeways.

A. Application for Certification of Registration

Prior to the operation of any new passenger ropeway, the operator shall apply to the Committee for a Certificate of Registration in such form as the Committee shall designate.

B. The Application must include the name, address and telephone number of operator of the ropeway, and operator's designation of the ropeway. The application and certifications must be in accordance with R920-50-3.A and submitted as follows:

1. A Pre-Operational Inspection Report must be submitted by an approved Ropeway Inspector, and must include the name and address of the Inspector and date of his or her inspection.

2. Any Request for Exception from Standards for Passenger Ropeway shall be submitted in accordance with R920-50-10. Any known items that require a Request for Exception from Standards for Passenger Ropeways must be submitted to the Committee before work begins.

3. A Certification of Ropeway Design for New or Modified Passenger Ropeways, must be submitted. The Qualified Engineer in responsible charge of the design shall certify to the Committee on the top drawing of the design drawing packet that the design, plans and specifications conform to the Utah Passenger Ropeway Safety Act, the Governing Standard and the Utah Ropeway Operations Safety Rules. This Certification must be submitted prior to the performance of the Acceptance Inspection and Test and must state the following:

"I hereby certify that the design for this ropeway or ropeway modification is in complete compliance with the Utah Passenger Ropeway Safety Act, Governing Standard and the Utah Ropeway Operations Safety Rules[~~ and that I accept responsibility for the engineering designs, calculations, drawings and specifications for this ropeway or ropeway modification~~]." This statement shall be placed on the top drawing of the drawing packet and signed and sealed by the Qualified Engineer. Each additional sheet of this drawing packet shall be sealed by the Qualified Engineer. Any variation from the design drawings shall be noted in the drawings and approved by the Qualified Design Engineer. The drawings and specifications shall include the Quality Assurance methods used for the evaluation of the re-used components and shall be submitted for review a minimum of 30 days prior to installation. Any component on the Utah Passenger Ropeway Safety Committee Lift Data Form must be addressed.

4. A Certification of Compliance for Passenger Ropeway shall be made on the Application for Certificate of Registration for New or Modified Ropeway. This Certification shall include the following statement, signed and dated by the ropeway owner or area operator: "I certify that the reports, requests and certificates attached hereto were provided and signed by the persons required by law to provide them, and the deficiencies noted in the inspection report have been corrected with the exception of those listed in the Request for Exception from Standards for Passenger Ropeway."

5. A Certification of [~~Fabrication and Materials~~]Manufacture for Passenger Ropeway must be submitted by a Qualified Engineer of the manufacturing concern or concerns directly responsible for the supply of equipment for this ropeway. This Certification must be submitted prior to the performance of the Acceptance Inspection and Test. This Certification must include the following information:

a. Name, address and telephone number of operator of the ropeway, name of ropeway supervisor, operator's designation of the ropeway.

b. Name and address of manufacturing concern, and name, seal and Utah license number of the qualified engineer making certification.

c. A certifying statement signed by the Qualified Engineer, to read as follows: "I hereby certify that the newly manufactured parts used in this[~~all components, all fabrication procedures and all material used in the production of the equipment for this~~] ropeway, or ropeway modification, conform with the Utah Passenger Ropeway Safety Act, Governing Standard, the Utah Ropeway Operations Safety Rules and the drawings and specifications issued for this ropeway or ropeway modification by the Qualified Design Engineer."

6. A Certification of Construction for Passenger Ropeways must be submitted by a Qualified Engineer directly responsible for the construction for the ropeway. This Certification must be submitted prior to the performance of the Acceptance Inspection and Test. This Certification shall include the following information:

a. Name, address and telephone number of operator of the ropeway name of ropeway supervisor, operator's designation of the ropeway identification number, as assigned by the committee for the ropeway;

b. Name, Utah license number and seal of the Qualified Engineer making the certification.

c. A certifying statement signed by the Qualified Engineer, to read as follows: "I hereby certify that the construction and installation has been completed in accordance with the[~~all footings and other concrete structures, field assembly, excavations, placement of reinforcing steel and anchoring components, quality of concrete and placement of concrete were carried out in accordance with plans and specifications, so that the design bearing value will be attained, as specified by the~~] drawings and specifications issued for this ropeway or ropeway modification by the Qualified Design Engineer."

7. A final Acceptance Test report must be submitted to the Committee. A copy of the acceptance test procedure proposed and submitted by the designer or manufacturer must be provided to the Committee for review at least fourteen (14) days before acceptance testing begins. Acceptance inspection and tests will be scheduled by the Committee or Committee's representative as the acceptance test procedures are received. The owner or area operator shall notify the Committee in writing before the scheduled date that the passenger ropeway has been operated in accordance with the Governing Standard, section X.1.1.11.2.

8. A Certification of "As-Built" Profile for Passenger Ropeway must be submitted by a Land Surveyor or Civil Engineer licensed in the state of Utah. This Certification must be submitted prior to the performance of the Acceptance Inspection and Test, and shall be signed by the Civil Engineer or Land Surveyor, and shall read as

follows: "I hereby certify that the attached "as-built" profile of the herein-identified ropeway is as represented on the attached profile drawing and that the completed ropeway conforms to the profile as identified in the plans and specifications prepared by the Qualified Design Engineer."

9. A Utah Passenger Ropeway Safety Committee Lift Data Form must be submitted along with other requested supporting documents. This form must be submitted prior to the performance of the Acceptance Inspection and Test.

KEY: transportation safety, tramways, ropeways, tramway permits
[~~August 18, 2003~~]2005
Notice of Continuation December 13, 2002
72-11-201 through 72-11-216
63-46b-1 et seq.

Workforce Services, Workforce Information and Payment Services

R994-307-101

Relief of Charges to Contributing Employers

NOTICE OF PROPOSED RULE
(Amendment)
DAR FILE NO.: 27919
FILED: 05/16/2005, 14:25

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The reason for the change is to make the rule for part-time concurrent contributing employers the same as reimbursable employers.

SUMMARY OF THE RULE OR CHANGE: In October 2004, the Department filed changes to the "part-time concurrent reimbursable" rule (Section R994-401-302) to clarify when a part-time reimbursable employer will be relieved of liability. This current amendment is to make the rule the same for part-time concurrent contributory employers. Basically, if a claimant works for two or more employer and is separated from one of those employers, the other employers who still employ the claimant should not be liable for benefit costs. The employment no longer needs to be concurrent provided it is in the benefit year and the claimant worked for the employer in the week before filing the claim.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 35A-1-104, and Subsections 35A-1-104(4) and 35A-4-502(1)(b)

ANTICIPATED COST OR SAVINGS TO:
❖ THE STATE BUDGET: This is a federally-funded program and there will be no cost or savings to the state budget. The state is not a contributory employer and is unaffected by this amendment.
❖ LOCAL GOVERNMENTS: This is a federally-funded state-run program and there will be no cost or savings to any local governmental entity. Even though local governments pay unemployment benefits, they are reimbursable and thus not affected by this rule.
❖ OTHER PERSONS: There will be no cost or savings to other persons. Employers not contributing to unemployment have always been relieved of costs; this amendment just clarifies when the contributory employer can be relieved of benefit costs.

COMPLIANCE COSTS FOR AFFECTED PERSONS: This amendment is not a big change from how relief is currently determined so it is not believed any claimants or employers will be affected by this change. There are no costs for complying with this rule change.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: There will be no fiscal impact on business as a result of this change. Businesses are already relieved of charges for part-time concurrent employees, this proposed amendment will include a few part-time employers in the definition by dropping the "concurrent" requirement. Tani Downing, Executive Director

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
WORKFORCE SERVICES
WORKFORCE INFORMATION
AND PAYMENT SERVICES
140 E 300 S
SALT LAKE CITY UT 84111-2333, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
Suzan Pixton at the above address, by phone at 801-526-9645, by FAX at 801-526-9211, or by Internet E-mail at spixton@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 07/01/2005.

THIS RULE MAY BECOME EFFECTIVE ON: 07/02/2005

AUTHORIZED BY: Tani Downing, Executive Director

R994. Workforce Services, Workforce Information and Payment Services.
R994-307. Social Costs -- Relief of Charges.
R994-307-101. Relief of Charges to Contributing Employers.

(1) Under the following circumstances a written request is required for relief of charges:

(a) Separation Issues.

(i) Relief may be granted based only on the circumstance which caused the claim to be filed or a separation which occurred prior to the initial filing of the claim. If there is more than one [~~reason for~~]separation from the same employer, charges or relief of charges will be based on the reason for the last separation occurring prior to the

effective date of the claim. Separations occurring after the initial filing of a claim do not result in relief of charges on that claim, but may be the basis for relief of charges on a subsequent claim.

(A) The claimant voluntarily left work for that employer due to circumstances which would have resulted in a denial of benefits under Subsection 35A-4-405(1) of the Act.

(B) The separation from that employer would have resulted in an allowance of benefits made under the provisions of "equity and good conscience" under circumstances not caused or aggravated by the employer. For example: If the claimant quit because of a personal circumstance which was not the result of this employment the employer would be relieved of charges. However, if the quit was precipitated by a reduction in the claimant's hours of work, even though the change in working conditions was necessitated by economic conditions, the employer would NOT be relieved of charges.

(C) The claimant quit that employer for health reasons which were beyond reasonable control of the employer. Although the job may have caused or aggravated the health problems, the employer is eligible for relief if it was in compliance with industry safety standards.

(D) The claimant quit work for that employer not because of adverse working conditions, but solely due to a personal decision to accept work with another employer.

(E) The claimant quit work from that employer for personally compelling circumstances not within the employer's power to control or prevent.

(F) The claimant quit new work from that employer after a short trial period, and through no fault of the employer the new work was unsuitable as defined in Subsections 35-4-405(3)(c), (d), and (e).

(G) The claimant was discharged from that employer for circumstances which would have resulted in a denial of benefits under Section 35A-4-405(2) of the Act.

(H) The claimant was discharged for nonperformance due to medical reasons. The employer is eligible for relief:

(I) only if the employer complied with industry health and safety standards, and

(II) the non-performance was due to a chronic medical condition, and

(III) the medical circumstances are expected to continue. The medical problems may be attributed to the worker or to a dependent. A series of unrelated absences attributed to medical problems do not qualify as chronic without medical verification that the conditions will probably continue to cause absences.

(I) The claimant continued to work for an acquiring employer when a portion of the business assets was sold or transferred to another business entity. For the purpose of this rule, employees are not considered assets and there must be an actual sale or transfer of business assets. Because the selling employer lost control of the employees to the acquiring employer, the selling employer may be eligible for relief of charges. Such relief may be sought by a timely written request following the claimant's subsequent claim for benefits. "Continued to work for the acquiring employer" means the claimant began work as soon as work was available [~~with~~]for the acquiring employer.

(b) Non-Separation Issues.

(i) When the claimant worked for two or more employers during the base period and is separated from one or more of these employers, but continues in regular part-time work for one of those employers, the nonseparating, part-time employer will not be liable for benefit costs provided;

(A) the claimant earned wages from a nonseparating employer within seven days prior to the date when the claim was filed,

(B) the claimant is not working on an "on call" basis,

(C) the number of hours of work has not been reduced, and

(D) the nonseparating employer makes a request that it not be held liable for benefit costs within ten days of the first notification of the employer's potential liability.[~~The claimant's customary hours of work with the concurrent employer, even though not necessarily constant have not been reduced either during the base period or prior to the filing of the claim below the least number of hours worked during the base period. For this circumstance to exist, the claimant must have worked for two or more employers during the base period of his claim, and when separated from one of the employers, he continues to work less than full-time for the other employer. Only the part-time employer can be relieved of benefit costs under the provisions of this section.~~]

(ii) The employer was previously charged for the same wages which are being used a second time to establish a new claim. For example, as the result of a change in the method of computing the base period, or overlapping base periods due to the effective date of the claim.

(iii) The claimant did not work for the employer during the base period.

(iv) The Department incorrectly used wages which were or should have been correctly reported by the employer in determining the claimant's weekly benefit amount or maximum benefit amount.

(c) The Department may, on its own motion, grant relief of charges without a written request if in the Department representative's discretion there is sufficient information in the record to justify relief.

(2) Under the following circumstances a written request is NOT required for relief of charges:

(a) All employers shall be relieved of benefit costs:

(i) resulting from the state's share of extended benefit payments;

(ii) which, during the same fiscal year, have been designated by the Department as benefit overpayments;

(iii) resulting from combined wage claims that are charged to Utah employers, which are insufficient when separately considered for a monetary claim under Utah law but have been transferred to a paying state;

(iv) resulting from payments made after December 31, 1985 to claimants who have been given [~~commission~~]Department approval to attend school. Relief is granted only for those benefit costs during the period of [~~commission~~]Department approval.

(b) An employer shall be relieved of benefit costs if the employer has terminated coverage.

KEY: unemployment compensation, rates
[~~April 1, 2002~~]2005
Notice of Continuation June 11, 2003
35A-4-303

▼ ▼

Workforce Services, Workforce Information and Payment Services

R994-309-105

Reimbursable Employer's Liability for Benefits Paid

NOTICE OF PROPOSED RULE
(Amendment)
DAR FILE NO.: 27921
FILED: 05/16/2005, 15:32

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The reason for the change is to clarify when a reimbursable employer is liable for unemployment benefits paid.

SUMMARY OF THE RULE OR CHANGE: A reimbursable employer is not liable for benefits paid in the event of agency error. This amendment attempts to clarify that provision. Additionally, in the event of an overpayment to the claimant where the reimbursable employer is eligible for reimbursement, this new rule allows the Department to reimburse the employer immediately or credit the reimbursable employer's account.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 35A-1-104, and Subsections 35A-1-104(4) and 35A-4-502(1)(b)

ANTICIPATED COST OR SAVINGS TO:
❖ THE STATE BUDGET: This is a federally-funded program and there will be no cost or savings to the state budget. This amendment only applies to nonprofit organizations.
❖ LOCAL GOVERNMENTS: This is a federally-funded state-run program and there will be no cost or savings to any local governmental entity. This amendment only applies to nonprofit organizations.
❖ OTHER PERSONS: There will be no cost or savings to other persons. Reimbursable employers have not been held liable for benefit costs resulting from agency error for the last 20 years.

COMPLIANCE COSTS FOR AFFECTED PERSONS: There are no compliance costs associated with this proposed amendment for any persons.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: There will be no impact on businesses as a result of this rule. Reimbursable nonprofit organizations have not been liable for agency errors for 20 years when the first rule amendment was passed regarding such errors. Tani Downing, Executive Director

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
WORKFORCE SERVICES
WORKFORCE INFORMATION
AND PAYMENT SERVICES
140 E 300 S
SALT LAKE CITY UT 84111-2333, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
Suzan Pixton at the above address, by phone at 801-526-9645, by FAX at 801-526-9211, or by Internet E-mail at spixton@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 07/01/2005.

THIS RULE MAY BECOME EFFECTIVE ON: 07/02/2005

AUTHORIZED BY: Tani Downing, Executive Director

R994. Workforce Services, Workforce Information and Payment Services.
R994-309. Nonprofit Organizations.
R994-309-105. Reimbursable Employer's Liability for Benefits Paid.

[~~The reimbursable employer's liability will be limited to the benefits paid to the claimant and benefits overpaid as a result of the failure of the reimbursable employer to provide complete and accurate information within the time limitations of the Department's request. The employer will not be liable for benefits overpaid as a result of a Department decision which is later reversed. Any benefits established as an overpayment due to claimant fault will be deducted from the employer's liability or refunded as the overpayment is repaid by the claimant.~~](1) The reimbursable employer's liability is limited to the amount of benefits paid to the claimant.

(2) The employer is not liable for benefits overpaid as a result of agency error or a Department decision which is later reversed unless the reversal was due in whole or in part to the failure of the reimbursable employer to provide complete and accurate information within the time limits prescribed by the Department.

(3) Any benefits established as an overpayment, except overpayments due to the failure of the employer to provide information as provided in subparagraph (2) above, will be deducted from the employer's liability or, at the Department's discretion, refunded as the overpayment is recovered.

(4) If a claimant continues working part-time for a reimbursable employer and had other employment during the base period, the reimbursable employer may be eligible for relief of charges if all the requirements of rule R994-401-302(1) are met.

KEY: unemployment compensation, nonprofit organization
[~~1989~~]2005
Notice of Continuation July 14, 2004
35A-4-309

▼ ▼

Workforce Services, Workforce Information and Payment Services
R994-311
Governmental Units

NOTICE OF PROPOSED RULE
(Amendment)
DAR FILE NO.: 27922
FILED: 05/16/2005, 15:50

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The reason for the change is to clarify when a reimbursable employer is liable for unemployment benefits paid and to add Indian Tribes as governmental units as per 2001 legislation (S.B. 179) and contained in Subsection 35A-4-311(1). (DAR NOTE: S.B. 179 is found at UT L 2001 Ch 265, and was effective 04/30/2001.)

SUMMARY OF THE RULE OR CHANGE: The legislature passed legislation in 2001 adding Indian Tribes to the definition of a governmental unit. The Department has never changed its rule to reflect that change. A reimbursable employer is not liable for benefits paid in the event of agency error. This amendment attempts to clarify that provision. Additionally, in the event of an overpayment to the claimant where the reimbursable employer is eligible for reimbursement, this new rule allows the Department to reimburse the employer immediately or credit the reimbursable employer's account. Some reimbursable employers want the Department to credit the employer's account and some want immediate reimbursement. Some overpayments are repaid to the Department in monthly installment payments and writing checks for each repayment is too costly and administratively burdensome. The Department needs the flexibility to credit employers with large accounts and reimburse other, smaller, employers.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 35A-1-104, and Sections 35A-1-104(4) and 35A-4-502(1)(b)

ANTICIPATED COST OR SAVINGS TO:

❖ THE STATE BUDGET: This is a federally-funded program and there will be no cost or savings to the state budget. Although the state is a reimbursable employer covered by this proposed amendment, the amendment does not change the liability of a reimbursable employer it simply seeks to clarify when a reimbursable employer is not liable.

❖ LOCAL GOVERNMENTS: This is a federally-funded state-run program and there will be no cost or savings to any local governmental entity. Although most local governmental entities are reimbursable employers, this rule does not affect the government's liability.

❖ OTHER PERSONS: There will be no cost or savings to other persons. Reimbursable employers have not been held liable for benefit costs resulting from agency error for the last 20 years.

COMPLIANCE COSTS FOR AFFECTED PERSONS: There are no compliance costs associated with this proposed amendment for any persons. Reimbursable employers have not been held liable for benefit costs resulting from agency error for the last 20 years.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: There will be no impact on businesses as a result of this rule. Reimbursable employers have not been liable for agency errors for 20 years when the first rule amendment was passed regarding such errors. Tani Downing, Executive Director

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

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AND PAYMENT SERVICES
140 E 300 S
SALT LAKE CITY UT 84111-2333, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
Suzan Pixton at the above address, by phone at 801-526-9645, by FAX at 801-526-9211, or by Internet E-mail at spixton@utah.gov

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THIS RULE MAY BECOME EFFECTIVE ON: 07/02/2005

AUTHORIZED BY: Tani Downing, Executive Director

R994. Workforce Services, Workforce Information and Payment Services.

R994-311. Governmental Units and Indian Tribes.

R994-311-102. Governmental Units.

Section 35A-4-311 applies to governmental units including: any county, city, town, school district, or political subdivision and instrumentality of the foregoing or any combination thereof and political subdivisions or instrumentalities of the State of Utah or other states as provided by Subsection 35A-4-204(2)(d) and Indian Tribes. A political subdivision or instrumentality of a state or county, city, town or school district is a subdivision thereof to which has been delegated certain functions of that state, county, etc. Examples of governmental units to which this section applies are county water conservancy districts, state universities, city fire departments, associations of county governments, etc. [~~Indian tribes are not among the governmental entities included in this section and do not qualify to elect reimbursable status.~~]The provisions of this rule to not apply to federal agencies.

R994-311-105. Reimbursable Employer's Liability for Benefits Paid.

[~~The reimbursable employer's liability will be limited to the benefits paid to the claimant and benefits overpaid as a result of the failure of the reimbursable employer to provide complete and accurate information within the time limitations of the Department's request. The employer will be liable even if good cause for the failure to properly provide the information can be established. The employer will not be liable for benefits overpaid as a result of a Department decision which is later reversed. Any benefits established as an overpayment due to claimant fault will be deducted from the employer's liability or refunded as the overpayment is repaid by the claimant. Federal regulation 20 CFR Sections 609.11 and 614.11 state that federal agencies receive adjustments (credits) when overpayments are recovered.~~](1) The reimbursable employer's liability is limited to the amount of benefits paid to the claimant.

(2) The employer is not liable for benefits overpaid as a result of agency error or a Department decision which is later reversed unless the reversal was due in whole or in part to the failure of the

reimbursable employer to provide complete and accurate information within the time limits prescribed by the Department.

(3) Any benefits established as an overpayment, except overpayments due to the failure of the employer to provide information as provided in subparagraph (2) above, will be deducted from the employer's liability or, at the Department's discretion, refunded as the overpayment is recovered.

(4) If a claimant continues working part-time for a reimbursable employer and had other employment during the base period, the reimbursable employer may be eligible for relief of charges if all the requirements of rule R994-401-302(1) are met.

KEY: unemployment compensation, government corporations [~~1989~~]2005
Notice of Continuation July 14, 2004
35A-4-311

Workforce Services, Workforce Information and Payment Services
R994-401
Payment of Benefits

NOTICE OF PROPOSED RULE
(Amendment)
DAR FILE NO.: 27924
FILED: 05/16/2005, 16:16

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The purpose of this amendment is to clarify language.

SUMMARY OF THE RULE OR CHANGE: This amendment is to clarify language about the 50% Social Security deduction and to make minor changes to the part-time concurrent rule. Currently, the employment with the part-time employer must be concurrent, this change provides it need not be concurrent but within seven days of the claim being filed. This amendment also provides that a recalculation due to receipt of retirement benefits need only be made in the first full week of benefits otherwise the calculation is too difficult to make. This amendment merely codifies current Department practice.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 35A-1-104, and Subsections 35A-1-104(4) and 35A-4-502(1)(b)

ANTICIPATED COST OR SAVINGS TO:
❖ THE STATE BUDGET: There will be no costs or savings to the state budget. This is a federally-funded program and the state is not a contributory employer. The full week change reflects Department practice and affects a very small number of claimants.
❖ LOCAL GOVERNMENTS: There will be no costs or savings to local governmental entities. These changes reflect Department practice and affect a very small number of claimants.
❖ OTHER PERSONS: These changes reflect Department practice in calculating retirement income and because it is a federally-funded program there will be no costs or savings to any other persons.

COMPLIANCE COSTS FOR AFFECTED PERSONS: There are no costs associated with complying with this proposed amendment.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: There will be no fiscal impact on any businesses as a result of these changes. The change regarding calculation of retirement income reflects current Department practice. The other changes do not reflect a change in practice. Tani Downing, Executive Director

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WORKFORCE SERVICES
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AND PAYMENT SERVICES
140 E 300 S
SALT LAKE CITY UT 84111-2333, or
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THIS RULE MAY BECOME EFFECTIVE ON: 07/02/2005

AUTHORIZED BY: Tani Downing, Executive Director

R994. Workforce Services, Workforce Information and Payment Services.
R994-401. Payment of Benefits.
R994-401-203. Retirement or Disability Retirement Income.

(1) A claimant's WBA is reduced by 100%[~~percent~~] of any retirement benefits, social security, pension, or disability retirement pay (referred to collectively in this section as "retirement benefits" or "retirement pay") received by the claimant. Except, [~~for social security retirement benefits, the reduction is 50 percent~~]for claims with an effective date on or after July 4, 2004, and on or before July 2, 2006 the reduction for social security retirement benefits will only be 50%. The payments must be:

(a) from a plan contributed to by a base-period employer. Payments made by the employer for whom the claimant did not work during the benefit year are not counted. Social security payments are counted if a base period employer contributed to social security even if the social security payment is not based on employment during the base period;

(b) based on prior employment and the claimant qualifies because of age, length of service, disability, or any combination of these criteria. Disability payments must be based, at least in part, by length of service. Savings plans such as a 401(k) or IRA should not be used to

reduce the WBA Payments from workers' compensation for temporary disability, black lung disability income, and benefits from the Department of Veterans Affairs are not counted because the amount of the payment is based on disability and not on length of service. Payments received as a spouse or beneficiary are not counted. That portion of retirement benefits payable to a claimant's former spouse is not counted if the paying entity pays the former spouse directly and it is pursuant to court order or a signed, stipulated agreement in accordance with the law;

(c) periodic and not made in a lump sum. Lump sum payments, even if drawn from the employer's contributions to a fund established for the purpose of retirement, are not treated as severance pay under Subsection 35A-4-405(7); and

(d) payable during the benefit year. A claimant's WBA is not reduced if the claimant is eligible for, but not receiving, retirement income. However, if the claimant subsequently receives a retroactive payment of retirement benefits which, if received during the time unemployment insurance claims were filed, would have resulted in a reduced payment, an overpayment will be established. The period of time the payment represents, not the time of the receipt, is the determining factor. An assumption that a claimant is entitled to receive a pension, even if correct, is not sufficient basis to recompute the WBA. However, if a claimant has applied for a pension and expects to be determined eligible for a specific amount attributable to weeks when Unemployment Insurance benefits are payable, and the claimant is only awaiting receipt of those payments, a reduction of the claimant's WBA will be made.

(2) A claimant who could be eligible for a retirement income, but [~~chooses~~]does not [~~to~~]apply until after the Unemployment Insurance benefits have been paid, will be at fault for any overpayment resulting from a retroactive payment of retirement benefits.

(3) The formula for recomputation of the MBA in the event a claimant begins receiving retirement income after the beginning of the benefit year is found in Subsection 35A-4-401(2)(d). The recomputation is effective with the first full calendar week in which the claimant is eligible to receive applicable retirement benefits or adjustments to those benefits.

R994-401-302. Liability of Part-time Concurrent Reimbursable Employers When There is No Job Separation from the Part-Time Reimbursable Employer.

(1) If the claimant worked [~~concurrently~~]for two or more employers during the base period and is separated from one or more of these employers, but continues in the regular part-time work with a reimbursable employer, [~~that~~]the nonseparating part-time employer will not be liable for benefit costs provided;

(a) the claimant earned wages from a nonseparating employer within seven days prior to the date when the claim was filed,

(b) the claimant is not working on an "on call" basis,

(c) the number of hours of work [~~has~~]have not been reduced, and

(d) the nonseparating employer makes a request that it not be held liable for benefit costs within ten days of the first notification of the employer's potential liability.

(2) The claimant's WBA will be determined on the basis of the total base period employment and earnings, however, earnings from the part-time reimbursable employer will be excluded from the calculation of the MBA.

(3) If the claimant is later separated from this employer within the benefit year or the claimant's hours of work are reduced below the customary number of hours worked during the base period, the reimbursable employer will be liable to pay the proportionate amount of benefit payments paid thereafter. A new monetary determination can also be made at the request of the claimant and would include all base period wages. The effective date of the revised monetary determination will be the first day of the week in which the request is made. See R994-307-101 for contributory employers.

KEY: unemployment compensation, benefits
[~~November 16, 2004~~]2005
Notice of Continuation May 23, 2002
35A-4-401(1)
35A-4-401(2)
35A-4-401(3)
35A-4-401(6)

Workforce Services, Workforce Information and Payment Services
R994-404-101
Claimants Who Qualify for an Adjustment to the Base Period

NOTICE OF PROPOSED RULE
(Amendment)
DAR FILE NO.: 27926
FILED: 05/16/2005, 17:38

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The purpose for the change is to clarify Department intent.

SUMMARY OF THE RULE OR CHANGE: The current rule provides that a claimant must be off work for seven weeks to use the alternative base period in the event of a workers' compensation injury. The Department intended that the claimant be receiving temporary total disability (TTD) for seven weeks, not just off work and has interpreted the rule that way since last amended. This proposed amendment clarifies the Department's position and insures uniform treatment in these cases.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 35A-1-104, and Subsections 35A-1-104(4) and 35A-4-502(1)(b)

ANTICIPATED COST OR SAVINGS TO:
❖ THE STATE BUDGET: There will be no costs or savings to the state budget. This is a federally-funded program and this proposed amendment is intended to interpret and clarify state law on this issue. If anything, this will result in a minor savings to the state in the case where an individual was off work for seven weeks but did not receive seven weeks of TTD.
❖ LOCAL GOVERNMENTS: There will be no costs or savings to local governments. This is a federally-funded program. If anything, this will result in a minor savings to local governments in the case where an individual was off work for seven weeks but did not receive seven weeks of TTD.

❖ OTHER PERSONS: This could result in a very slight savings to employers but only in cases where the claimant was off work for seven weeks but on TTD for less than seven weeks. Claimants will not lose benefits just not be able to use an alternative base year. It is not seen as affecting more than one or two claimant's per year, if at all.

COMPLIANCE COSTS FOR AFFECTED PERSONS: There are no compliance costs associated with this proposed amendment and thus it will not cost any persons any sums of money to comply with this rule.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: There will be no fiscal impact on businesses. Some employers might see a very tiny savings in unemployment compensation costs but it is so slight as to be insignificant. Tani Downing, Executive Director

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

WORKFORCE SERVICES
WORKFORCE INFORMATION
AND PAYMENT SERVICES
140 E 300 S
SALT LAKE CITY UT 84111-2333, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
Suzan Pixton at the above address, by phone at 801-526-9645, by FAX at 801-526-9211, or by Internet E-mail at spixton@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 07/01/2005.

THIS RULE MAY BECOME EFFECTIVE ON: 07/02/2005

AUTHORIZED BY: Tani Downing, Executive Director

R994. Workforce Services, Workforce Information and Payment Services.
R994-404. Payments Following Workers' Compensation.
R994-404-101. Claimants Who Qualify for an Adjustment to the Base Period.

(1) A claimant who was off work due to a work related illness or injury may qualify for an adjusted base period if all of the following elements are satisfied:

(a) ~~[the claimant must have been off work for at least seven weeks during the normal base period due to a work related illness or injury. The weeks need not be consecutive;~~

~~(b) ~~]the claimant must have received temporary total disability (TTD) compensation for the illness or injury under the workers' compensation or occupational disease laws of this state or under federal law;

(b) the claimant must have received TTD for at least seven weeks during the normal base period. The weeks need not be consecutive;

(c) the initial claim for unemployment insurance benefits must have been filed no later than 90 calendar days after the claimant was released by his or her health care provider to return to full-time work. This does not include release to limited or light duty work. The effective date of the eligible claim must be within the 90 days regardless of the date on which the claimant contacts the Department to file a claim. For example, if the 90th day falls on Wednesday and the claimant files a claim on Thursday, the effective date of the claim would be Sunday of that calendar week and would fall within the 90 day time limitation;

(d) the initial claim for unemployment insurance benefits must have been filed within 36 months of the week the covered injury or illness occurred.

(2) Wages previously used to establish a benefit year cannot be re-used.

KEY: unemployment compensation, workers' compensation
[~~August 18, 2004~~]2005
Notice of Continuation May 23, 2002
35A-4-404

▼ ▼

Workforce Services, Workforce Information and Payment Services
R994-405
Ineligibility for Benefits

NOTICE OF PROPOSED RULE
(Amendment)
DAR FILE NO.: 27927
FILED: 05/16/2005, 18:35

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The Department is in the process of rewriting all our rules. The fraud provisions in Rule R994-405 have been moved to R994-406 with the other overpayment provisions. (DAR NOTE: The proposed amendment to Rule R994-406 is under DAR No. 27928 in this issue.)

SUMMARY OF THE RULE OR CHANGE: This proposed amendment moves the fraud provisions from one rule to another. The other overpayment provisions are in Rule R994-406 and it made sense to have them altogether.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 35A-1-104, and Subsections 35A-1-104(4) and 35A-4-502(1)(b)

ANTICIPATED COST OR SAVINGS TO:
❖ THE STATE BUDGET: There will be no costs or savings to the state by moving these provisions from one rule to another.
❖ LOCAL GOVERNMENTS: There will be no costs or savings to local government because the amendment just moves language.

❖ OTHER PERSONS: There will be no costs or savings to any person from moving these provisions.

COMPLIANCE COSTS FOR AFFECTED PERSONS: There are no compliance costs associated with this rule change.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: There will be no fiscal impact on any business by this change. Tani Downing, Executive Director

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AND PAYMENT SERVICES
140 E 300 S
SALT LAKE CITY UT 84111-2333, or
at the Division of Administrative Rules.

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THIS RULE MAY BECOME EFFECTIVE ON: 07/02/2005

AUTHORIZED BY: Tani Downing, Executive Director

R994. Workforce Services, Workforce Information and Payment Services.
R994-405. Ineligibility for Benefits.
[~~**R994-405-501. Fraud - General Definition.**~~
~~The Department relies primarily on information provided by the claimant when paying unemployment insurance benefits. Fraud penalties do not apply if the overpayment was the result of an inadvertent error. Fraud requires a willful misrepresentation or concealment of information for the purpose of obtaining unemployment benefits. The absence of an admission or direct proof of intent to defraud does not prevent a finding of fraud.~~

~~**R994-405-502. Elements of Fraud.**~~
~~The elements necessary to establish an intentional misrepresentation, sufficient to constitute fraud are:~~
~~(1) Materiality.~~
~~Materiality is established when a claimant makes false statements or fails to provide accurate information for the purpose of obtaining waiting week credit or any benefit payment to which he is not entitled. Benefits received by fraud may include an amount as small as $1 over the amount a claimant was entitled to receive.~~
~~(2) Knowledge.~~
~~A claimant must have known or should have known the information submitted to the Department was incorrect or that he failed to provide information required by the Department. He does NOT have to know that the information will result in a denial of benefits or a reduction in the benefit amount. Knowledge is established when a claimant recklessly makes representations knowing he has insufficient information upon which to base such representations. A claimant has an obligation to read material provided by the Department or to ask a Department representative when he has a question about what information to report.~~
~~(3) Willfulness.~~
~~A claimant must have made the false statement or deliberate omission for the purpose of obtaining benefits. Willfulness is established when a claimant files claims or other documents containing false statements, responses or deliberate omissions. If a claimant delegates the responsibility to personally provide information or allows access to his or her Personal Identification Number (PIN) so that someone else may file a telephone claim, the claimant is responsible for the information provided or omitted by the other person, even if the claimant had no advance knowledge that the information provided was false or important information was omitted.~~

~~**R994-405-503. Evidence and Burden of Proof.**~~
~~(1) Prior Knowledge of Ineligibility by the Department.~~
~~If the Department has sufficient evidence to assess a disqualification prior to paying benefits, a fraud disqualification shall not be assessed even if the documents submitted by the claimant contain false statements or deliberate omissions. However, non-fraud overpayments may be established under the law regarding fault and non-fault overpayments in Subsections 35A-4-406(4)(b) and 35A-4-406(5)(a), respectively.~~
~~(2) Initial Burden of Proof.~~
~~Fraud may not be presumed whenever false information has been provided or material information omitted and benefits overpaid. The Department has the burden of proof, which is the responsibility to establish all the elements of fraud.~~
~~(3) Standard of Proof.~~
~~The elements of fraud must be established by a preponderance of the evidence. There does not have to be an admission or direct proof of intent.~~

~~**R994-405-504. Disqualification and Penalty.**~~
~~(1) Penalty Cannot Be Modified.~~
~~The Department has no authority to reduce or otherwise modify the period of disqualification or the monetary penalties imposed by statute.~~
~~(2) Week of Fraud.~~
~~A "week of fraud" shall include each week any benefits have been paid due to fraud.~~
~~(3) Overpayment and Penalty.~~
~~For any fraud decision where the initial fraud determination was issued on or before June 30, 2004, the claimant shall repay to the division an overpayment which is equal to the amount of the benefits actually received. In addition, a claimant shall be required to repay, as a civil penalty, the amount of benefits received as a direct result of fraud. "Benefits actually received" means the benefits paid or constructively paid by the Department. Constructively paid refers to benefits used to reduce or off-set an overpayment or used as a payment to the Office of Recovery Services for child support obligations or other payments as required by law.~~
~~(4) For all fraud decisions where the initial department determination is issued on or after July 1, 2004, the claimant shall repay to the division the overpayment and, as a civil penalty, an amount equal to the overpayment. The overpayment in this subparagraph is the amount of benefits the claimant received by direct reason of fraud.~~

~~(5) Additional Penalties.~~

~~Criminal prosecution of fraud may be pursued as provided by Subsection 35A-4-104(1) in addition to the administrative penalties.~~

~~**R994-405-505. Repayment.**~~

~~Overpayments established under Subsection 35A-4-405(5) will be collected in accordance with Subsection 35A-4-406(4)(b) and Section R994-406-404 or by civil action or warrant as provided by Subsections 35A-4-305(3) and 35A-4-305(5), respectively. The Department may use unemployment insurance benefits payable for weeks prior to the penalty period to reduce overpayments.~~

~~**R994-405-506. Future Eligibility.**~~

~~A claimant shall be ineligible for unemployment benefits or waiting week credit following a disqualification for fraud until any overpayment established in conjunction with the disqualification has been satisfied in full. Any overpayment established under Subsection 35A-4-405(5) may NOT be satisfied by deductions from benefit checks for weeks claimed after the penalty period ends, as a claimant is precluded from receiving any future benefits or waiting week credit as long as there is an outstanding fraud overpayment. However, a claimant may be permitted to file a new claim to preserve a particular benefit year. An overpayment shall be considered satisfied as of the beginning of the week during which the cash payment or credit card payment is received by the Department or in the case of payment by personal check, the beginning of the week during which the check is honored by the bank. Benefits will be allowed as of the effective date of a new claim if a claimant repays the outstanding fraud overpayment and penalty within seven days of the date the notice of the outstanding overpayment is mailed.~~

~~**R994-405-507. Examples.**~~

~~Depending on the issue, a disqualification could result in a denial of benefits for one week, a specific number of weeks or an indefinite number of weeks. A disqualifying separation results in an indefinite denial, continuing until the claimant has returned to work and earned six times his or her weekly benefit amount. The disqualification applicable to the reason for the underlying denial determines the amount of the fraud penalties and disqualification periods in each case.~~

~~(1) Failure to Report Reason for Separation. A claimant who was discharged for disqualifying conduct reports the separation as a layoff and receives benefits. Each benefit check received is paid due to the original false statements, even though the claimant may subsequently answer the Department's weekly questions correctly. Therefore, all benefits received would be "due to fraud." The fraud penalties and disqualification periods would, therefore, apply to all weeks benefits were received.~~

~~(2) Failure to Report Earnings.~~

~~The fraud overpayment and penalty, where the initial department fraud determination was issued on or before June 30, 2004, is calculated as in the following example: The claimant has a weekly benefit amount of $100 and reports no earnings when there was $50 in reportable earnings for the week at issue. The Act provides a claimant may earn up to 30% of his or her weekly benefit amount with no deduction. After considering the 30% factor in the present example, the claimant was overpaid in the amount of $20. If the elements of fraud were established, all benefits paid for a disqualified week would be established as an overpayment. The claimant would also be liable to repay, as a civil penalty, the $20 received by direct reason of fraud. Therefore, in this example, the claimant would be liable for a total overpayment of $120, an amount that would have to repaid in its entirety before the claimant would be eligible for any further waiting week credit or unemployment benefits. The claimant would also be subject to a 13-week penalty period. If the initial department fraud determination was issued on or after July 1, 2004, the overpayment would be $20 and the penalty would be $20 for a total due of $40.~~]

KEY: unemployment compensation, employment, employee's rights, employee termination
[~~November 16, 2004~~]2005
Notice of Continuation June 27, 2002
35A-4-502(1)(b)
35A-1-104(4)
35A-4-405

▼ ▼

Workforce Services, Workforce Information and Payment Services
R994-406
Fraud and Fault

NOTICE OF PROPOSED RULE
(Amendment)
DAR FILE NO.: 27928
FILED: 05/16/2005, 19:20

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The reason or the change is too clarify procedure and make changes to reflect the new computer system.

SUMMARY OF THE RULE OR CHANGE: The Department is rewriting all of its rules and instituting a new computer system. These proposed amendments are to reflect changes in procedures for the new computer system, as well as, Department policy. All fraud, fault and nonfault overpayment provisions have been moved into one rule to make them easier to find. In the case of fault overpayments, 100% of a claimant's benefits will be used to retire any fault obligation owed to the Department instead of 50% as it now stands. The waiver provisions of the nonfault overpayment rules have been "tightened up" so that individuals can be called on to prove need after a waiver has been granted. Discretion in the collection of fault overpayments will only be allowed in shared fault situations. The burden of proof in fraud cases will now be clear and convincing evidence to make unemployment cases the same as public assistance cases administered by the Department. Because several provisions were moved, the strike out and underline approach to this amendment would have been too confusing so the entire text of the current Rule R994-406 was struck through and added back anew; but most of the other changes are minor to conform to current practice and policy.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 35A-1-104, and Subsections 35A-1-104(4) and 35A-4-502(1)(b)

ANTICIPATED COST OR SAVINGS TO:
❖ THE STATE BUDGET: There will be no costs or savings to the state budget. With the recovery of 100% in fault cases it may be that the Department recovers more overpayments in cases where the state is a party but it is not anticipated this will be a significant amount of money. This is a federally-funded program and there are no costs to the state.
❖ LOCAL GOVERNMENTS: Local government may see the same changes discussed in the state information above. There will be no costs to local governments.
❖ OTHER PERSONS: There will be no costs or savings to any other persons with the expectation that some employer may see a greater recovery in fault cases.

COMPLIANCE COSTS FOR AFFECTED PERSONS: The Department has determined that there are no costs associated with complying with this provision of the rule. Individuals who correctly file their claims for benefits are not subject to the overpayment provisions of this rule.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: There will be no fiscal impact on businesses in Utah. The potential savings by changing the rate from 50% to 100% will be minimal but may benefit employers overall. Tani Downing, Executive Director

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140 E 300 S
SALT LAKE CITY UT 84111-2333, or
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THIS RULE MAY BECOME EFFECTIVE ON: 07/02/2005

AUTHORIZED BY: Tani Downing, Executive Director

R994. Workforce Services, Workforce Information and Payment Services.
R994-406. Fraud, [~~and~~]Fault and Nonfault Overpayments.
[~~R994-406-205. Obligation of Department Employees.~~
~~Employees of the Department are obligated, regardless of when the information is discovered, to bring to the attention of the proper Department representatives any information that may affect an individual's eligibility for unemployment insurance benefits or information affecting the employer's contributions.~~

~~R994-406-401. Fault Overpayments - General Definition.~~
~~Subsection 35A-4-406(4) identifies the repayment requirements of individuals who have been overpaid due to fraud, or due to claimant fault not constituting fraud.~~

~~R994-406-402. Fraud.~~
~~(1) When the Department has evidence of an overpayment resulting from the claimant's failure to properly report material information, the claimant will be notified of the issue, given an opportunity to provide information concerning the issue, and told that payments are being held pending a decision. In such circumstances, payment of benefits for claims currently in process may be held for up to two weeks pending the issuance of a fraud or overpayment decision. Benefit payments which have not been paid for eligible weeks prior to the disqualification period under Subsection 35A-4-405(5), shall be used to reduce such an overpayment. 100% of the benefit check to which he is entitled will be used to reduce the overpayment.~~
~~(2) The overpayment and penalties for fraud are established only when benefits have been denied under Subsection 35A-4-405(5). The repayment amount is determined by Subsection 35A-4-405(5) and, following a decision, repayment must be made in cash before the claimant will be eligible to establish a waiting week credit or receive future benefit payments. Therefore, the overpayment and penalties cannot be offset.~~

~~R994-406-403. Claimant Fault.~~
~~(1) Elements of Fault.~~
~~Fault is established if all three of the following elements are present. If one or more element cannot be established, the overpayment does not fall under the provisions of Subsection 35A-4-405(5).~~
~~(a) Materiality.~~
~~Benefits were paid to which the claimant was not entitled.~~
~~(b) Control.~~
~~Benefits were paid based on incorrect information or an absence of information which the claimant reasonably could have provided.~~
~~(c) Knowledge.~~
~~The claimant had sufficient notice that the information might be reportable.~~
~~(2) Claimant Responsibility.~~
~~The claimant is responsible for providing all of the information requested of him in written documents regarding his Unemployment Insurance claim, as well as any verbal instructions given by a Department representative. Before certifying that he is eligible for benefits, he is under obligation to make proper inquiry if he has any questions to determine definitely what is required. Therefore, when a claimant has knowledge that certain information may affect his claim, but makes his own determination that the information is not material or if he ignores it, he is at fault.~~
~~(3) Receipt of Settlement or Back-Pay.~~
~~(a) A claimant is "at fault" for an overpayment created if he fails to advise the Department that grievance procedures are being pursued which may result in payment of wages for weeks he claims benefits.~~
~~(b) When the claimant advises the Department prior to receiving a settlement that he has filed a grievance with his employer, and he makes an assignment directing the employer to pay to the Department that portion of the settlement equivalent to the amount of unemployment compensation he receives, he will not be "at fault" if an overpayment is created due to payment of wages attributable to weeks for which he receives benefits. If the grievance is resolved in favor of~~

the claimant and the employer was properly notified of the wage assignment, the employer is liable to immediately reimburse the Unemployment Insurance Fund upon settlement of the grievance. If reimbursement is not made to the Department consistent with the provisions of the Assignment, collection procedures will be initiated against the employer.

(c) If the claimant refuses to make an assignment of the wages he is claiming in a grievance proceeding, benefits will be withheld on the basis that he is not unemployed because he anticipates receipt of wages. In this case, the claimant should file weekly claims and if he does not receive back wages when the grievance is resolved, benefits will be paid for weeks properly claimed provided he is otherwise eligible.

R994-406-404. Method of Repayment of Fault Overpayments.

(1) When the claimant has been determined to be "at fault" in the creation of an overpayment, the overpayment must be repaid. If payment is made by personal check, no benefit checks will be released until the personal check has been honored by the bank. If the claimant is otherwise eligible and files for additional benefits during the same or any subsequent benefit year, 50% of the benefit check to which he is entitled will be used to reduce the overpayment.

(2) Discretion for Repayment.

(a) Full restitution is required of all overpayments established under Subsection 35A-4-405(5). At the discretion of the Department, however, the claimant may not be required to make payments and legal collection proceedings may be held in abeyance. The overpayment will be deducted from future benefits payable during the current or subsequent benefit years. Discretion may be exercised:

(i) if the Department or the employer share fault in the creation of the overpayment, or

(ii) if installment payments would impose unreasonable hardship such as in the case of an individual with an income which does not provide for additional money beyond minimum living requirements.

(b) The Department cannot exercise repayment discretion for fraud overpayments and these amounts are subject to all collection procedures.

(3) Installment Payments.

(a) If repayment in full has not been made within 90 days of the first billing the Department shall enter into an agreement with the claimant whereby repayment of the money owed is collectible by monthly installments. The Department shall notify the claimant in writing of the minimum installment payment which the claimant is required to make. If the claimant is unable to make the minimum installment payments, he may request a review within ten days of the date written notice is mailed or delivered.

(b) Installment agreements shall be established as follows:

Overpayments Equaling Minimum Monthly Payment

$3,000 or less 50% of claimant's weekly benefit entitlement

3,001 to 5,000 100% of claimant's weekly benefit entitlement

5,001 to 10,000 125% of claimant's weekly benefit entitlement

10,001 or more 150% of claimant's weekly benefit entitlement

(c) Installment agreements will not be approved in amounts less than those established above except in cases of extreme hardship. An ability to make a minimal payment is presumed if the claimant has a household income which is in excess of the poverty level guidelines as established by the federal government and used to grant waivers of overpayments under Subsection 35A-4-406(5). The installment agreement will be reviewed periodically and adjustments made based upon changes in the claimant's income or circumstance. A due date will be established for each installment agreement which is mutually agreed upon by the claimant and the Department.

(4) Collection Procedures.

(a) Billings are sent to claimants with overpayments on a monthly basis. After 30 days, if payment is not made, the account is considered delinquent. If no payment has been received in 90 days the individual is notified that a warrant will be filed unless a payment is received within 10 days. However, there may be other circumstances under which a warrant may be filed on any outstanding overpayment. A warrant attaches a lien to any personal or real property and establishes a judgment that is collectible under Utah Rules of Civil Procedure.

(b) All outstanding overpayments are reported to the State Auditor for collection whereby any refunds due to the individual from State income tax or any such rebates, refunds, or other amounts owed by the state and subject to legal attachment may be applied against the overpayment.

(5) Offset In Time.

Offset in time occurs when the claimant files valid weekly claims to replace weeks of benefits which were overpaid. When an overpayment is established after the claimant has exhausted all benefits, the claimant may file claims for additional weeks during the same benefit year provided he is otherwise eligible. Offset in time will be allowed on claims that have expired if a written request is made within 30 days of the notification of the overpayment. No offset in time will be allowed on overpayments established under Subsection 35A-4-405(5). One hundred percent (100%) of the weekly benefit amount for the weeks claimed will be credited against the established overpayment up to the amount of the balance owed to the Department. No penalty for late filing will be assessed when a claimant is otherwise eligible to file claims to offset in time.

R994-406-501. Non-Fault Overpayments - General Definition.

Subsection 35A-4-406(5) identifies the repayment requirements of individuals who have received an overpayment of benefits through no fault of their own. Such overpayments are referred to as "accounts not receivable" (ANR).

R994-406-502. Responsibility.

(1) The claimant is responsible for providing all of the information requested in written documents as well as any verbal request from a Department representative. If the claimant has provided such information, and then receives benefits to which he is not entitled through an error of the Department or an employer, he is not at fault for the overpayment.

(2) "Through no fault of his own" does not mean the claimant can shift responsibility for providing correct information to another person such as a spouse, parent, or friend. The claimant is responsible for all information required on his claim.

R994-406-503. Method of Repayment.

Even though the claimant is without fault in the creation of the overpayment, 50 percent of the claimant's weekly benefit amount will be deducted from any future benefits payable to him until the overpayment is repaid. No billings will be made and no collection procedures will be initiated.

R994-406-504. Waiver of Recovery of Overpayment.

(1) If waiver of recovery of overpayment is granted under Subsection 35A-4-406(5), the amount of the overpayment owing at the time the request is granted is withdrawn, forgiven or forgotten and the claimant has no further repayment obligation. Granting of a waiver will not be retroactive for any of the overpayment which has already

~~been offset except if the offset was made pending a decision on a timely waiver request.~~

~~(a) Time Limitation for Requesting Waiver.~~

~~A waiver must be requested within 10 days of the notification of opportunity to request a waiver or within 10 days of the first offset of benefits following a reopening or upon a showing of a significant change of the claimant's financial circumstances. Good cause will be considered if the claimant can show the failure to request a waiver within these time limitations was due to circumstances which were reasonable or beyond his control.~~

~~(b) Basic Needs of Survival.~~

~~The claimant may be granted a waiver of the overpayment if recovery by 50 percent offset would create an inability to pay for the basic needs of survival for the immediate family, dependents and other household members. In making this waiver determination, the Department shall take into consideration all the potential resources of the claimant, the claimant's family, dependents and other household members. The claimant will be required to provide documentation of claimed resources. The claimant must also provide social security numbers of family members, dependents and household members. "Economically disadvantaged" for federal programs is defined as 70 percent of the Lower Living Standard Income Level (LLSIL). "Inability to meet the basic needs of survival" is defined consistent with "economically disadvantaged." Therefore, if the claimant's total family resources in relation to family size are not in excess of 70 percent of the LLSIL, the waiver will be granted provided the economic circumstances are not expected to change within an indefinite period of time. Individual expenses will not be considered.~~

~~(c) Indefinite Period.~~

~~An indefinite period of time is defined as the current month and at least the next two months. Therefore, the duration of the financial hardship must be expected to last at least three months. If the claimant or household members expect to return to work within the three months the anticipated income will be included in determining if he lacks basic needs of survival for an indefinite period of time. Available resources will be averaged for the three months.~~]

R994-406-101. Claimant Responsible for Providing Complete, Correct Information.

(1) The claimant is responsible for providing all of the information requested in written documents as well as any verbal request from a Department representative. The claimant is also responsible for following all Department instructions.

(2) The claimant can not shift responsibility for providing correct information to another person such as a spouse, parent, or friend. The claimant is responsible for all information required on his or her claim.

R994-406-201. Nonfault Overpayments.

(1) If the claimant followed all instructions and provided complete and correct information as required in R994-406-101(1) and then received benefits to which he or she was not entitled due to an error made by the Department or an employer, the claimant is not at fault in the creation of the overpayment.

(2) The claimant is not liable to repay overpayments created through no fault of the claimant except that the sum will be deducted from any future benefits.

R994-406-203. Method of Repayment of Nonfault Overpayments.

Even though the claimant is without fault in the creation of the overpayment, 50% of the claimant's weekly benefit amount will be deducted from any future benefits payable to him or her until the overpayment is repaid. No billings will be made and no collection procedures will be initiated.

R994-406-204. Waiver of Recovery of Nonfault Overpayments.

(1) The Department may waive recovery of a nonfault overpayment if the claimant:

(a) requests a waiver within 10 days of notification of the opportunity to request a waiver, within 10 days of the first offset of benefits following a reopening, or upon a showing of a significant change in the claimant's financial circumstances. Good cause will be considered if the claimant can show the failure to request a waiver within these time limitations was due to circumstances which were beyond the claimant's control or were compelling and reasonable; and

(b) can show that recovery of the 50% offset as provided in R994-406-203 would render the claimant unable to pay for the basic needs of survival for his or her immediate family, dependents and other household members.

(i) The claimant must provide verification of financial resources and the social security numbers of family members, dependents and household members.

(ii) Before granting the waiver, the Department must consider all potential financial resources of the claimant, the claimant's family, dependents and other household members.

(iii) "Unable to pay for the basic needs of survival" means "economically disadvantaged" and is defined as 70% of the Lower Living Standard Income Level (LLSIL). Therefore, if the claimant's total family resources in relation to family size are not in excess of 70% of the LLSIL, the waiver will be granted provided the economic circumstances are not expected to change within the next 90 days. Individual expenses will not be considered. Available financial resources, current income, and anticipated income will be included and averaged for the three months.

(2) Any nonfault overpayment outstanding at the time the request is granted is forgiven and the claimant has no further repayment obligation.

(3) A waiver cannot be granted retroactively for any payments made against an overpayment or any of the overpayment which has already been offset except if the offset was made pending a decision on a timely waiver request which is ultimately granted.

R994-406-301. Claimant Fault.

(1) Elements of Fault.

Fault is established if all three of the following elements are present, or as provided in subsection (4) of this section. If one or more elements cannot be established, the overpayment does not fall under the provisions of Subsection 35A-4-405(5).

(a) Materiality.

Benefits were paid to which the claimant was not entitled.

(b) Control.

Benefits were paid based on incorrect information or an absence of information which the claimant reasonably could have provided.

(c) Knowledge.

The claimant had sufficient notice that the information might be reportable.

(2) Claimant Responsibility.

The claimant is responsible for providing all of the information requested by the Department regarding his or her Unemployment Insurance claim. If the claimant has any questions about his or her eligibility for unemployment benefits, or the Department's instructions, the claimant must ask the Department for clarification before certifying to eligibility. If the claimant fails to obtain clarification, he or she will be at fault in any resulting overpayment.

(3) Receipt of Settlement or Back-Pay.

(a) A claimant is "at fault" for the resulting overpayment if he or she fails to advise the Department that grievance procedures are being pursued which may result in payment of wages for weeks during which he or she claims benefits.

(b) If the claimant advises the Department prior to receiving a settlement that he or she has filed a grievance with the employer and makes an assignment directing the employer to pay to the Department that portion of the settlement equivalent to the amount of unemployment compensation received, the claimant will not be "at fault" if an overpayment is created due to payment of wages attributable to weeks for which the claimant received benefits. If the grievance is resolved in favor of the claimant and the employer was properly notified of the wage assignment, the employer is liable to immediately reimburse the Department upon settlement of the grievance. If reimbursement is not made to the Department consistent with the provisions of the assignment, collection procedures will be initiated against the employer.

(c) If the claimant refuses to make an assignment of the wages claimed in a grievance proceeding, benefits will be withheld on the basis that the claimant is not unemployed because of anticipated receipt of wages. In this case, the claimant should file weekly claims and if back wages are not received when the grievance is resolved, benefits will be paid for weeks properly claimed provided the claimant is otherwise eligible.

(4) Receipt of Retirement Income.

Notwithstanding any other provision of this section, a claimant who could be eligible for retirement income but does not apply until after unemployment benefits have been paid, is "at fault" for any overpayment resulting from a retroactive payment of retirement benefits. See R994-401-203(1)(d) and (2)

R994-406-302. Repayment and Collection of Fault Overpayments.

(1) When the claimant has been determined to be "at fault" in the creation of an overpayment, the overpayment must be repaid. If the claimant is otherwise eligible and files for additional benefits during the same or any subsequent benefit year, 100% of the benefit payment to which the claimant is entitled will be used to reduce the overpayment.

(2) Discretion for Repayment.

(a) Full restitution is required for all fault overpayments. However, legal collection proceedings may be held in abeyance at the Department's discretion and the overpayment will be deducted from future benefits payable during the current or subsequent benefit years. Discretion will only be exercised if the Department or the employer share fault in the creation of the overpayment but it is determined the claimant was more at fault under the provisions of rule R994-403-119e.

(3) Collection Procedures.

(a) The Department will send an initial overpayment notice on all outstanding fault or fraud overpayments. If, after 15 days, the claimant does not either make payment in full or enter into an installment payment agreement as provided in subsection (4) below the account is considered delinquent and the claimant is notified that a warrant will be filed unless a payment is received or an installment agreement entered into within 15 days. However, there may be other circumstances under which a warrant may be filed on any outstanding overpayment. A warrant attaches a lien to any personal or real property and establishes a judgment that is collectible under Utah Rules of Civil Procedure.

(b) All outstanding overpayments on which a lien has been filed are reported to the State Division of Finance for collection whereby any refunds due to the claimant from State income tax or any such rebates, refunds, or other amounts owed by the state and subject to legal attachment may be applied against the overpayment.

(c) No warrant will be issued on fault overpayments provided the claimant entered into an installment agreement within 30 days of the issuance of the initial overpayment notice and all payments are made in a timely manner in accordance with the installment agreement.

(4) Installment Payments.

(a) If repayment in full has not been made within 30 days of the initial overpayment notice or the claimant has not voluntarily entered into an installment agreement, the Department will allow the claimant to pay in installments by notifying the claimant in writing of the minimum installment payment which the claimant is required to make. If the claimant is unable to make the minimum installment payments, the claimant may request a review within ten days of the date written notice is mailed.

(b) Whether voluntarily or involuntary, installment payments will be established as follows:

If the entire overpayment is:

(i) $3,000 or less, the monthly installment payment is equal to 50% of claimant's weekly benefit entitlement

(ii) $3,001 to 5,000, the monthly installment payment is equal to 100% of claimant's weekly benefit entitlement

(iii) $5,001 to 10,000 the monthly installment payment is equal to 125% of claimant's weekly benefit entitlement

(iv) $10,001 or more the monthly installment payment is equal to 150% of claimant's weekly benefit entitlement

(c) Installment agreements will not be approved in amounts less than those established above except in cases where the claimant meets the requirements of economically disadvantaged as defined in R994-406-204(1)(b)(iii). On a periodic basis the Department may send notice to the claimant requesting verification of his or her disadvantaged status. If the claimant fails to provide the verification as requested, or no longer qualifies for a lesser installment payment, the Department will send the claimant a new monthly payment amount. The new installment payment amount may be in accordance with the percentages in subparagraph (b) or a lesser amount depending on the information received from the claimant.

(d) Minimum monthly installment agreement payments must be received by the Department by the last day of each month. Payments not made timely are considered delinquent.

(5) Offsetting overpayments with subsequent eligible weeks.

If an overpayment is set up under Section R994-406-301 or R994-406-403 for weeks paid on a claim, the claimant may repay the overpayment by filing for open weeks in the same benefit year after the claim has been exhausted, provided the claimant is otherwise eligible. 100% of the compensation amount for each

eligible week claimed will be credited to the established overpayment(s) up to the total amount of the outstanding overpayment balance owed to the Department.

R994-406-401. Claimant Fraud.

(1) All three elements of fraud must be proved to establish an intentional misrepresentation sufficient to constitute fraud. See section 35A-4-405(5). The three elements are:

(a) Materiality.

(i) Materiality is established when a claimant makes false statements or fails to provide accurate information for the purpose of obtaining:

(A) any benefit payment to which the claimant is not entitled, or

(B) waiting week credit which results in a benefit payment to which the claimant is not entitled.

(ii) A benefit payment received by fraud may include an amount as small as one dollar over the amount a claimant was entitled to receive.

(b) Knowledge.

A claimant must have known or should have known the information submitted to the Department was incorrect or that he or she failed to provide information required by the Department. The claimant does NOT have to know that the information will result in a denial of benefits or a reduction of the benefit amount. Knowledge can also be established when a claimant recklessly makes representations knowing he or she has insufficient information upon which to base such representations. A claimant has an obligation to read material provided by the Department or to ask a Department representative when he or she has a question about what information to report.

(c) Willfulness.

Willfulness is established when a claimant files claims or other documents containing false statements, responses or deliberate omissions. If a claimant delegates the responsibility to personally provide information or allows access to his or her Personal Identification Number (PIN) so that someone else may file a claim, the claimant is responsible for the information provided or omitted by the other person, even if the claimant had no advance knowledge that the information provided was false or important information was omitted.

(2) The Department relies primarily on information provided by the claimant when paying unemployment insurance benefits. Fraud penalties do not apply if the overpayment was the result of an inadvertent error. Fraud requires a willful misrepresentation or concealment of information for the purpose of obtaining unemployment benefits.

(3) The absence of an admission or direct proof of intent to defraud does not prevent a finding of fraud.

R994-406-402. Burden and Standard of Proof in Fraud Cases.

(1) The Department has the burden of proving each element of fraud.

(2) The elements of fraud must be established by clear and convincing evidence. There does not have to be an admission or direct proof of intent.

R994-406-403. Fraud Disqualification and Penalty.

(1) Penalty Cannot be Modified.

The Department has no authority to reduce or otherwise modify the period of disqualification or the monetary penalties imposed by statute. The Department cannot exercise repayment discretion for fraud overpayments and these amounts are subject to all collection procedures.

(2) Week of Fraud.

(a) A "week of fraud" shall include each week any benefits were received due to fraud. The only exception to this is if the fraud occurred during the waiting week causing the next eligible week to become the new waiting week. In that case, the new waiting week will not be considered as a week of fraud for disqualification purposes. However, because the new waiting week is a non-payable week, any benefits received during that week will be assessed as an overpayment and because the overpayment was as a result of fraud, a fraud penalty will also be assessed.

(b) If a claimant commits a fraudulent act during one week, and benefits are paid in later weeks which would not have been paid but for the original fraud, each week wherein benefits were paid is a week of fraud subject to an overpayment determination, a penalty and a disqualification period.

(c) If the only week of fraud was the waiting week and no benefit payments were made, there will be no disqualification period.

(3) Disqualification Period.

(a) The claimant is ineligible for benefits for a period of 13 weeks for the first week of fraud. For each additional week of fraud, the claimant will be ineligible for benefits for an additional six weeks. The total number of weeks of disqualification will not exceed 49 weeks for each fraud determination. The Department will issue a fraud determination on all weeks of fraud the Department knows about at the time of the determination.

(b) The disqualification period begins the Sunday following the date the Department fraud determination is made.

(4) Overpayment and Penalty.

(a) For any fraud decision where the initial fraud determination was issued on or before June 30, 2004, the claimant shall repay to the division an overpayment which is equal to the amount of the benefits actually received. In addition, a claimant shall be required to repay, as a civil penalty, the amount of benefits received as a direct result of fraud. "Benefits actually received" means the benefits paid or constructively paid by the Department. Constructively paid refers to benefits used to reduce or off-set an overpayment, deducted at the request of the claimant to pay income taxes, or used as a payment to the Office of Recovery Services for child support obligations or other payments as required by law. For example: The claimant has a weekly benefit amount of $100 and reports no earnings during a week when he or she actually had $50 in reportable earnings. Because a claimant may earn up to 30% of his or her weekly benefit amount with no deduction, the claimant was entitled to receive $80 for that week and was thus overpaid the amount of $20. If the elements of fraud are established, the claimant is disqualified during that week of fraud and all benefits paid for that week are considered an overpayment. The claimant would also be liable to repay, as a civil penalty, the $20 received by direct reason of fraud. Therefore, in this example, the claimant would be liable for a total overpayment and penalty of $120, an amount that would have to be repaid in its entirety before the claimant would be eligible for any further waiting week credit or unemployment benefits. The claimant would also be subject to a 13-week penalty period.

(b) For all fraud decisions where the initial department determination is issued on or after July 1, 2004, the claimant shall repay to the division the overpayment and, as a civil penalty, an amount equal to the overpayment. The overpayment in this

subparagraph is the amount of benefits the claimant received by direct reason of fraud. In the example in subsection (3)(a) of this section, the overpayment would be $20 and the penalty would be $20 for a total due of $40. The overpayment and penalty would have to be repaid in its entirety before the claimant would be eligible for any further waiting week credit or unemployment benefits. The claimant would also be subject to a 13-week penalty period.

(4) Additional Penalties. Criminal prosecution of fraud may be pursued as provided by Subsection 35A-4-104(1) in addition to the administrative penalties.

R994-406-404. Repayment and Collection of Fraud Overpayments and Penalties.

Fraud overpayments and penalties will be collected in accordance with rule R994-406-302 except that a warrant will always issue in fraud overpayments even if the claimant enters into an installment agreement and is current in the monthly payments. Fraud overpayments and penalties may also be collected by civil action or warrant as provided by Subsections 35A-4-305(3) and 35A-4-305(5), respectively. The Department may use unemployment insurance benefits payable for weeks prior to the penalty period to reduce overpayments and penalties.

R994-406-405. Future Eligibility in Fraud Cases.

A claimant is ineligible for unemployment benefits or waiting week credit after a disqualification for fraud until any overpayment and penalty established in conjunction with the disqualification has been satisfied in full. Wage credits earned by the claimant cannot be used to pay benefits or transferred to another state until the overpayment and penalty are satisfied. An outstanding overpayment or penalty may NOT be satisfied by deductions from benefit payments for weeks claimed after the disqualification period ends, as a claimant is precluded from receiving any future benefits or waiting week credit as long as there is an outstanding fraud overpayment. However, a claimant may be permitted to file a new claim to preserve a particular benefit year. An overpayment is considered satisfied as of the beginning of the week during which payment is received by the Department. Benefits will be allowed as of the effective date of the new claim if a claimant repays the overpayment and penalty within seven days of the date the notice of the outstanding overpayment and penalty is mailed.

R994-406-406. Agency Error in Determining Disqualification Periods.

If the division has sufficient evidence to assess a disqualification prior to paying benefits, but fails to take action, a fraud disqualification will not be assessed even if the claimant provided false or information or deliberate omissions. The resulting overpayment will be assessed under the provisions of Subsections 35A-4-406(4)(b) or 35A-4-406(5)(a).

KEY: [~~appellate procedures, jurisdiction, ~~]overpayments, unemployment compensation
[~~November 16, 2004~~]2005
Notice of Continuation May 23, 2002
35A-4-406(2)
35A-4-406(3)
35A-4-406(4)
35A-4-406(5)

▼ ▼

End of the Notices of Proposed Rules Section

NOTICES OF
CHANGES IN PROPOSED RULES

After an agency has published a PROPOSED RULE in the *Utah State Bulletin*, it may receive public comment that requires the PROPOSED RULE to be altered before it goes into effect. A CHANGE IN PROPOSED RULE allows an agency to respond to comments it receives.

As with a PROPOSED RULE, a CHANGE IN PROPOSED RULE is preceded by a RULE ANALYSIS. This analysis provides summary information about the CHANGE IN PROPOSED RULE including the name of a contact person, anticipated cost impact of the rule, and legal cross-references.

Following the RULE ANALYSIS, the text of the CHANGE IN PROPOSED RULE is usually printed. The text shows only those changes made since the PROPOSED RULE was published in an earlier edition of the *Utah State Bulletin*. Additions made to the rule appear underlined (e.g., example). Deletions made to the rule appear struck out with brackets surrounding them (e.g., [~~example~~]). A row of dots in the text (· · · · · ·) indicates that unaffected text was removed to conserve space. If a CHANGE IN PROPOSED RULE is too long to print, the Division of Administrative Rules will include only the RULE ANALYSIS. A copy of rules that are too long to print is available from the agency or from the Division of Administrative Rules.

While a CHANGE IN PROPOSED RULE does not have a formal comment period, there is a 30-day waiting period during which interested parties may submit comments. The 30-day waiting period for CHANGES IN PROPOSED RULES published in this issue of the *Utah State Bulletin* ends July 1, 2005. At its option, the agency may hold public hearings.

From the end of the waiting period through September 29, 2005, the agency may notify the Division of Administrative Rules that it wants to make the CHANGE IN PROPOSED RULE effective. When an agency submits a NOTICE OF EFFECTIVE DATE for a CHANGE IN PROPOSED RULE, the PROPOSED RULE as amended by the CHANGE IN PROPOSED RULE becomes the effective rule. The agency sets the effective date. The date may be no fewer than 30 days nor more than 120 days after the publication date of this issue of the *Utah State Bulletin*. Alternatively, the agency may file another CHANGE IN PROPOSED RULE in response to additional comments received. If the Division of Administrative Rules does not receive a NOTICE OF EFFECTIVE DATE or another CHANGE IN PROPOSED RULE, the CHANGE IN PROPOSED RULE filing, along with its associated PROPOSED RULE, lapses and the agency must start the process over.

CHANGES IN PROPOSED RULES are governed by *Utah Code* Section 63-46a-6 (2001); and *Utah Administrative Code* Rule R15-2, and Sections R15-4-3, R15-4-5, R15-4-7, and R15-4-9.

The Changes in Proposed Rules Begin on the Following Page.

Insurance, Administration
R590-203
Health Grievance Review Process and Disability Claims

NOTICE OF CHANGE IN PROPOSED RULE
(Second)
DAR File No.: 27504
Filed: 05/06/2005, 14:22

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: As a result of the second comment period, additional clarifying changes to the rule have been suggested by the insurance industry.

SUMMARY OF THE RULE OR CHANGE: The changes to the rule clarify that income replacement, short-term, and long-term disability policies are required to comply with Sections R590-203-7 and R590-203-8. (DAR NOTE: This is the second change in proposed rule (CPR) for Rule R590-203. The original proposed new rule upon which the first CPR was based was published in the November 15, 2004, issue of the Utah State Bulletin, on page 47. The first CPR upon which this second CPR is based was published in the January 15, 2005, issue of the Utah State Bulletin, on page 95. Underlining in the rule below indicates text that has been added since the publication of the proposed rule mentioned above; strike-out indicates text that has been deleted. You must view the first CPR, the second CPR, and the proposed new rule together to understand all of the changes that will be enforceable should the agency make this rule effective.)

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Sections 31A-2-201, 31A-2-203, 31A-4-116, and 31A-22-629

ANTICIPATED COST OR SAVINGS TO:
❖ THE STATE BUDGET: The changes to this rule will not require anything new of department licensees. There will be no change in filing requirements nor change in fees going to the state's budget.
❖ LOCAL GOVERNMENTS: The changes to this rule will have no fiscal impact on local governments since the changes deal with the relationship between the State Insurance Department and their licensees only.
❖ OTHER PERSONS: The changes to this rule will create no change in what is already required of health insurers. It simply clarifies that income replacement, short-term ,and long-term disability policies must comply with Sections R590-203-7 and R590-203-8.

COMPLIANCE COSTS FOR AFFECTED PERSONS: The changes to this rule will create no change in what is already required of health insurers. It simply clarifies that income replacement, short-term, and long-term disability policies must comply with Sections R590-203-7 and R590-203-8.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: The changes to this rule are for clarification purposes only and will create no fiscal impact on Utah businesses. D. Kent Michie, Insurance Commissioner

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
INSURANCE
ADMINISTRATION
Room 3110 STATE OFFICE BLDG
450 N MAIN ST
SALT LAKE CITY UT 84114-1201, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
Jilene Whitby at the above address, by phone at 801-538-3803, by FAX at 801-538-3829, or by Internet E-mail at jwhitby@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 07/01/2005.

THIS RULE MAY BECOME EFFECTIVE ON: 07/02/2005

AUTHORIZED BY: Jilene Whitby, Information Specialist

R590. Insurance, Administration.
R590-203. Health Grievance Review Process and Disability Claims.
R590-203-1. Authority.

This rule is specifically authorized by 31A-22-629(4) and 31A-4-116, which requires the commissioner to establish minimum standards for grievance review procedures. The rule is also promulgated pursuant to Subsections 31A-2-201(1) and 31A-2-201(3)(a) in which the commissioner is empowered to administer and enforce this title and to make rules to implement the provisions of this title. The authority to examine insurer records, files, and documentation is provided by 31A-2-203.

R590-203-2. Purpose.

The purpose of this rule is to ensure that insurer's grievance review procedures for individual and group health insurance and income replacement plans comply with the Department of Labor, Pension and Welfare Benefits Administration Rules and Regulations for Administration and Enforcement: Claims Procedure, 29 CFR 2560.503-1, and Utah Code Sections 31A-4-116 and 31A-22-629.

R590-203-3. Applicability and Scope.

(1) This rule applies to individual and group:
(a) policies issued or renewed and effective on or after January 1, 2001;
(b) income replacement policies;
(i) including short-term, and
(ii) long-term disability policies;
(c) health insurance; and
(d) health maintenance organization contracts.

(2) Long Term Care and Medicare supplement policies are not considered health insurance for the purpose of this rule.

(3) Income replacement, short-term and long-term disability policies are controlled by section R590-203-7.

R590-203-4. Definitions.

For the purposes of this rule:

(1) "Consumer Representative" may be an employee of the insurer who is a consumer of a health insurance or an income replacement policy, as long as the employee is not;

(a) the individual who made the adverse determination, or

(b) a subordinate to the individual who made the adverse determination.

(2) "Health Insurance" means a contract of:

(a) health care insurance as defined in 31A-1-301; and

(b) health maintenance organization as defined in 31A-8-101.

(3) "Medical Necessity" means:

(a) health care services or products that a prudent health care professional would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or [~~it~~]its symptoms in a manner that is:

(i) in accordance with generally accepted standards of medical practice in the United States;

(ii) clinically appropriate in terms of type, frequency, extent, site, and duration;

(iii) not primarily for the convenience of the patient, physician, or other health care provider; and

(iv) covered under the contract; and

(b) that when a medical question-of-fact exists medical necessity shall include the most appropriate available supply or level of service for the individual in question, considering potential benefits and harms to the individual, and known to be effective.

(i) For interventions not yet in widespread use, the effectiveness shall be based on scientific evidence.

(ii) For established interventions, the effectiveness shall be based on:

(A) scientific evidence;

(B) professional standards; and

(C) expert opinion.

(4)(a) "Scientific evidence" means:

(i) scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff; or

(ii) findings, studies or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes.

(b) Scientific evidence shall not include published peer-reviewed literature sponsored to a significant extent by a pharmaceutical manufacturing company or medical device manufacturer or a single study without other supportable studies.

R590-203-5. Adverse Benefit Determination.

(1) An insurer's adverse benefit determination review procedure shall be compliant with the adverse benefit determination review requirements set forth in the Department of Labor, Pension and Welfare Benefits Administration Rules and Regulations for Administration and Enforcement: Claims Procedure, 29 CFR 2560.503-1, effective January 20, 2001. This document is incorporated by reference and available for inspection at the Insurance Department and the Department of Administrative Rules.

(2) The provision of this rule and federal regulation applies to claims filed under individual or group plans on or after the first day of the first plan year beginning on or after July 1, 2002, but no later than January 1, 2003.

(3) An insurer's adverse benefit determination appeal board or body shall include at least one consumer representative that shall be present at every meeting.

R590-203-6. Independent and Expedited Adverse Benefit Determination Reviews for Health Insurance.

(1) An insurer shall provide an independent review procedure as a voluntary option for the resolution of adverse benefit determinations of medical necessity.

(2) An independent review procedure shall be conducted by an independent review organization, person, or entity other than the insurer, the plan, the plan's fiduciary, the employer, or any employee or agent of any of the foregoing, that do not have any material professional, familial, or financial conflict of interest with the health plan, any officer, director, or management employee of the health plan, the enrollee, the enrollee's health care provider, the provider's medical group or independent practice association, the health care facility where service would be provided and the developer or manufacturer of the service being provided.

(3) Independent review organizations shall be designated by the insurer, and the independent review organization chosen shall not own or control, be a subsidiary of, or in any way be owned or controlled by, or exercise control with a health insurance plan, a national, state, or local trade association of health insurance plans, and a national, state, or local trade association of health care providers.

(4) The submission to an independent review procedure is purely voluntary and left to the discretion of the claimant.

(5) An insurer's voluntary independent review procedure shall:

(a) waive any right to assert that a claimant has failed to exhaust administrative remedies because the claimant did not elect to submit a dispute of medical necessity to a voluntary level of appeal provided by the plan;

(b) agree that any statute of limitations or other defense based on timeliness is tolled during the time a voluntary appeal is pending;

(c) allow a claimant to submit a dispute of medical necessity to a voluntary level of appeal only after exhaustion of the appeals permitted under 29 CFR Subsection 2560.503-1(c)(2), of the Department of Labor, Pension and Welfare Benefits Administration Rules and Regulations for the Administration and Enforcement: Claims Procedure;

(d) upon request from any claimant, provide sufficient information relating to the voluntary level of appeal to enable the claimant to make an informed decision about whether to submit a dispute of medical necessity to the voluntary level of appeal. This information shall contain a statement that the decision to use a voluntary level of appeal will not effect the claimant's rights to any other benefits under the plan and information about the applicable rules, the claimant's right to representation, and the process for selecting the decision maker.

(e) An independent review conducted in compliance with Section 31A-22-629, and this rule, can be binding on both parties. A claimant's submission to a binding independent review is purely voluntary and appropriate disclosure and notification must be given as required by the Department of Labor, Pension and Welfare

Benefits Administration Rules and Regulations for Administration and Enforcement: Claims Procedure, 29 CFR 2560.503-1.

(6) Standards for voluntary independent review:

(a) The insurer's internal adverse benefit determination process must be exhausted unless the insurer and insured mutually agree to waive the internal process.

(b) Any adverse benefit determination of medical necessity may be the subject of an independent review.

(c) The claimant has 180 calendar days from the date of the final internal review decision to request an independent review.

(d) An insurer shall use the same minimum standards and times of notification requirement for an independent review that are used for internal levels of review, as set forth in 29 CFR Subsection 2560.503-1(h)(3), (i)(2) and (j).

(7) An insurer shall provide an expedited review process for cases involving urgent care claims.

(8) A request for an expedited review of an adverse benefit determination of medical necessity may be submitted either orally or in writing. If the request is made orally an insurer shall, within 24 hours, send written confirmation to the claimant acknowledging the receipt of the request for an expedited review.

(9) An expedited review requires:

(a) all necessary information, including the plan's original benefit determination, be transmitted between the plan and the claimant by telephone, facsimile, or other available similarly expeditious method;

(b) an insurer to notify the claimant of the benefit review determination, as soon as possible, taking into account the medical urgency, but not later than 72 hours after receipt of the claimant's request for review of an adverse benefit determination; and

(c) an insurer to use the same minimum standard for timing and notification as set forth in 29 CFR Subsection 2560.503-1(h), 503-1(i)(2)(i), and 503-1(j).

(10) This section does not apply to income replacement policies.

R590-203-7. Income Replacement Adverse Benefit Determination Review.

(1) For initial level of review, an insurer will resolve a disability claim within 45 days of receipt of the claim for benefits.

(2) For reasons beyond the control of the plan administrator or the insurer, there may be a 30-day extension granted.

(3) If after the first 30-day extension, the plan administrator or the insurer should determine that they still cannot determine benefits and it is still out of their control, a final 30-day extension will be allowed.

(4) Upon request, relevant information free-of-charge, must be provided to the insured on any adverse benefit determination.

R590-203-8. File and Record Documentation.

An insurer selling health insurance or income replacement insurance shall make available upon request by the commissioner, or the commissioner's duly appointed designees, all adverse benefit determination review files and related documentation. An insurer shall keep these records for the current calendar year plus [~~three~~]five years.

R590-203-9. Compliance.

Insurers are to be compliant with the provisions of this rule and the Department of Labor, Pension and Welfare Benefits Administration Rules and Regulations for Administration and Enforcement: Claims Procedure, 29 CFR 2560.503-1, by July 1, 2002.

R590-203-10. Relationship to Federal Rules.

If an insurer complies with the requirements of the Department of Labor, Pension and Welfare Benefits Administration Rules and Regulations for Administration and Enforcement: Claims Procedure, 29 CFR 2560.503-1, then this rule is not applicable to employer plans, except for Sections 4, 5, 6, 7, and 8 of this rule. All individual plans will remain subject to this rule in its entirety.

R590-203-11. Severability.

If a provision or clause of this rule or its application to any person or circumstance is for any reason held to be invalid, the remainder of the rule and the application of these provisions shall not be affected.

KEY: insurance
2005
31A-2-201
31A-2-203
31A-4-116
31A-22-629

End of the Notices of Changes in Proposed Rules Section

FIVE-YEAR NOTICES OF REVIEW AND STATEMENTS OF CONTINUATION

Within five years of an administrative rule's original enactment or last five-year review, the responsible agency is required to review the rule. This review is designed to remove obsolete rules from the *Utah Administrative Code*.

Upon reviewing a rule, an agency may: repeal the rule by filing a PROPOSED RULE; continue the rule as it is by filing a NOTICE OF REVIEW AND STATEMENT OF CONTINUATION (NOTICE); or amend the rule by filing a PROPOSED RULE and by filing a NOTICE. By filing a NOTICE, the agency indicates that the rule is still necessary.

NOTICES are not followed by the rule text. The rule text that is being continued may be found in the most recent edition of the *Utah Administrative Code*. The rule text may also be inspected at the agency or the Division of Administrative Rules. NOTICES are effective when filed. NOTICES are governed by *Utah Code* Section 63-46a-9 (1998).

Education, Administration
R277-473
Testing Procedures

FIVE YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION
DAR FILE NO.: 27872
FILED: 05/09/2005, 16:17

NOTICE OF REVIEW AND STATEMENT OF CONTINUATION

CONCISE EXPLANATION OF THE PARTICULAR STATUTORY PROVISIONS UNDER WHICH THE RULE IS ENACTED AND HOW THESE PROVISIONS AUTHORIZE OR REQUIRE THE RULE: Subsection 53A-1-603(3) directs the State Board of Education to adopt rules for the conduct and administration of the Utah Performance Assessment System for Students (U-PASS).

SUMMARY OF WRITTEN COMMENTS RECEIVED DURING AND SINCE THE LAST FIVE YEAR REVIEW OF THE RULE FROM INTERESTED PERSONS SUPPORTING OR OPPOSING THE RULE: No written comments have been received.

REASONED JUSTIFICATION FOR CONTINUATION OF THE RULE, INCLUDING REASONS WHY THE AGENCY DISAGREES WITH COMMENTS IN OPPOSITION TO THE RULE, IF ANY: This rule continues to be necessary because it provides time periods for administering and returning testing materials, procedures for security of testing materials, State Office of Education and school responsibility for crisis indicators in state assessments, and other procedures for school districts/schools/educators to use and follow when administering tests under U-PASS.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

EDUCATION
ADMINISTRATION
250 E 500 S
SALT LAKE CITY UT 84111-3272, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
Carol Lear at the above address, by phone at 801-538-7835, by FAX at 801-538-7768, or by Internet E-mail at clear@usoe.k12.ut.us

AUTHORIZED BY: Carol Lear, Coordinator School Law and Legislation

EFFECTIVE: 05/09/2005

Environmental Quality, Drinking Water
R309-100
Administration: Drinking Water Program

FIVE YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION
DAR FILE NO.: 27912
FILED: 05/16/2005, 07:43

NOTICE OF REVIEW AND STATEMENT OF CONTINUATION

CONCISE EXPLANATION OF THE PARTICULAR STATUTORY PROVISIONS UNDER WHICH THE RULE IS ENACTED AND HOW THESE PROVISIONS AUTHORIZE OR REQUIRE THE RULE: Title 19, Chapter 4, Safe Drinking Water Act, gives the Drinking Water Board the authority to promulgate rules that govern the construction of facilities for and quality of water provided by public water systems.

SUMMARY OF WRITTEN COMMENTS RECEIVED DURING AND SINCE THE LAST FIVE YEAR REVIEW OF THE RULE FROM INTERESTED PERSONS SUPPORTING OR OPPOSING THE RULE: No written comments have been received by the Division on this rule.

REASONED JUSTIFICATION FOR CONTINUATION OF THE RULE, INCLUDING REASONS WHY THE AGENCY DISAGREES WITH COMMENTS IN OPPOSITION TO THE RULE, IF ANY: This rule defines a public water system (PWS) and the categories of public water systems which determine the amount of monitoring that is required of each PWS. The rule gives authority for Division personnel and local health departments to inspect PWSs in order to evaluate their condition and therefore the safety and integrity of the water delivered to the public. In addition, this

rule requires the Drinking Water Board to require plan approval for PWS construction, assess the overall condition of the PWS and issue administrative orders when appropriate in order to protect the public from tainted water supplies. The continuation of this rule is necessary to protect the quality and safety of the drinking water served the public by PWSs and thereby public health.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
ENVIRONMENTAL QUALITY
DRINKING WATER
150 N 1950 W
SALT LAKE CITY UT 84116-3085, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
Ken Bousfield or Patti Fauver at the above address, by phone at 801-536-4207 or 801-536-4196, by FAX at 801-536-4211 or 801-536-4211, or by Internet E-mail at kbousfield@utah.gov or pfauver@utah.gov

AUTHORIZED BY: Kevin Brown, Director

EFFECTIVE: 05/16/2005

Environmental Quality, Drinking Water
R309-105
Administration: General Responsibilities of Public Water Systems

FIVE YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION
DAR FILE NO.: 27907
FILED: 05/16/2005, 07:40

NOTICE OF REVIEW AND STATEMENT OF CONTINUATION

CONCISE EXPLANATION OF THE PARTICULAR STATUTORY PROVISIONS UNDER WHICH THE RULE IS ENACTED AND HOW THESE PROVISIONS AUTHORIZE OR REQUIRE THE RULE: Title 19, Chapter 4, Safe Drinking Water Act, gives the Drinking Water Board the authority to promulgate rules that govern the construction of facilities and quality of water provided by public water systems.

SUMMARY OF WRITTEN COMMENTS RECEIVED DURING AND SINCE THE LAST FIVE YEAR REVIEW OF THE RULE FROM INTERESTED PERSONS SUPPORTING OR OPPOSING THE RULE: No written comments have been received by the Division on this rule.

REASONED JUSTIFICATION FOR CONTINUATION OF THE RULE, INCLUDING REASONS WHY THE AGENCY DISAGREES WITH COMMENTS IN OPPOSITION TO THE RULE, IF ANY: This rule defines the requirements for plan approval of public water system (PWS) construction projects. In addition, this rule outlines routine operation and maintenance that must be carried out in order to protect the quality of the water. The rule also outlines the requirements for disinfection, cross connection control, certified operators and acceptable products to add to the water or to come in contact with the water. The continuation of this rule is necessary to protect the quality and safety of the drinking water served the public by PWSs and thereby public health.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
ENVIRONMENTAL QUALITY
DRINKING WATER
150 N 1950 W
SALT LAKE CITY UT 84116-3085, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
Patti Fauver at the above address, by phone at 801-536-4196, by FAX at 801-536-4211, or by Internet E-mail at pfauver@utah.gov

AUTHORIZED BY: Kevin Brown, Director

EFFECTIVE: 05/16/2005

Environmental Quality, Drinking Water
R309-110
Administration: Definitions

FIVE YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION
DAR FILE NO.: 27911
FILED: 05/16/2005, 07:43

NOTICE OF REVIEW AND STATEMENT OF CONTINUATION

CONCISE EXPLANATION OF THE PARTICULAR STATUTORY PROVISIONS UNDER WHICH THE RULE IS ENACTED AND HOW THESE PROVISIONS AUTHORIZE OR REQUIRE THE RULE: Title 19, Chapter 4, Safe Drinking Water Act, gives the Drinking Water Board the authority to promulgate rules that govern the construction of facilities and quality of water provided by public water systems.

SUMMARY OF WRITTEN COMMENTS RECEIVED DURING AND SINCE THE LAST FIVE YEAR REVIEW OF THE RULE FROM INTERESTED PERSONS SUPPORTING OR OPPOSING THE RULE: No written comments have been received by the Division on this rule other than those received during a formal proposed rule change. The comments received during the rule change were were related to incorrect citations of 40 CFR 141. The citations were corrected in subsequent rulemaking.

REASONED JUSTIFICATION FOR CONTINUATION OF THE RULE, INCLUDING REASONS WHY THE AGENCY DISAGREES WITH COMMENTS IN OPPOSITION TO THE RULE, IF ANY: This rule contains definition of terms and acronyms used in associated Rules R309-100 through R309-705. The continuation of this rule is necessary

because of it association with other rules that protect the quantity and quality of drinking water provided to the public via public water systems.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

ENVIRONMENTAL QUALITY
DRINKING WATER
150 N 1950 W
SALT LAKE CITY UT 84116-3085, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
Patti Fauver or Ken Bousfield at the above address, by phone at 801-536-4196 or 801-536-4207, by FAX at 801-536-4211 or 801-536-4211, or by Internet E-mail at pfauver@utah.gov or kbousfield@utah.gov

AUTHORIZED BY: Kevin Brown, Director

EFFECTIVE: 05/16/2005

Environmental Quality, Drinking Water
R309-115
Administration: Administrative Procedures

FIVE YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION
DAR FILE NO.: 27908
FILED: 05/16/2005, 07:41

NOTICE OF REVIEW AND STATEMENT OF CONTINUATION

CONCISE EXPLANATION OF THE PARTICULAR STATUTORY PROVISIONS UNDER WHICH THE RULE IS ENACTED AND HOW THESE PROVISIONS AUTHORIZE OR REQUIRE THE RULE: Title 19, Chapter 4, Safe Drinking Water Act, gives the Drinking Water Board the authority to promulgate rules that govern the construction of facilities and quality of water provided by public water systems.

SUMMARY OF WRITTEN COMMENTS RECEIVED DURING AND SINCE THE LAST FIVE YEAR REVIEW OF THE RULE FROM INTERESTED PERSONS SUPPORTING OR OPPOSING THE RULE: No written comments have been received by the Division with regard to this rule since its initial adoption.

REASONED JUSTIFICATION FOR CONTINUATION OF THE RULE, INCLUDING REASONS WHY THE AGENCY DISAGREES WITH COMMENTS IN OPPOSITION TO THE RULE, IF ANY: This rule outlines the procedures for conducting adjudicative proceedings under the Utah Safe Drinking Water Act and Utah Administrative Procedures Act. The continuation of this rule is necessary to ensure consistency of all formal adjudicative proceeding before the Drinking Water Board with these Acts.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

ENVIRONMENTAL QUALITY
DRINKING WATER
150 N 1950 W
SALT LAKE CITY UT 84116-3085, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
Patti Fauver at the above address, by phone at 801-536-4196, by FAX at 801-536-4211, or by Internet E-mail at pfauver@utah.gov

AUTHORIZED BY: Kevin Brown, Director

EFFECTIVE: 05/16/2005

Environmental Quality, Drinking Water
R309-150
Water System Rating Criteria

FIVE YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION
DAR FILE NO.: 27909
FILED: 05/16/2005, 07:42

NOTICE OF REVIEW AND STATEMENT OF CONTINUATION

CONCISE EXPLANATION OF THE PARTICULAR STATUTORY PROVISIONS UNDER WHICH THE RULE IS ENACTED AND HOW THESE PROVISIONS AUTHORIZE OR REQUIRE THE RULE: Title 19, Chapter 4, Safe Drinking Water Act, gives the Drinking Water Board the authority to promulgate rules that govern the construction of facilities and quality of water provided by public water systems.

SUMMARY OF WRITTEN COMMENTS RECEIVED DURING AND SINCE THE LAST FIVE YEAR REVIEW OF THE RULE FROM INTERESTED PERSONS SUPPORTING OR OPPOSING THE RULE: No written comments have been received by the Division on this rule.

REASONED JUSTIFICATION FOR CONTINUATION OF THE RULE, INCLUDING REASONS WHY THE AGENCY DISAGREES WITH COMMENTS IN OPPOSITION TO THE RULE, IF ANY: This rule is a mechanism to measure the compliance of public water systems with regard to the requirement of other drinking water rules (R309-100 through R309-705), it does not add any additional requirements. The continuation of this rule will be instrumental in the prioritization of technical assistance and enforcement action with regard to the public water system that are in noncompliance with: water quality, monitoring, reporting and record keeping requirements; the design, construction and maintenance requirements; and watershed and water source protection requirements.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
ENVIRONMENTAL QUALITY
DRINKING WATER
150 N 1950 W
SALT LAKE CITY UT 84116-3085, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
Ken Bousfield or Patti Fauver at the above address, by phone at 801-536-4207 or 801-536-4196, by FAX at 801-536-4211 or 801-536-4211, or by Internet E-mail at kbousfield@utah.gov or pfauver@utah.gov

AUTHORIZED BY: Kevin Brown, Director

EFFECTIVE: 05/16/2005

Environmental Quality, Drinking Water
R309-200
Monitoring and Water Quality: Drinking Water Standards

FIVE YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION
DAR FILE NO.: 27913
FILED: 05/16/2005, 07:43

NOTICE OF REVIEW AND STATEMENT OF CONTINUATION

CONCISE EXPLANATION OF THE PARTICULAR STATUTORY PROVISIONS UNDER WHICH THE RULE IS ENACTED AND HOW THESE PROVISIONS AUTHORIZE OR REQUIRE THE RULE: Title 19, Chapter 4, Safe Drinking Water Act, gives the Drinking Water Board the authority to promulgate rules that govern the construction of facilities and quality of water provided by public water systems.

SUMMARY OF WRITTEN COMMENTS RECEIVED DURING AND SINCE THE LAST FIVE YEAR REVIEW OF THE RULE FROM INTERESTED PERSONS SUPPORTING OR OPPOSING THE RULE: No written comments have been received by the Division on this rule.

REASONED JUSTIFICATION FOR CONTINUATION OF THE RULE, INCLUDING REASONS WHY THE AGENCY DISAGREES WITH COMMENTS IN OPPOSITION TO THE RULE, IF ANY: This rule states the quality standards (maximum contaminant levels (MCLs)) for the contaminants that are required to be monitored by public water systems. The MCLs have been set by the United States Environmental Protection Agency (EPA) under authority of the Federal Safe Drinking Water Act to levels that are protective of public health for both short term (acute) and long term (chronic) health effects. The Drinking Water Board is required to adopt quality standards that are at least as stringent as the EPA (40 CFR 141 and 40 CFR 142). The continuation of this rule is necessary to protect the quality of the drinking water and thereby public health and to retain primacy of the drinking water program.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
ENVIRONMENTAL QUALITY
DRINKING WATER
150 N 1950 W
SALT LAKE CITY UT 84116-3085, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
Ken Bousfield or Patti Fauver at the above address, by phone at 801-536-4207 or 801-536-4196, by FAX at 801-536-4211 or 801-536-4211, or by Internet E-mail at kbousfield@utah.gov or pfauver@utah.gov

AUTHORIZED BY: Kevin Brown, Director

EFFECTIVE: 05/16/2005

Environmental Quality, Drinking Water
R309-205
Monitoring and Water Quality: Source Monitoring Requirements

FIVE YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION
DAR FILE NO.: 27917
FILED: 05/16/2005, 07:45

NOTICE OF REVIEW AND STATEMENT OF CONTINUATION

CONCISE EXPLANATION OF THE PARTICULAR STATUTORY PROVISIONS UNDER WHICH THE RULE IS ENACTED AND HOW THESE PROVISIONS AUTHORIZE OR REQUIRE THE RULE: Title 19, Chapter 4, Safe Drinking Water Act, gives the Drinking Water Board the authority to promulgate rules that govern the construction of facilities and quality of water provided by public water systems.

SUMMARY OF WRITTEN COMMENTS RECEIVED DURING AND SINCE THE LAST FIVE YEAR REVIEW OF THE RULE FROM INTERESTED PERSONS SUPPORTING OR OPPOSING THE RULE: No written comments have been received by the Division on this rule other than those received during a formal proposed rule change. The comments received during the rule change were were related to incorrect citations of 40 CFR 141. The citations were corrected in subsequent rulemaking.

REASONED JUSTIFICATION FOR CONTINUATION OF THE RULE, INCLUDING REASONS WHY THE AGENCY DISAGREES WITH COMMENTS IN OPPOSITION TO THE RULE, IF ANY: This rule states the type of source samples that are required per category of public water system, the required number of samples and the frequency for collecting the samples all of which are required in 40 CFR 141

and 40 CFR 142 by the United States Environmental Protection Agency under the authority of the Federal Safe Drinking Water Act. The Drinking Water Board is required to adopt rules that are as stringent as the federal rules in order to maintain primacy for enforcement of the drinking water program. The continuation of this rule is necessary to protect the quality and safety of the drinking water and thereby public health and to maintain primacy of the drinking water program.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

ENVIRONMENTAL QUALITY
DRINKING WATER
150 N 1950 W
SALT LAKE CITY UT 84116-3085, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
Ken Bousfield or Patti Fauver at the above address, by phone at 801-536-4207 or 801-536-4196, by FAX at 801-536-4211 or 801-536-4211, or by Internet E-mail at kbousfield@utah.gov or pfauver@utah.gov

AUTHORIZED BY: Kevin Brown, Director

EFFECTIVE: 05/16/2005

Environmental Quality, Drinking Water
R309-210
Monitoring and Water Quality: Distribution System Monitoring

FIVE YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION
DAR FILE NO.: 27918
FILED: 05/16/2005, 07:45

NOTICE OF REVIEW AND STATEMENT OF CONTINUATION

CONCISE EXPLANATION OF THE PARTICULAR STATUTORY PROVISIONS UNDER WHICH THE RULE IS ENACTED AND HOW THESE PROVISIONS AUTHORIZE OR REQUIRE THE RULE: Title 19, Chapter 4, Safe Drinking Water Act, gives the Drinking Water Board the authority to promulgate rules that govern the construction of facilities and quality of water provided by public water systems.

SUMMARY OF WRITTEN COMMENTS RECEIVED DURING AND SINCE THE LAST FIVE YEAR REVIEW OF THE RULE FROM INTERESTED PERSONS SUPPORTING OR OPPOSING THE RULE: No written comments have been received by the Division on this rule other than those received during a formal proposed rule change. The comments received during the rule change were were related to incorrect citations of 40 CFR 141. The citations were corrected in subsequent rulemaking.

REASONED JUSTIFICATION FOR CONTINUATION OF THE RULE, INCLUDING REASONS WHY THE AGENCY DISAGREES WITH COMMENTS IN OPPOSITION TO THE RULE, IF ANY: This rule states the type of distribution system samples that are required per category of public water system, the required number of samples and the frequency for collecting the samples, all of which are required in 40 CFR 141 and 40 CFR 142 by the United States Environmental Protection Agency under the authority of the Federal Safe Drinking Water Act. The Drinking Water Board is required to adopt rules that are as stringent as the federal rules in order to maintain primacy for enforcement of the drinking water program. The continuation of this rule is necessary to protect the quality and safety of the drinking water and thereby public health and to maintain primacy of the drinking water program.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

ENVIRONMENTAL QUALITY
DRINKING WATER
150 N 1950 W
SALT LAKE CITY UT 84116-3085, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
Patti Fauver or Ken Bousfield at the above address, by phone at 801-536-4196 or 801-536-4207, by FAX at 801-536-4211 or 801-536-4211, or by Internet E-mail at pfauver@utah.gov or kbousfield@utah.gov

AUTHORIZED BY: Kevin Brown, Director

EFFECTIVE: 05/16/2005

Environmental Quality, Drinking Water
R309-215
Monitoring and Water Quality: Treatment Plant Monitoring

FIVE YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION
DAR FILE NO.: 27910
FILED: 05/16/2005, 07:42

NOTICE OF REVIEW AND STATEMENT OF CONTINUATION

CONCISE EXPLANATION OF THE PARTICULAR STATUTORY PROVISIONS UNDER WHICH THE RULE IS ENACTED AND HOW THESE PROVISIONS AUTHORIZE OR REQUIRE THE RULE: Title 19, Chapter 4, Safe Drinking Water Act, gives the Drinking Water Board the authority to promulgate rules that govern the construction of facilities and quality of water provided by public water systems.

SUMMARY OF WRITTEN COMMENTS RECEIVED DURING AND SINCE THE LAST FIVE YEAR REVIEW OF THE RULE FROM INTERESTED PERSONS SUPPORTING OR OPPOSING THE RULE: No written comments have been received by the Division on this rule other than those received during a formal proposed rule change. The comments received during the rule change were related to incorrect citations of 40 CFR 141. The citations were corrected in subsequent rulemaking.

REASONED JUSTIFICATION FOR CONTINUATION OF THE RULE, INCLUDING REASONS WHY THE AGENCY DISAGREES WITH COMMENTS IN OPPOSITION TO THE RULE, IF ANY: This rule states the type of treatment plant that are required per category of public water system, the required number of samples and the frequency for collecting the samples all of which are required in 40 CFR 141 and 40 CFR 142 by the United States Environmental Protection Agency under the authority of the Federal Safe Drinking Water Act. The Drinking Water Board is required to adopt rules that are as stringent as the federal rules in order to maintain primacy for enforcement of the drinking water program. The continuation of this rule is necessary to protect the quality and safety of the drinking water and thereby public health and to maintain primacy of the drinking water program.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

ENVIRONMENTAL QUALITY
DRINKING WATER
150 N 1950 W
SALT LAKE CITY UT 84116-3085, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
Patti Fauver or Ken Bousfield at the above address, by phone at 801-536-4196 or 801-536-4207, by FAX at 801-536-4211 or 801-536-4211, or by Internet E-mail at pfauver@utah.gov or kbousfield@utah.gov

AUTHORIZED BY: Kevin Brown, Director

EFFECTIVE: 05/16/2005

Environmental Quality, Drinking Water
R309-220
Monitoring and Water Quality: Public Notification Requirements

FIVE YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION
DAR FILE NO.: 27914
FILED: 05/16/2005, 07:44

NOTICE OF REVIEW AND STATEMENT OF CONTINUATION

CONCISE EXPLANATION OF THE PARTICULAR STATUTORY PROVISIONS UNDER WHICH THE RULE IS ENACTED AND HOW THESE PROVISIONS AUTHORIZE OR REQUIRE THE RULE: Title 19, Chapter 4, Safe Drinking Water Act, gives the Drinking Water Board the authority to promulgate rules that govern the construction of facilities and quality of water provided by public water systems.

SUMMARY OF WRITTEN COMMENTS RECEIVED DURING AND SINCE THE LAST FIVE YEAR REVIEW OF THE RULE FROM INTERESTED PERSONS SUPPORTING OR OPPOSING THE RULE: No written comments have been received by the Division on this rule other than those received during a formal proposed rule change. The comments received during the rule change were related to incorrect citations of 40 CFR 141 and the requirement to potentially provide public notice in a second language. The citations were corrected in subsequent rulemaking and the non-English issue was resolved.

REASONED JUSTIFICATION FOR CONTINUATION OF THE RULE, INCLUDING REASONS WHY THE AGENCY DISAGREES WITH COMMENTS IN OPPOSITION TO THE RULE, IF ANY: The rule outlines the public notification requirements of a public water system if it exceed a drinking water quality standard. The requirements of this rule are also specified in 40 CFR 141 by the United States Environmental Protection Agency under authority of the Federal Safe Drinking Water Act. The Drinking Water Board is required to adopt rules that are as stringent as the federal rules in order to maintain primacy for enforcement of the drinking water program. The continuation of the rule is necessary to ensure timely notification of the public water system consumers in the event a water quality standard is exceeded and to maintain primacy of the drinking water program.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

ENVIRONMENTAL QUALITY
DRINKING WATER
150 N 1950 W
SALT LAKE CITY UT 84116-3085, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
Patti Fauver or Ken Bousfield at the above address, by phone at 801-536-4196 or 801-536-4207, by FAX at 801-536-4211 or 801-536-4211, or by Internet E-mail at pfauver@utah.gov or kbousfield@utah.gov

AUTHORIZED BY: Kevin Brown, Director

EFFECTIVE: 05/16/2005

Environmental Quality, Drinking Water
R309-225
Monitoring and Water Quality: Consumer Confidence Reports

FIVE YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION
DAR FILE NO.: 27905
FILED: 05/16/2005, 07:35

NOTICE OF REVIEW AND STATEMENT OF CONTINUATION

CONCISE EXPLANATION OF THE PARTICULAR STATUTORY PROVISIONS UNDER WHICH THE RULE IS ENACTED AND HOW THESE PROVISIONS AUTHORIZE OR REQUIRE THE RULE: Title 19, Chapter 4, Safe Drinking Water Act, gives the Drinking Water Board the authority to promulgate rules that govern the construction of facilities and quality of water provided by public water systems.

SUMMARY OF WRITTEN COMMENTS RECEIVED DURING AND SINCE THE LAST FIVE YEAR REVIEW OF THE RULE FROM INTERESTED PERSONS SUPPORTING OR OPPOSING THE RULE: No written comments have been received by the Division on this rule.

REASONED JUSTIFICATION FOR CONTINUATION OF THE RULE, INCLUDING REASONS WHY THE AGENCY DISAGREES WITH COMMENTS IN OPPOSITION TO THE RULE, IF ANY: The rule outlines the information and timelines of a water quality report given to the public. The requirements of this rule are also specified in 40 CFR 141 by the United States Environmental Protection Agency under authority of the Federal Safe Drinking Water Act. The Drinking Water Board is required to adopt rules that are as stringent as the federal rules in order to maintain primacy for enforcement of the drinking water program. The continuation of the rule is necessary to ensure water quality information is provided to the public water system consumers and to maintain primacy of the drinking water program.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
ENVIRONMENTAL QUALITY
DRINKING WATER
150 N 1950 W
SALT LAKE CITY UT 84116-3085, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
Ken Bousfield or Patti Fauver at the above address, by phone at 801-536-4207 or 801-536-4196, by FAX at 801-536-4211 or 801-536-4211, or by Internet E-mail at kbousfield@utah.gov or pfauver@utah.gov

AUTHORIZED BY: Kevin Brown, Director

EFFECTIVE: 05/16/2005

Environmental Quality, Drinking Water
R309-300
Certification Rules for Water Supply Operators

FIVE YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION
DAR FILE NO.: 27906
FILED: 05/16/2005, 07:39

NOTICE OF REVIEW AND STATEMENT OF CONTINUATION

CONCISE EXPLANATION OF THE PARTICULAR STATUTORY PROVISIONS UNDER WHICH THE RULE IS ENACTED AND HOW THESE PROVISIONS AUTHORIZE OR REQUIRE THE RULE: Title 19, Chapter 4, Safe Drinking Water Act, gives the Drinking Water Board the authority to promulgate rules that govern the construction of facilities and quality of water provided by public water systems. Subsection 19-4-104(2) authorizes the Board to adopt and enforce standards and establish fees for certification of operators of any public water system.

SUMMARY OF WRITTEN COMMENTS RECEIVED DURING AND SINCE THE LAST FIVE YEAR REVIEW OF THE RULE FROM INTERESTED PERSONS SUPPORTING OR OPPOSING THE RULE: No written comments have been received by the Division on this rule.

REASONED JUSTIFICATION FOR CONTINUATION OF THE RULE, INCLUDING REASONS WHY THE AGENCY DISAGREES WITH COMMENTS IN OPPOSITION TO THE RULE, IF ANY: The continuation of this rule will help to ensure that the individuals involved in operating drinking water systems are and remain competent to do so. This effort will greatly assist in protecting the quality and safety of the drinking water from the source through vast distribution systems to the end consumer, the public. The certification of operators is required by the United States Environmental Protection Agency and is required to retain primacy for the drinking water program.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
ENVIRONMENTAL QUALITY
DRINKING WATER
150 N 1950 W
SALT LAKE CITY UT 84116-3085, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
Patti Fauver or Ken Bousfield at the above address, by phone at 801-536-4196 or 801-536-4207, by FAX at 801-536-4211 or 801-536-4211, or by Internet E-mail at pfauver@utah.gov or kbousfield@utah.gov

AUTHORIZED BY: Kevin Brown, Director

EFFECTIVE: 05/16/2005

Environmental Quality, Drinking Water
R309-305
Certification Rules for Backflow Technicians

FIVE YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION
DAR FILE NO.: 27915
FILED: 05/16/2005, 07:44

NOTICE OF REVIEW AND STATEMENT OF CONTINUATION

CONCISE EXPLANATION OF THE PARTICULAR STATUTORY PROVISIONS UNDER WHICH THE RULE IS ENACTED AND HOW THESE PROVISIONS AUTHORIZE OR REQUIRE THE RULE: Title 19, Chapter 4, Safe Drinking Water Act, gives the Drinking Water Board the authority to promulgate rules that govern the construction of facilities and quality of water provided by public water systems. Subsection 19-4-104(4)(a) authorizes the Board to adopt and enforce standards and establish fees for certification of persons engaged in administering cross connection control programs or backflow prevention assembly training, repair, and maintenance testing.

SUMMARY OF WRITTEN COMMENTS RECEIVED DURING AND SINCE THE LAST FIVE YEAR REVIEW OF THE RULE FROM INTERESTED PERSONS SUPPORTING OR OPPOSING THE RULE: No written comments have been received by the Division on this rule other than those received during a formal proposed rule change. In summary, the comments received during the rule change addressed some minor grammatical errors, the change in reference from a "licensed journeyman plumber" to an "appropriate licensure" from the Division of Occupational and Professional Licensing and some lingering confusion over the classification of backflow technicians and their renewal requirements.

REASONED JUSTIFICATION FOR CONTINUATION OF THE RULE, INCLUDING REASONS WHY THE AGENCY DISAGREES WITH COMMENTS IN OPPOSITION TO THE RULE, IF ANY: The continuation of this rule will help ensure that the individuals involved in testing backflow valves, training testers, and those administering cross connection control programs are and remain competent to do so. This effort will greatly assist in protecting the quality and safety of the drinking water from the source through the vast distribution systems to the end consumer, the public.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
ENVIRONMENTAL QUALITY
DRINKING WATER
150 N 1950 W
SALT LAKE CITY UT 84116-3085, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
Patti Fauver or Ken Bousfield at the above address, by phone at 801-536-4196 or 801-536-4207, by FAX at 801-536-4211 or 801-536-4211, or by Internet E-mail at pfauver@utah.gov or kbousfield@utah.gov

AUTHORIZED BY: Kevin Brown, Director

EFFECTIVE: 05/16/2005

Environmental Quality, Drinking Water
R309-405
Compliance and Enforcement: Administrative Penalty

FIVE YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION
DAR FILE NO.: 27916
FILED: 05/16/2005, 07:44

NOTICE OF REVIEW AND STATEMENT OF CONTINUATION

CONCISE EXPLANATION OF THE PARTICULAR STATUTORY PROVISIONS UNDER WHICH THE RULE IS ENACTED AND HOW THESE PROVISIONS AUTHORIZE OR REQUIRE THE RULE: Title 19, Chapter 4, Safe Drinking Water Act, gives the Drinking Water Board the authority to promulgate rules that govern the construction of facilities and quality of water provided by public water systems.

SUMMARY OF WRITTEN COMMENTS RECEIVED DURING AND SINCE THE LAST FIVE YEAR REVIEW OF THE RULE FROM INTERESTED PERSONS SUPPORTING OR OPPOSING THE RULE: No written comments have been received by the Division on this rule other than those received during a formal proposed rule change. The comments received during the rule change addressed minor grammatical errors.

REASONED JUSTIFICATION FOR CONTINUATION OF THE RULE, INCLUDING REASONS WHY THE AGENCY DISAGREES WITH COMMENTS IN OPPOSITION TO THE RULE, IF ANY: This rule sets the criteria and procedures the Drinking Water Board will use in assessing penalties to public drinking water systems for violations of the public drinking water rules (R309-100 through R309-705). The United States Environmental Protection Agency requires the Board to have administrative penalty authority in 40 CFR 142 in order to maintain primary enforcement authority of the drinking water program.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
ENVIRONMENTAL QUALITY
DRINKING WATER
150 N 1950 W
SALT LAKE CITY UT 84116-3085, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
Patti Fauver or Ken Bousfield at the above address, by phone at 801-536-4196 or 801-536-4207, by FAX at 801-536-4211 or 801-536-4211, or by Internet E-mail at pfauver@utah.gov or kbousfield@utah.gov

AUTHORIZED BY: Kevin Brown, Director

EFFECTIVE: 05/16/2005

Human Services, Child and Family Services

R512-75

Rules Governing Adjudication of Consumer Complaints

FIVE YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION
DAR FILE NO.: 27883
FILED: 05/12/2005, 14:33

NOTICE OF REVIEW AND STATEMENT OF CONTINUATION

CONCISE EXPLANATION OF THE PARTICULAR STATUTORY PROVISIONS UNDER WHICH THE RULE IS ENACTED AND HOW THESE PROVISIONS AUTHORIZE OR REQUIRE THE RULE: State agencies are permitted by Subsection 63-46b-1(4) to resolve consumer complaints before formal adjudicative proceedings are commenced. The provisions of Sections 62A-4a-102, 62A-4a-115, and 62A-4a-207 support the need for this rule to provide needed processes and reports concerning consumer complaints.

SUMMARY OF WRITTEN COMMENTS RECEIVED DURING AND SINCE THE LAST FIVE YEAR REVIEW OF THE RULE FROM INTERESTED PERSONS SUPPORTING OR OPPOSING THE RULE: No written comments have been received.

REASONED JUSTIFICATION FOR CONTINUATION OF THE RULE, INCLUDING REASONS WHY THE AGENCY DISAGREES WITH COMMENTS IN OPPOSITION TO THE RULE, IF ANY: A rule is still needed to provide directions to the agency and the public for adjudication of consumer complaints. Therefore, this rule should be continued.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
HUMAN SERVICES
CHILD AND FAMILY SERVICES
Room 225
120 N 200 W
SALT LAKE CITY UT 84103-1500, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
Steven Bradford at the above address, by phone at 801-538-8210, by FAX at 801-538-3993, or by Internet E-mail at sbradford@utah.gov

AUTHORIZED BY: Richard Anderson, Director

EFFECTIVE: 05/12/2005

Human Services, Recovery Services

R527-394

Posting Bond or Security

FIVE YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION
DAR FILE NO.: 27881
FILED: 05/12/2005, 14:03

NOTICE OF REVIEW AND STATEMENT OF CONTINUATION

CONCISE EXPLANATION OF THE PARTICULAR STATUTORY PROVISIONS UNDER WHICH THE RULE IS ENACTED AND HOW THESE PROVISIONS AUTHORIZE OR REQUIRE THE RULE: Subsection 62A-11-321(1) of the Utah Code requires the Office of Recovery Services to establish rules for determining when it is appropriate to seek a court order requiring a noncustodial parent to post a bond or provide other security for the payment of a support debt. The federal regulation at 45 CFR 303.104(c) requires each State to develop guidelines available to the public for determining when it is not appropriate to require a noncustodial parent to post security, bond, or some other guarantee of payment of overdue support. The criteria listed in Rule R527-394 meet these requirements.

SUMMARY OF WRITTEN COMMENTS RECEIVED DURING AND SINCE THE LAST FIVE YEAR REVIEW OF THE RULE FROM INTERESTED PERSONS SUPPORTING OR OPPOSING THE RULE: No written comments have been received.

REASONED JUSTIFICATION FOR CONTINUATION OF THE RULE, INCLUDING REASONS WHY THE AGENCY DISAGREES WITH COMMENTS IN OPPOSITION TO THE RULE, IF ANY: This rule continues to be necessary because State law and Federal regulations require it, and to ensure that legal action to require a noncustodial parent to post bond or other security is only taken when circumstances clearly warrant it.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
HUMAN SERVICES
RECOVERY SERVICES
515 E 100 S
SALT LAKE CITY UT 84102-4211, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
Kristen Lowe at the above address, by phone at 801-536-0347, by FAX at 801-536-8833, or by Internet E-mail at klowe@utah.gov

AUTHORIZED BY: Emma Chacon, Director

EFFECTIVE: 05/12/2005

Insurance, Administration

R590-172

Notice to Uninsurable Applicants for Health Insurance

FIVE YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION
DAR FILE NO.: 27866
FILED: 05/05/2005, 14:11

NOTICE OF REVIEW AND STATEMENT OF CONTINUATION

CONCISE EXPLANATION OF THE PARTICULAR STATUTORY PROVISIONS UNDER WHICH THE RULE IS ENACTED AND HOW THESE PROVISIONS AUTHORIZE OR REQUIRE THE RULE: Section 31A-29-116 requires the department to write a rule governing the notice of availability to be given by insurers to potential enrollees in the Health Insurance Pool (HIP). This rule sets requirements as to when and to whom the notice is to be given and the wording required in the notice.

SUMMARY OF WRITTEN COMMENTS RECEIVED DURING AND SINCE THE LAST FIVE YEAR REVIEW OF THE RULE FROM INTERESTED PERSONS SUPPORTING OR OPPOSING THE RULE: The Health Insurance Pool Board has requested the contact information in the rule be updated. This rule change is in process now. No other written comments have been received.

REASONED JUSTIFICATION FOR CONTINUATION OF THE RULE, INCLUDING REASONS WHY THE AGENCY DISAGREES WITH COMMENTS IN OPPOSITION TO THE RULE, IF ANY: This rule provides the language that insurers must use to notify someone that they are being denied coverage and that they have the option to go to the Utah HIP. The notice provides the consumer with time frames and the residency requirements to qualify for the Pool. Therefore, this rule should be continued.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
INSURANCE
ADMINISTRATION
Room 3110 STATE OFFICE BLDG
450 N MAIN ST
SALT LAKE CITY UT 84114-1201, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
Jilene Whitby at the above address, by phone at 801-538-3803, by FAX at 801-538-3829, or by Internet E-mail at jwhitby@utah.gov

AUTHORIZED BY: Jilene Whitby, Information Specialist

EFFECTIVE: 05/05/2005

Natural Resources, Wildlife Resources
R657-15
Closure of Gunnison, Cub and Hat Islands

FIVE YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION
DAR FILE NO.: 27863
FILED: 05/05/2005, 09:49

NOTICE OF REVIEW AND STATEMENT OF CONTINUATION

CONCISE EXPLANATION OF THE PARTICULAR STATUTORY PROVISIONS UNDER WHICH THE RULE IS ENACTED AND HOW THESE PROVISIONS AUTHORIZE OR REQUIRE THE RULE: Under Section 23-21a-3, the Wildlife Board and Division of Wildlife Resources are authorized to provide for the management of Gunnison, Cub, and Hat Islands for the protection and perpetuation of the American white pelican.

SUMMARY OF WRITTEN COMMENTS RECEIVED DURING AND SINCE THE LAST FIVE YEAR REVIEW OF THE RULE FROM INTERESTED PERSONS SUPPORTING OR OPPOSING THE RULE: The division has not received any written comments regarding this rule. The public is welcome to view the Regional Advisory Council minutes, Wildlife Board minutes, and administrative record for this rule at the Division of Wildlife Resources.

REASONED JUSTIFICATION FOR CONTINUATION OF THE RULE, INCLUDING REASONS WHY THE AGENCY DISAGREES WITH COMMENTS IN OPPOSITION TO THE RULE, IF ANY: This rule places restrictions of access on, around, and over these islands. This protection from disturbance will ensure the continued use of these areas and result in successful brood rearing by the birds. The other habitat needs of these colonial nesting waterbirds are being met and their populations are healthy at this time. Therefore, this rule should be continued.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
NATURAL RESOURCES
WILDLIFE RESOURCES
1594 W NORTH TEMPLE
SALT LAKE CITY UT 84116-3154, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
Debbie Merrill at the above address, by phone at 801-538-4707, by FAX at 801-538-4745, or by Internet E-mail at debbiemerrill@utah.gov

AUTHORIZED BY: James F Karpowitz, Director

EFFECTIVE: 05/05/2005

Natural Resources, Wildlife Resources
R657-21
Cooperative Wildlife Management Units for Small Game and Waterfowl

FIVE YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION
DAR FILE NO.: 27864
FILED: 05/05/2005, 09:49

NOTICE OF REVIEW AND STATEMENT OF CONTINUATION

CONCISE EXPLANATION OF THE PARTICULAR STATUTORY PROVISIONS UNDER WHICH THE RULE IS ENACTED AND HOW THESE PROVISIONS AUTHORIZE OR REQUIRE THE RULE: Under Section 23-23-3, the Wildlife Board is authorized to provide rules applicable to cooperative wildlife management units organized for the hunting of small game and waterfowl.

SUMMARY OF WRITTEN COMMENTS RECEIVED DURING AND SINCE THE LAST FIVE YEAR REVIEW OF THE RULE FROM INTERESTED PERSONS SUPPORTING OR OPPOSING THE RULE: The Division of Wildlife Resources and the Wildlife Board have not received written comments supporting or opposing this rule. However, during Regional Advisory Council and Wildlife Board public meetings, the Division has received verbal comment, both in support and opposition to Rule R657-21. Any comments received in opposition to the rule are resolved using existing policies and procedures or the issue is placed on the Regional Advisory Council's and Wildlife Board's agenda for review and discussion during the process for taking public input. The public is welcome to view the Regional Advisory Council minutes, Wildlife Board minutes and administrative record for this rule at the Division of Wildlife Resources.

REASONED JUSTIFICATION FOR CONTINUATION OF THE RULE, INCLUDING REASONS WHY THE AGENCY DISAGREES WITH COMMENTS IN OPPOSITION TO THE RULE, IF ANY: Rule R657-21 provides the procedures, standards, and requirements for the establishment of a cooperative wildlife management unit. The provisions adopted in this rule are effective in providing the standards and requirements for establishing cooperative wildlife management units and providing adequate protection to landowners who open their lands for hunting and provide additional hunting opportunities. Continuation of this rule is necessary for continued success of this program.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
NATURAL RESOURCES
WILDLIFE RESOURCES
1594 W NORTH TEMPLE
SALT LAKE CITY UT 84116-3154, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
Debbie Merrill at the above address, by phone at 801-538-4707, by FAX at 801-538-4745, or by Internet E-mail at debbiemerrill@utah.gov

AUTHORIZED BY: James F Karpowitz, Director

EFFECTIVE: 05/05/2005

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Public Safety, Driver License
R708-32
Uninsured Motorist Database

FIVE YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION
DAR FILE NO.: 27877
FILED: 05/10/2005, 17:01

NOTICE OF REVIEW AND STATEMENT OF CONTINUATION

CONCISE EXPLANATION OF THE PARTICULAR STATUTORY PROVISIONS UNDER WHICH THE RULE IS ENACTED AND HOW THESE PROVISIONS AUTHORIZE OR REQUIRE THE RULE: Subsection 41-12a-803(7) says the department shall make rules and develop procedures in cooperation with the Motor Vehicle Division to use the database for the purpose of administering and enforcing this provision of this statute.

SUMMARY OF WRITTEN COMMENTS RECEIVED DURING AND SINCE THE LAST FIVE YEAR REVIEW OF THE RULE FROM INTERESTED PERSONS SUPPORTING OR OPPOSING THE RULE: No written comments have been received.

REASONED JUSTIFICATION FOR CONTINUATION OF THE RULE, INCLUDING REASONS WHY THE AGENCY DISAGREES WITH COMMENTS IN OPPOSITION TO THE RULE, IF ANY: This rule needs to be continued so the division can maintain a database on uninsured motorists as per statute and to protect the public.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
PUBLIC SAFETY
DRIVER LICENSE
CALVIN L RAMPTON COMPLEX
4501 S 2700 W 3RD FL
SALT LAKE CITY UT 84119-5595, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
Vinn Roos at the above address, by phone at 801-965-4456, by FAX at 801-964-4482, or by Internet E-mail at vroos@utah.gov

AUTHORIZED BY: Nannette Rolfe, Director

EFFECTIVE: 05/10/2005

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Public Safety, Driver License
R708-36
Disclosure of Personal Identifying Information in MVRs

FIVE YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION
DAR FILE NO.: 27878
FILED: 05/11/2005, 08:46

NOTICE OF REVIEW AND STATEMENT OF CONTINUATION

CONCISE EXPLANATION OF THE PARTICULAR STATUTORY PROVISIONS UNDER WHICH THE RULE IS ENACTED AND HOW THESE PROVISIONS AUTHORIZE OR REQUIRE THE RULE: Subsection 53-3-109(6) gives the division authority to make rules to designate: 1) what information shall be included in a report on the driving record of a person; 2) the form of a report or copy of the report which may include electronic format; 3) the form of a certified copy, as required under Section 53-3-216, which may include electronic format; 4) the form of a signature required under this chapter which may include electronic format; and 5) the form of written request to the division required under this chapter which may include electronic format. Subsection 53-3-109(5) defines how long a driving record may be kept.

SUMMARY OF WRITTEN COMMENTS RECEIVED DURING AND SINCE THE LAST FIVE YEAR REVIEW OF THE RULE FROM INTERESTED PERSONS SUPPORTING OR OPPOSING THE RULE: No written comments have been received.

REASONED JUSTIFICATION FOR CONTINUATION OF THE RULE, INCLUDING REASONS WHY THE AGENCY DISAGREES WITH COMMENTS IN OPPOSITION TO THE RULE, IF ANY: This rule needs to be continued to provide driving records to the public, insurance companies, law enforcement, and others who qualify under the Privacy Act.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
PUBLIC SAFETY
DRIVER LICENSE
CALVIN L RAMPTON COMPLEX
4501 S 2700 W 3RD FL
SALT LAKE CITY UT 84119-5595, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
Vinn Roos at the above address, by phone at 801-965-4456, by FAX at 801-964-4482, or by Internet E-mail at vroos@utah.gov

AUTHORIZED BY: Nannette Rolfe, Director

EFFECTIVE: 05/11/2005

Public Safety, Driver License
R708-37
Certification of Licensed Instructors of Commercial Driver Training Schools or Testing Only Schools to Administer Driving Skills Tests

FIVE YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION
DAR FILE NO.: 27898
FILED: 05/13/2005, 14:11

NOTICE OF REVIEW AND STATEMENT OF CONTINUATION

CONCISE EXPLANATION OF THE PARTICULAR STATUTORY PROVISIONS UNDER WHICH THE RULE IS ENACTED AND HOW THESE PROVISIONS AUTHORIZE OR REQUIRE THE RULE: Subsection 53-3-510(a) states the division shall establish procedures and standards to certify licensed instructors of driver training courses under this part to administer skills tests. This rule details the procedures and standards for individuals who want to be certified to teach in commercial driver training schools and to administer driving skills tests.

SUMMARY OF WRITTEN COMMENTS RECEIVED DURING AND SINCE THE LAST FIVE YEAR REVIEW OF THE RULE FROM INTERESTED PERSONS SUPPORTING OR OPPOSING THE RULE: No written comments have been received.

REASONED JUSTIFICATION FOR CONTINUATION OF THE RULE, INCLUDING REASONS WHY THE AGENCY DISAGREES WITH COMMENTS IN OPPOSITION TO THE RULE, IF ANY: This rule needs to be continued to be in compliance with the statute to allow commercial driving training schools to have certified instructors as testers.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
PUBLIC SAFETY
DRIVER LICENSE
CALVIN L RAMPTON COMPLEX
4501 S 2700 W 3RD FL
SALT LAKE CITY UT 84119-5595, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
Vinn Roos at the above address, by phone at 801-965-4456, by FAX at 801-964-4482, or by Internet E-mail at vroos@utah.gov

AUTHORIZED BY: Nannette Rolfe, Director

EFFECTIVE: 05/13/2005

Public Safety, Highway Patrol
R714-500
Chemical Analysis Standards and Training

FIVE YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION

DAR FILE NO.: 27882

FILED: 05/12/2005, 14:04

NOTICE OF REVIEW AND STATEMENT OF CONTINUATION

CONCISE EXPLANATION OF THE PARTICULAR STATUTORY PROVISIONS UNDER WHICH THE RULE IS ENACTED AND HOW THESE PROVISIONS AUTHORIZE OR REQUIRE THE RULE: The rule is governed under Subsection 41-6a-515(1). This statute says that the Commissioner of Public Safety shall establish standards for breath testing. This rule is the standards that has been set up for the administration of this program.

SUMMARY OF WRITTEN COMMENTS RECEIVED DURING AND SINCE THE LAST FIVE YEAR REVIEW OF THE RULE FROM INTERESTED PERSONS SUPPORTING OR OPPOSING THE RULE: There have been no comments in favor of, or against this particular rule.

REASONED JUSTIFICATION FOR CONTINUATION OF THE RULE, INCLUDING REASONS WHY THE AGENCY DISAGREES WITH COMMENTS IN OPPOSITION TO THE RULE, IF ANY: This rule is critical to the standards and operations of the breath-testing program. Without this rule, many DUI (Driving Under the Influence) cases would be dismissed. This rule outlines the standard, procedures, and training needed for the breath-testing program. This program is used for all agencies in the state of Utah. Therefore, this rule should be continued.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

PUBLIC SAFETY
HIGHWAY PATROL
CALVIN L RAMPTON COMPLEX
4501 S 2700 W
SALT LAKE CITY UT 84119-5994, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:

Steven Winward at the above address, by phone at 801-284-5509, by FAX at 801-284-5556, or by Internet E-mail at swinward@utah.gov

AUTHORIZED BY: Scott Duncan, Superintendent

EFFECTIVE: 05/12/2005

End of the Five-Year Notices of Review and Statements of Continuation Section

NOTICES OF RULE EFFECTIVE DATES

These are the effective dates of PROPOSED RULES or CHANGES IN PROPOSED RULES published in earlier editions of the *Utah State Bulletin*. These effective dates are at least 31 days and not more than 120 days after the date the following rules were published.

Abbreviations
AMD = Amendment
CPR = Change in Proposed Rule
NEW = New Rule
R&R = Repeal and Reenact
REP = Repeal

Administrative Services
Child Welfare Parental Defense (Office of)
No. 27518 (NEW): R19-1. Parental Defense Counsel Training.
Published: November 15, 2004
Effective: May 13, 2005

No. 27518 (CPR): R19-1. Parental Defense Training Standards.
Published: January 15, 2005
Effective: May 13, 2005

Environmental Quality
Radiation Control
No. 27746 (AMD): R313-12. General Provisions.
Published: April 1, 2005
Effective: May 13, 2005

No. 27744 (AMD): R313-15. Standards for Protection Against Radiation.
Published: April 1, 2005
Effective: May 13, 2005

No. 27745 (AMD): R313-19. Requirements of General Applicability to Licensing of Radioactive Material.
Published: April 1, 2005
Effective: May 13, 2005

No. 27747 (AMD): R313-22. Specific Licenses.
Published: April 1, 2005
Effective: May 13, 2005

No. 27748 (AMD): R313-32. Medical Use of Radioactive Material.
Published: April 1, 2005
Effective: May 13, 2005

Health
Epidemiology and Laboratory Services, Epidemiology
No. 27496 (AMD): R386-702. Communicable Disease Rule.
Published: November 1, 2004
Effective: May 16, 2005

No. 27496 (CPR): R386-702. Communicable Disease Rule.
Published: February 1, 2005
Effective: May 16, 2005

Health Systems Improvement, Licensing
No. 27692 (AMD): R432-270-10. Admissions.
Published: March 1, 2005
Effective: May 10, 2005

Human Services
Services for People with Disabilities
No. 27724 (NEW): R539-4. Behavior Interventions.
Published: March 15, 2005
Effective: May 3, 2005

No. 27753 (REP): R539-4. Quality Assurance.
Published: April 1, 2005
Effective: May 3, 2005

Money Management Council
Administration
No. 27743 (NEW): R628-15. Certification as an Investment Adviser.
Published: April 1, 2005
Effective: May 5, 2005

No. 27742 (R&R): R628-19. Requirements for the Use of Investment Advisers by Public Treasurers.
Published: April 1, 2005
Effective: May 5, 2005

Public Safety
Fire Marshal
No. 27754 (AMD): R710-9-6. Amendments and Additions.
Published: April 1, 2005
Effective: May 4, 2005

Workforce Services
Employment Development
No. 27771 (AMD): R986-200-214. Assistance for Specified Relatives.
Published: April 1, 2005
Effective: May 12, 2005

Workforce Information and Payment Services
No. 27770 (NEW): R994-304. Special Provisions Regarding Transfers of Unemployment Experience and Assigning Rates.

Published: April 1, 2005
Effective: May 12, 2005

End of the Notices of Rule Effective Dates Section

RULES INDEX
BY AGENCY (CODE NUMBER)
AND
BY KEYWORD (SUBJECT)

The *Rules Index* is a cumulative index that reflects all effective changes to Utah's administrative rules. The current *Index* lists changes made effective from January 1, 2005, including notices of effective date received through May 16, 2005, the effective dates of which are no later than June 1, 2005. The *Rules Index* is published in the *Utah State Bulletin* and in the annual *Index of Changes*. Nonsubstantive changes, while not published in the *Bulletin*, do become part of the *Utah Administrative Code (Code)* and are included in this *Index*, as well as 120-Day (Emergency) rules that do not become part of the *Code*. The rules are indexed by Agency (Code Number) and Keyword (Subject).

DAR NOTE: The index may contain inaccurate page number references. Also the index is incomplete in the sense that index entries for Changes in Proposed Rules (CPRs) are not preceded by entries for their parent Proposed Rules. Bulletin issue information and effective date information presented in the index are, to the best of our knowledge, complete and accurate. If you have any questions regarding the index and the information it contains, please contact Nancy Lancaster (801 538-3218), Mike Broschinsky (801 538-3003), or Kenneth A. Hansen (801 538-3777).

A copy of the *Rules Index* is available for public inspection at the Division of Administrative Rules (4120 State Office Building, Salt Lake City, UT), or may be viewed online at the Division's web site (http://www.rules.utah.gov/).

RULES INDEX - BY AGENCY (CODE NUMBER)

ABBREVIATIONS

AMD = Amendment
CPR = Change in proposed rule
EMR = Emergency rule (120 day)
NEW = New rule
EXD = Expired
NSC = Nonsubstantive rule change
REP = Repeal
R&R = Repeal and reenact
5YR = Five-Year Review

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ABBREVIATIONS

AMD = Amendment
CPR = Change in proposed rule
EMR = Emergency rule (120 day)
NEW = New rule
EXD = Expired
NSC = Nonsubstantive rule change
REP = Repeal
R&R = Repeal and reenact
5YR = Five-Year Review

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educational testing					
Education, Administration	27872	R277-473	5YR	05/09/2005	2005-11/91
	27547	R277-473	AMD	01/04/2005	2004-23/43
educational tuition					
Education, Administration	27798	R277-407	AMD	05/19/2005	2005-8/15
educator license renewal					
Education, Administration	27722	R277-501	5YR	02/23/2005	2005-6/35
effluent standards					
Environmental Quality, Water Quality	27659	R317-1	AMD	04/20/2005	2005-3/5
electronic high school					
Education, Administration	27507	R277-725	NSC	01/01/2005	Not Printed
electronic preliminary lien filing					
Commerce, Occupational and Professional Licensing	27734	R156-38b	NEW	04/18/2005	2005-6/6
elevators					
Labor Commission, Safety	27590	R616-3-3	AMD	02/01/2005	2005-1/30
emergency medical services					
Health, Health Systems Improvement, Emergency Medical Services	27519	R426-12	AMD	02/01/2005	2004-22/26
	27521	R426-13	AMD	02/01/2005	2004-23/47
	27584	R426-14-303	NSC	02/01/2005	Not Printed
	27522	R426-15	AMD	02/01/2005	2004-23/48
emergency preparedness					
Education, Administration	27539	R277-400	NSC	01/01/2005	Not Printed
employment support procedures					
Workforce Services, Employment Development	27661	R986-100	AMD	04/07/2005	2005-4/24
employment tests					
Workforce Services, Workforce Information and Payment Services	27789	R994-204	5YR	04/01/2005	2005-8/59
	27791	R994-205	5YR	04/01/2005	2005-8/59
	27796	R994-206	5YR	04/01/2005	2005-8/60
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Natural Resources, Forestry, Fire and State Lands	27843	R652-120	5YR	04/28/2005	2005-10/53
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Community and Economic Development, Community Development, Community Services	27418	R202-202-202	AMD	01/12/2005	2004-19/24
	27421	R202-203-324	AMD	01/12/2005	2004-19/25
	27419	R202-203-328	AMD	01/12/2005	2004-19/26
	27420	R202-207-702	AMD	01/12/2005	2004-19/27

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Capitol Preservation Board (State), Administration	27711	R131-1	5YR	02/16/2005	2005-6/33
Commerce, Occupational and Professional Licensing	27698	R156-22	AMD	04/04/2005	2005-5/2
enrollment options					
Education, Administration	27799	R277-437	AMD	05/19/2005	2005-8/17
environmental health					
Environmental Quality, Drinking Water	27816	R309-600	5YR	04/14/2005	2005-9/76
	27815	R309-605	5YR	04/14/2005	2005-9/76
environmental protection					
Environmental Quality, Drinking Water	27912	R309-100	5YR	05/16/2005	2005-11/91
	27909	R309-150	5YR	05/16/2005	2005-11/94
	27906	R309-300	5YR	05/16/2005	2005-11/98
	27781	R309-405	NSC	05/16/2005	Not Printed
	27916	R309-405	5YR	05/16/2005	2005-11/99
exemptions					
Environmental Quality, Radiation Control	27746	R313-12	AMD	05/13/2005	2005-7/29
	27745	R313-19	AMD	05/13/2005	2005-7/34
facilities use					
Capitol Preservation Board (State), Administration	27712	R131-2	5YR	02/16/2005	2005-6/33
family employment program					
Workforce Services, Employment Development	27771	R986-200-214	AMD	05/12/2005	2005-7/71
fertilizers					
Agriculture and Food, Plant Industry	27645	R68-3	5YR	01/07/2005	2005-3/58
finance					
Education, Administration	27702	R277-422	NSC	03/01/2005	Not Printed
financial information					
Human Services, Recovery Services	27640	R527-10	5YR	01/06/2005	2005-3/58
financial institutions					
Money Management Council, Administration	27689	R628-11	AMD	03/22/2005	2005-4/18
fire prevention					
Public Safety, Fire Marshal	27653	R710-4-3	AMD	03/04/2005	2005-3/44
	27574	R710-8	NSC	01/01/2005	Not Printed
	27655	R710-9-6	AMD	03/04/2005	2005-3/47
	27754	R710-9-6	AMD	05/04/2005	2005-7/68
fish					
Natural Resources, Wildlife Resources	27432	R657-13	AMD	01/03/2005	2004-20/33
	27432	R657-13	CPR	01/03/2005	2004-22/66

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Natural Resources, Wildlife Resources	27432	R657-13	CPR	01/03/2005	2004-22/66
	27432	R657-13	AMD	01/03/2005	2004-20/33
fleet expansion					
Administrative Services, Fleet Operations	27543	R27-4	AMD	01/10/2005	2004-23/5
fleet expansion vehicle replacement					
Administrative Services, Fleet Operations	27594	R27-4-1	NSC	02/01/2005	Not Printed
food inspection					
Agriculture and Food, Animal Industry	27693	R58-10	5YR	02/03/2005	2005-5/28
Agriculture and Food, Regulatory Services	27514	R70-440	NSC	01/01/2005	Not Printed
	27628	R70-440-2	AMD	02/15/2005	2005-2/23
	27667	R70-440-2	NSC	03/01/2005	Not Printed
	27569	R70-540-14	AMD	03/18/2005	2004-24/7
fuel dispensing					
Administrative Services, Fleet Operations	27544	R27-6	AMD	01/10/2005	2004-23/7
game laws					
Natural Resources, Wildlife Resources	27550	R657-5	AMD	01/15/2005	2004-24/38
	27649	R657-33	AMD	03/04/2005	2005-3/36
geothermal steam					
School and Institutional Trust Lands, Administration	27601	R850-27	NEW	04/01/2005	2005-2/86
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Administrative Services, Records Committee	27621	R35-1a	NEW	03/08/2005	2005-2/17
	27625	R35-2	AMD	03/04/2005	2005-2/18
	27622	R35-3	AMD	03/04/2005	2005-2/19
	27624	R35-4	AMD	03/04/2005	2005-2/20
	27623	R35-5	AMD	03/04/2005	2005-2/21
	27620	R35-6	AMD	03/04/2005	2005-2/22
Community and Economic Development, Community Development, Community Services	27420	R202-207-702	AMD	01/12/2005	2004-19/27
government hearings					
Commerce, Administration	27636	R151-46b	AMD	02/15/2005	2005-2/32
gravel					
School and Institutional Trust Lands, Administration	27609	R850-23	NEW	04/01/2005	2005-2/72
grievance procedures					
Human Services, Child and Family Services	27883	R512-75	5YR	05/12/2005	2005-11/99
health effects					
Environmental Quality, Drinking Water	27914	R309-220	5YR	05/16/2005	2005-11/96
health facilities					
Health, Health Systems Improvement, Licensing	27674	R432-7	5YR	01/28/2005	2005-4/47

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	27676	R432-9	5YR	01/28/2005	2005-4/48
	27677	R432-10	5YR	01/28/2005	2005-4/49
	27678	R432-11	5YR	01/28/2005	2005-4/49
	27679	R432-12	5YR	01/28/2005	2005-4/50
	27680	R432-13	5YR	01/28/2005	2005-4/50
	27681	R432-14	5YR	01/28/2005	2005-4/51
	27682	R432-30	5YR	01/28/2005	2005-4/51
	27683	R432-270	5YR	01/31/2005	2005-4/52
	27692	R432-270-10	AMD	05/10/2005	2005-5/24
health insurance					
Human Services, Recovery Services	27640	R527-10	5YR	01/06/2005	2005-3/58
Insurance, Administration	27866	R590-172	5YR	05/05/2005	2005-11/100
hearings					
Environmental Quality, Drinking Water	27908	R309-115	5YR	05/16/2005	2005-11/93
Professional Practices Advisory Commission, Administration	27542	R686-100	NSC	01/01/2005	Not Printed
HEAT					
Community and Economic Development, Community Development, Community Services	27418	R202-202-202	AMD	01/12/2005	2004-19/24
higher education					
Education, Administration	27662	R277-713	AMD	03/21/2005	2005-4/14
	27666	R765-604	AMD	03/22/2005	2005-4/22
	27663	R765-604	5YR	01/19/2005	2005-4/56
	27841	R765-626	5YR	04/26/2005	2005-10/53
hospitals					
Health, Health Care Financing, Coverage and Reimbursement Policy	27582	R414-1B	NSC	02/01/2005	Not Printed
human services					
Human Services, Administration, Administrative Services, Licensing	27673	R501-18	5YR	01/27/2005	2005-4/52
	27839	R501-19	5YR	04/25/2005	2005-10/51
	27836	R501-20	5YR	04/21/2005	2005-10/51
	27837	R501-21	5YR	04/22/2005	2005-10/52
	27838	R501-22	5YR	04/22/2005	2005-10/52
Human Services, Services for People with Disabilities	27568	R539-1	AMD	01/25/2005	2004-24/17
hunting					
Natural Resources, Wildlife Resources	27552	R657-38	AMD	01/15/2005	2004-24/48
illegal drug laboratories					
Health, Epidemiology and Laboratory Services, Environmental Services	27650	R392-600	NEW	05/02/2005	2005-3/19
immunization data reporting					
Health, Epidemiology and Laboratory Services, Epidemiology	27934	R386-800	5YR	05/24/2005	Not Printed

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income eligibility					
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	27419	R202-203-328	AMD	01/12/2005	2004-19/26
independent contractor					
Workforce Services, Workforce Information and Payment Services	27789	R994-204	5YR	04/01/2005	2005-8/59
industrial waste					
Environmental Quality, Water Quality	27659	R317-1	AMD	04/20/2005	2005-3/5
inspections					
Agriculture and Food, Animal Industry	27695	R58-22	5YR	02/03/2005	2005-5/29
Agriculture and Food, Plant Industry	27697	R68-20	5YR	02/04/2005	2005-5/30
Agriculture and Food, Regulatory Services	27523	R70-960-7	NSC	01/01/2005	Not Printed
Environmental Quality, Radiation Control	27746	R313-12	AMD	05/13/2005	2005-7/29
insurance					
Insurance, Administration	27785	R590-140	5YR	03/31/2005	2005-8/56
	27556	R590-147	R&R	02/10/2005	2004-24/21
	27719	R590-148-12	AMD	04/28/2005	2005-6/19
	27554	R590-163	REP	02/10/2005	2004-24/23
	27558	R590-196	AMD	02/10/2005	2004-24/25
	27644	R590-196	5YR	01/07/2005	2005-3/60
insurance companies					
Insurance, Administration	27685	R590-128	5YR	01/31/2005	2005-4/53
insurance law					
Insurance, Administration	27684	R590-88	5YR	01/31/2005	2005-4/53
	27686	R590-132	5YR	01/31/2005	2005-4/54
	27784	R590-164	5YR	03/31/2005	2005-8/57
	27555	R590-174	REP	02/10/2005	2004-24/24
intoxilyzer					
Public Safety, Highway Patrol	27882	R714-500	5YR	05/12/2005	2005-11/103
investigators					
Commerce, Administration	27633	R151-1	NEW	02/15/2005	2005-2/29
investment advisers					
Money Management Council, Administration	27743	R628-15	NEW	05/05/2005	2005-7/60
	27742	R628-19	R&R	05/05/2005	2005-7/64
irradiator					
Environmental Quality, Radiation Control	27738	R313-34	5YR	03/08/2005	2005-7/76
	27646	R313-34-1	NSC	02/01/2005	Not Printed
IT bid committee					
Governor, Planning and Budget, Chief Information Officer	27545	R365-101	NEW	03/09/2005	2004-23/45

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judicial conduct commission					
Judicial Conduct Commission, Administration	27580	R595-1	REP	02/01/2005	2005-1/26
	27330	R595-1	NEW	02/01/2005	2004-17/18
	27330	R595-1	CPR	02/01/2005	2004-24/59
	27331	R595-2	CPR	02/01/2005	2004-24/60
	27331	R595-2	NEW	02/01/2005	2004-17/23
	27332	R595-3	NEW	02/01/2005	2004-17/24
	27332	R595-3	CPR	02/01/2005	2004-24/61
	27668	R595-3-10	NSC	02/01/2005	Not Printed
	27333	R595-4	CPR	02/01/2005	2004-24/64
	27333	R595-4	NEW	02/01/2005	2004-17/26
law					
Public Safety, Fire Marshal	27754	R710-9-6	AMD	05/04/2005	2005-7/68
	27655	R710-9-6	AMD	03/04/2005	2005-3/47
lease operations					
School and Institutional Trust Lands, Administration	27607	R850-24	NEW	04/01/2005	2005-2/76
lease provisions					
School and Institutional Trust Lands, Administration	27612	R850-21	NEW	04/01/2005	2005-2/58
	27613	R850-22	NEW	04/01/2005	2005-2/65
	27606	R850-25	NEW	04/01/2005	2005-2/81
	27604	R850-26	NEW	04/01/2005	2005-2/84
	27601	R850-27	NEW	04/01/2005	2005-2/86
license					
Environmental Quality, Radiation Control	27745	R313-19	AMD	05/13/2005	2005-7/34
licensing					
Commerce, Occupational and Professional Licensing	27499	R156-1	NSC	01/01/2005	Not Printed
	27786	R156-17a	REP	05/17/2005	2005-8/2
	27529	R156-17b	CPR	05/17/2005	2005-8/43
	27529	R156-17b	CPR	05/17/2005	2005-4/31
	27529	R156-17b	NEW	05/17/2005	2004-23/20
	27600	R156-31b	AMD	02/17/2005	2005-2/36
	27752	R156-38	5YR	03/15/2005	2005-7/75
	27548	R156-47b	CPR	03/07/2005	2005-3/51
	27548	R156-47b	AMD	03/07/2005	2004-24/7
	27435	R156-50	AMD	01/18/2005	2004-20/12
	27435	R156-50	CPR	01/18/2005	2004-24/58
	27489	R156-56	AMD	01/01/2005	2004-21/6
	27490	R156-56-704	AMD	01/01/2005	2004-21/11
	27749	R156-60c	5YR	03/14/2005	2005-7/75

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	27533	R156-71-202	AMD	01/04/2005	2004-23/41
Commerce, Real Estate	27797	R162-102-1	AMD	05/25/2005	2005-8/12
Human Services, Administration, Administrative Services, Licensing	27673	R501-18	5YR	01/27/2005	2005-4/52
	27839	R501-19	5YR	04/25/2005	2005-10/51
	27836	R501-20	5YR	04/21/2005	2005-10/51
	27837	R501-21	5YR	04/22/2005	2005-10/52
	27838	R501-22	5YR	04/22/2005	2005-10/52
Natural Resources, Water Rights	27475	R655-4	NSC	02/01/2005	Not Printed
	27691	R655-4	5YR	02/01/2005	2005-4/55
	27392	R655-4	AMD	01/12/2005	2004-18/30
liens Commerce, Occupational and Professional Licensing	27752	R156-38	5YR	03/15/2005	2005-7/75
life insurance filing Insurance, Administration	27716	R590-226-3	AMD	04/28/2005	2005-6/21
liquefied petroleum gas Public Safety, Fire Marshal	27573	R710-6	AMD	01/19/2005	2004-24/54
livestock Agriculture and Food, Animal Industry	27688	R58-7	5YR	02/01/2005	2005-4/47
loans Agriculture and Food, Marketing and Conservation	27787	R65-10	5YR	03/31/2005	2005-8/56
local health departments Health, Administration	27571	R380-40	AMD	02/02/2005	2004-24/9
maintenance Capitol Preservation Board (State), Administration	27631	R131-8	NEW	03/03/2005	2005-2/24
massage therapy Commerce, Occupational and Professional Licensing	27548	R156-47b	CPR	03/07/2005	2005-3/51
	27548	R156-47b	AMD	03/07/2005	2004-24/7
material permit School and Institutional Trust Lands, Administration	27607	R850-24	NEW	04/01/2005	2005-2/76
materials handling School and Institutional Trust Lands, Administration	27602	R850-130	REP	04/01/2005	2005-2/89
Medicaid Health, Health Care Financing, Coverage and Reimbursement Policy	27582	R414-1B	NSC	02/01/2005	Not Printed
	27505	R414-7D	NEW	01/03/2005	2004-22/15
	27486	R414-10A-6	NSC	01/01/2005	Not Printed
	27733	R414-14	AMD	04/26/2005	2005-6/12
	27703	R414-33C	NEW	04/07/2005	2005-5/23
	27589	R414-34-6	AMD	02/01/2005	2005-1/21

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	27741	R414-61	5YR	03/11/2005	2005-7/77
	27586	R414-61-2	AMD	02/01/2005	2005-1/23
	27549	R414-63	AMD	01/26/2005	2004-24/13
	27557	R414-90	AMD	01/19/2005	2004-24/15
	27588	R414-200	AMD	02/01/2005	2005-1/24
	27629	R414-507	NEW	02/15/2005	2005-2/42
mental health					
Commerce, Occupational and Professional Licensing	27749	R156-60c	5YR	03/14/2005	2005-7/75
Human Services, Substance Abuse and Mental Health	27638	R523-1	AMD	03/07/2005	2005-3/28
mineral classification					
School and Institutional Trust Lands, Administration	27606	R850-25	NEW	04/01/2005	2005-2/81
mineral lease					
School and Institutional Trust Lands, Administration	27607	R850-24	NEW	04/01/2005	2005-2/76
mineral resources					
School and Institutional Trust Lands, Administration	27607	R850-24	NEW	04/01/2005	2005-2/76
Tax Commission, Auditing	27739	R865-16R	5YR	03/08/2005	2005-7/77
motor vehicle record					
Public Safety, Driver License	27878	R708-36	5YR	05/11/2005	2005-11/102
naturopathic physician					
Commerce, Occupational and Professional Licensing	27533	R156-71-202	AMD	01/04/2005	2004-23/41
naturopaths					
Commerce, Occupational and Professional Licensing	27533	R156-71-202	AMD	01/04/2005	2004-23/41
new source review					
Environmental Quality, Air Quality	27665	R307-210	AMD	04/19/2005	2005-4/17
non-traditional					
Health, Health Care Financing, Coverage and Reimbursement Policy	27588	R414-200	AMD	02/01/2005	2005-1/24
nonpublic schools					
Education, Administration	27705	R277-410	AMD	04/01/2005	2005-5/8
notice of commencement					
Commerce, Occupational and Professional Licensing	27734	R156-38b	NEW	04/18/2005	2005-6/6
notice of completion					
Commerce, Occupational and Professional Licensing	27734	R156-38b	NEW	04/18/2005	2005-6/6
nuclear medicine					
Environmental Quality, Radiation Control	27748	R313-32	AMD	05/13/2005	2005-7/38

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nurses					
Commerce, Occupational and Professional Licensing	27600	R156-31b	AMD	02/17/2005	2005-2/36
oath					
Commerce, Administration	27633	R151-1	NEW	02/15/2005	2005-2/29
occupational licensing					
Commerce, Occupational and Professional Licensing	27499	R156-1	NSC	01/01/2005	Not Printed
off-highway vehicles					
Natural Resources, Parks and Recreation	27566	R651-401	AMD	01/15/2005	2004-24/37
oil gas and hydrocarbons					
School and Institutional Trust Lands, Administration	27612	R850-21	NEW	04/01/2005	2005-2/58
oil shale					
School and Institutional Trust Lands, Administration	27613	R850-22	NEW	04/01/2005	2005-2/65
onsite wastewater systems					
Environmental Quality, Water Quality	27699	R317-4	5YR	02/10/2005	2005-5/30
opening and closing dates					
Community and Economic Development, Community Development, Community Services	27418	R202-202-202	AMD	01/12/2005	2004-19/24
operations					
School and Institutional Trust Lands, Administration	27612	R850-21	NEW	04/01/2005	2005-2/58
operator certification					
Environmental Quality, Water Quality	27656	R317-10-6	AMD	04/20/2005	2005-3/18
Public Safety, Highway Patrol	27882	R714-500	5YR	05/12/2005	2005-11/103
ownership					
Natural Resources, Water Rights	27690	R655-3	5YR	02/01/2005	2005-4/54
ozone					
Environmental Quality, Air Quality	27429	R307-110-11	CPR	03/04/2005	2005-3/52
	27429	R307-110-11	AMD	03/04/2005	2004-19/37
	27343	R307-110-12	AMD	01/04/2005	2004-17/12
	27343	R307-110-12	CPR	01/04/2005	2004-23/53
parental defense					
Administrative Services, Child Welfare Parental Defense (Office of)	27518	R19-1	CPR	05/13/2005	2005-2/94
	27518	R19-1	NEW	05/13/2005	2004-22/9
payment determination					
Community and Economic Development, Community Development, Community Services	27421	R202-203-324	AMD	01/12/2005	2004-19/25
	27419	R202-203-328	AMD	01/12/2005	2004-19/26
penalties					
Environmental Quality, Drinking Water	27916	R309-405	5YR	05/16/2005	2005-11/99

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people with disabilities					
Human Services, Services for People with Disabilities	27626	R539-2	NEW	03/12/2005	2005-2/45
	27792	R539-2-6	AMD	05/17/2005	2005-8/29
	27627	R539-3	NEW	03/12/2005	2005-2/47
	27793	R539-3-10	AMD	05/17/2005	2005-8/30
	27724	R539-4	NEW	05/03/2005	2005-6/16
performance standards					
Health, Administration	27571	R380-40	AMD	02/02/2005	2004-24/9
permit provisions					
School and Institutional Trust Lands, Administration	27609	R850-23	NEW	04/01/2005	2005-2/72
permit terms					
School and Institutional Trust Lands, Administration	27606	R850-25	NEW	04/01/2005	2005-2/81
permits					
Natural Resources, Forestry, Fire and State Lands	27750	R652-70-1900	AMD	05/20/2005	2005-7/66
	27740	R652-70-2300	AMD	05/20/2005	2005-7/67
	27843	R652-120	5YR	04/28/2005	2005-10/53
Natural Resources, Wildlife Resources	27553	R657-42-4	AMD	01/15/2005	2004-24/53
School and Institutional Trust Lands, Administration	27602	R850-130	REP	04/01/2005	2005-2/89
pharmacies					
Commerce, Occupational and Professional Licensing	27786	R156-17a	REP	05/17/2005	2005-8/2
	27529	R156-17b	CPR	05/17/2005	2005-4/31
	27529	R156-17b	CPR	05/17/2005	2005-8/43
	27529	R156-17b	NEW	05/17/2005	2004-23/20
pharmacists					
Commerce, Occupational and Professional Licensing	27786	R156-17a	REP	05/17/2005	2005-8/2
	27529	R156-17b	NEW	05/17/2005	2004-23/20
	27529	R156-17b	CPR	05/17/2005	2005-8/43
	27529	R156-17b	CPR	05/17/2005	2005-4/31
physicians					
Health, Health Care Financing, Coverage and Reimbursement Policy	27582	R414-1B	NSC	02/01/2005	Not Printed
pipeline					
Public Service Commission, Administration	27527	R746-409-1	NSC	01/01/2005	Not Printed
plan of operation					
School and Institutional Trust Lands, Administration	27604	R850-26	NEW	04/01/2005	2005-2/84
	27601	R850-27	NEW	04/01/2005	2005-2/86
planning					
Administrative Services, Facilities Construction and Management	27615	R23-3	AMD	03/15/2005	2005-2/9

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Capitol Preservation Board (State), Administration	27713	R131-7	5YR	02/16/2005	2005-6/34
PM10					
Environmental Quality, Air Quality	27429	R307-110-11	AMD	03/04/2005	2004-19/37
	27429	R307-110-11	CPR	03/04/2005	2005-3/52
	27343	R307-110-12	AMD	01/04/2005	2004-17/12
	27343	R307-110-12	CPR	01/04/2005	2004-23/53
PM2.5					
Environmental Quality, Air Quality	27429	R307-110-11	CPR	03/04/2005	2005-3/52
	27429	R307-110-11	AMD	03/04/2005	2004-19/37
	27343	R307-110-12	AMD	01/04/2005	2004-17/12
	27343	R307-110-12	CPR	01/04/2005	2004-23/53
policies and procedures					
Human Services, Substance Abuse and Mental Health	27638	R523-1	AMD	03/07/2005	2005-3/28
policy					
Capitol Preservation Board (State), Administration	27632	R131-9	NEW	03/03/2005	2005-2/26
preliminary notice					
Commerce, Occupational and Professional Licensing	27734	R156-38b	NEW	04/18/2005	2005-6/6
prescriptions					
Health, Health Care Financing, Coverage and Reimbursement Policy	27549	R414-63	AMD	01/26/2005	2004-24/13
primary term					
School and Institutional Trust Lands, Administration	27611	R850-20	REP	04/01/2005	2005-2/50
privacy					
Public Safety, Driver License	27878	R708-36	5YR	05/11/2005	2005-11/102
private probation provider					
Commerce, Occupational and Professional Licensing	27435	R156-50	AMD	01/18/2005	2004-20/12
	27435	R156-50	CPR	01/18/2005	2004-24/58
probation					
Commerce, Occupational and Professional Licensing	27435	R156-50	CPR	01/18/2005	2004-24/58
	27435	R156-50	AMD	01/18/2005	2004-20/12
procurement					
Administrative Services, Facilities Construction and Management	27603	R23-1	AMD	03/15/2005	2005-2/2
	27605	R23-2	AMD	03/15/2005	2005-2/7
	27615	R23-3	AMD	03/15/2005	2005-2/9
Capitol Preservation Board (State), Administration	27711	R131-1	5YR	02/16/2005	2005-6/33
professional counselors					
Commerce, Occupational and Professional Licensing	27749	R156-60c	5YR	03/14/2005	2005-7/75

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professional engineers					
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professional land surveyors					
Commerce, Occupational and Professional Licensing	27698	R156-22	AMD	04/04/2005	2005-5/2
program					
Capitol Preservation Board (State), Administration	27632	R131-9	NEW	03/03/2005	2005-2/26
psychologists					
Commerce, Occupational and Professional Licensing	27538	R156-61-502	AMD	01/04/2005	2004-23/40
public buildings					
Administrative Services, Facilities Construction and Management	27603	R23-1	AMD	03/15/2005	2005-2/2
Capitol Preservation Board (State), Administration	27712	R131-2	5YR	02/16/2005	2005-6/33
	27713	R131-7	5YR	02/16/2005	2005-6/34
Public Safety, Fire Marshal	27653	R710-4-3	AMD	03/04/2005	2005-3/44
public education					
Education, Administration	27799	R277-437	AMD	05/19/2005	2005-8/17
	27800	R277-438	AMD	05/19/2005	2005-8/19
public funds					
Money Management Council, Administration	27742	R628-19	R&R	05/05/2005	2005-7/64
public investments					
Money Management Council, Administration	27743	R628-15	NEW	05/05/2005	2005-7/60
public notification					
Environmental Quality, Drinking Water	27914	R309-220	5YR	05/16/2005	2005-11/96
public schools					
Education, Administration	27705	R277-410	AMD	04/01/2005	2005-5/8
public utilities					
Public Service Commission, Administration	27587	R746-200-6	AMD	02/25/2005	2005-1/32
	27302	R746-360-9	AMD	01/04/2005	2004-15/59
	27302	R746-360-9	CPR	01/04/2005	2004-23/54
quality standards					
Environmental Quality, Drinking Water	27913	R309-200	5YR	05/16/2005	2005-11/94
quarantines					
Agriculture and Food, Animal Industry	27581	R58-2	AMD	02/01/2005	2005-1/9
radiation					
Environmental Quality, Radiation Control	27738	R313-34	5YR	03/08/2005	2005-7/76
	27646	R313-34-1	NSC	02/01/2005	Not Printed
radiation safety					
Environmental Quality, Radiation Control	27738	R313-34	5YR	03/08/2005	2005-7/76

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radioactive material Environmental Quality, Radiation Control	27744	R313-15	AMD	05/13/2005	2005-7/33
	27748	R313-32	AMD	05/13/2005	2005-7/38
radioactive materials Environmental Quality, Radiation Control	27747	R313-22	AMD	05/13/2005	2005-7/36
radiopharmaceutical Environmental Quality, Radiation Control	27748	R313-32	AMD	05/13/2005	2005-7/38
real estate appraisal Commerce, Real Estate	27797	R162-102-1	AMD	05/25/2005	2005-8/12
real estate appraisals Commerce, Real Estate	27788	R162-107	AMD	05/25/2005	2005-8/14
reciprocity Environmental Quality, Radiation Control	27745	R313-19	AMD	05/13/2005	2005-7/34
reclamation Natural Resources, Oil, Gas and Mining; Coal	27778	R645-105	5YR	03/25/2005	2005-8/58
	27779	R645-400	5YR	03/25/2005	2005-8/58
records appeal hearings Administrative Services, Records Committee	27621	R35-1a	NEW	03/08/2005	2005-2/17
	27625	R35-2	AMD	03/04/2005	2005-2/18
	27622	R35-3	AMD	03/04/2005	2005-2/19
	27624	R35-4	AMD	03/04/2005	2005-2/20
	27623	R35-5	AMD	03/04/2005	2005-2/21
	27620	R35-6	AMD	03/04/2005	2005-2/22
recreation Natural Resources, Wildlife Resources	27552	R657-38	AMD	01/15/2005	2004-24/48
registry Health, Epidemiology and Laboratory Services, Epidemiology	27934	R386-800	5YR	05/24/2005	Not Printed
regulated contaminants Environmental Quality, Drinking Water	27913	R309-200	5YR	05/16/2005	2005-11/94
repository Governor, Planning and Budget, Chief Information Officer	27545	R365-101	NEW	03/09/2005	2004-23/45
residency requirements Community and Economic Development, Community Development, Community Services	27418	R202-202-202	AMD	01/12/2005	2004-19/24
resolution Administrative Services, Facilities Construction and Management	27614	R23-26	NEW	03/15/2005	2005-2/12

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rights					
Human Services, Services for People with Disabilities	27627	R539-3	NEW	03/12/2005	2005-2/47
	27793	R539-3-10	AMD	05/17/2005	2005-8/30
royalties					
School and Institutional Trust Lands, Administration	27611	R850-20	REP	04/01/2005	2005-2/50
rules					
Public Service Commission, Administration	27587	R746-200-6	AMD	02/25/2005	2005-1/32
rules and procedures					
Health, Epidemiology and Laboratory Services, Epidemiology	27496	R386-702	AMD	05/16/2005	2004-21/13
	27496	R386-702	CPR	05/16/2005	2005-3/53
Public Service Commission, Administration	27527	R746-409-1	NSC	01/01/2005	Not Printed
safety					
Education, Administration	27539	R277-400	NSC	01/01/2005	Not Printed
Environmental Quality, Radiation Control	27744	R313-15	AMD	05/13/2005	2005-7/33
Labor Commission, Safety	27616	R616-2-3	AMD	03/07/2005	2005-2/49
	27590	R616-3-3	AMD	02/01/2005	2005-1/30
Public Service Commission, Administration	27527	R746-409-1	NSC	01/01/2005	Not Printed
safety education					
Education, Administration	27539	R277-400	NSC	01/01/2005	Not Printed
sand					
School and Institutional Trust Lands, Administration	27609	R850-23	NEW	04/01/2005	2005-2/72
scholarship					
Regents (Board Of), Administration	27663	R765-604	5YR	01/19/2005	2005-4/56
scholarships					
Regents (Board Of), Administration	27666	R765-604	AMD	03/22/2005	2005-4/22
secondary education					
Regents (Board Of), Administration	27666	R765-604	AMD	03/22/2005	2005-4/22
	27663	R765-604	5YR	01/19/2005	2005-4/56
securities					
Commerce, Securities	27732	R164-2	5YR	02/28/2005	2005-6/34
	27777	R164-9-1	EMR	03/25/2005	2005-8/53
Money Management Council, Administration	27742	R628-19	R&R	05/05/2005	2005-7/64
securities regulation					
Commerce, Securities	27732	R164-2	5YR	02/28/2005	2005-6/34
	27777	R164-9-1	EMR	03/25/2005	2005-8/53
Money Management Council, Administration	27743	R628-15	NEW	05/05/2005	2005-7/60
self administered services					
Human Services, Services for People with Disabilities	27801	R539-5	NEW	05/17/2005	2005-8/33

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self-employment income					
Community and Economic Development, Community Development, Community Services	27421	R202-203-324	AMD	01/12/2005	2004-19/25
	27419	R202-203-328	AMD	01/12/2005	2004-19/26
septic tanks					
Environmental Quality, Water Quality	27699	R317-4	5YR	02/10/2005	2005-5/30
services					
Human Services, Services for People with Disabilities	27626	R539-2	NEW	03/12/2005	2005-2/45
settlement					
Administrative Services, Facilities Construction and Management	27614	R23-26	NEW	03/15/2005	2005-2/12
skills tests					
Public Safety, Driver License	27898	R708-37	5YR	05/13/2005	2005-11/103
small game					
Natural Resources, Wildlife Resources	27864	R657-21	5YR	05/05/2005	2005-11/101
social services					
Human Services, Services for People with Disabilities	27651	R539-2	REP	03/12/2005	2005-3/31
	27792	R539-2-6	AMD	05/17/2005	2005-8/29
	27652	R539-3	REP	03/12/2005	2005-3/34
	27753	R539-4	REP	05/03/2005	2005-7/58
	27802	R539-5	REP	05/17/2005	2005-8/31
	27795	R539-8	REP	05/17/2005	2005-8/35
source monitoring					
Environmental Quality, Drinking Water	27917	R309-205	5YR	05/16/2005	2005-11/95
sovereign lands					
Natural Resources, Forestry, Fire and State Lands	27750	R652-70-1900	AMD	05/20/2005	2005-7/66
	27740	R652-70-2300	AMD	05/20/2005	2005-7/67
specific licenses					
Environmental Quality, Radiation Control	27747	R313-22	AMD	05/13/2005	2005-7/36
state buildings					
Administrative Services, Facilities Construction and Management	27615	R23-3	AMD	03/15/2005	2005-2/9
Capitol Preservation Board (State), Administration	27713	R131-7	5YR	02/16/2005	2005-6/34
state HEAT office records					
Community and Economic Development, Community Development, Community Services	27420	R202-207-702	AMD	01/12/2005	2004-19/27
state records committee					
Administrative Services, Records Committee	27621	R35-1a	NEW	03/08/2005	2005-2/17
	27625	R35-2	AMD	03/04/2005	2005-2/18
	27622	R35-3	AMD	03/04/2005	2005-2/19

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	27623	R35-5	AMD	03/04/2005	2005-2/21
	27620	R35-6	AMD	03/04/2005	2005-2/22
state vehicle use Administrative Services, Fleet Operations	27599	R27-3-6	NSC	02/01/2005	Not Printed
stationary sources Environmental Quality, Air Quality	27665	R307-210	AMD	04/19/2005	2005-4/17
student loans Regents (Board Of), Administration	27841	R765-626	5YR	04/26/2005	2005-10/53
students Education, Administration	27662	R277-713	AMD	03/21/2005	2005-4/14
surface water treatment plant monitoring Environmental Quality, Drinking Water	27910	R309-215	5YR	05/16/2005	2005-11/96
survey Environmental Quality, Radiation Control	27738	R313-34	5YR	03/08/2005	2005-7/76
	27646	R313-34-1	NSC	02/01/2005	Not Printed
surveyors Commerce, Occupational and Professional Licensing	27698	R156-22	AMD	04/04/2005	2005-5/2
taxation Tax Commission, Auditing	27739	R865-16R	5YR	03/08/2005	2005-7/77
teacher certification Professional Practices Advisory Commission, Administration	27542	R686-100	NSC	01/01/2005	Not Printed
technology best practices Governor, Planning and Budget, Chief Information Officer	27545	R365-101	NEW	03/09/2005	2004-23/45
telecommunications Public Service Commission, Administration	27302	R746-360-9	CPR	01/04/2005	2004-23/54
	27302	R746-360-9	AMD	01/04/2005	2004-15/59
transportation Environmental Quality, Radiation Control	27745	R313-19	AMD	05/13/2005	2005-7/34
underground injection control Environmental Quality, Water Quality	27596	R317-7	NSC	02/01/2005	Not Printed
unemployment compensation Workforce Services, Workforce Information and Payment Services	27789	R994-204	5YR	04/01/2005	2005-8/59
	27791	R994-205	5YR	04/01/2005	2005-8/59
	27796	R994-206	5YR	04/01/2005	2005-8/60
unemployment experience rating Workforce Services, Workforce Information and Payment Services	27770	R994-304	NEW	05/12/2005	2005-7/72

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uninsured motorist database					
Public Safety, Driver License	27877	R708-32	5YR	05/10/2005	2005-11/102
units					
Environmental Quality, Radiation Control	27746	R313-12	AMD	05/13/2005	2005-7/29
universal service					
Public Service Commission, Administration	27302	R746-360-9	AMD	01/04/2005	2004-15/59
	27302	R746-360-9	CPR	01/04/2005	2004-23/54
utility service shutoff					
Public Service Commission, Administration	27587	R746-200-6	AMD	02/25/2005	2005-1/32
vehicle replacement					
Administrative Services, Fleet Operations	27543	R27-4	AMD	01/10/2005	2004-23/5
waste disposal					
Environmental Quality, Radiation Control	27744	R313-15	AMD	05/13/2005	2005-7/33
Environmental Quality, Water Quality	27659	R317-1	AMD	04/20/2005	2005-3/5
waste water					
Environmental Quality, Water Quality	27699	R317-4	5YR	02/10/2005	2005-5/30
wastewater					
Environmental Quality, Water Quality	27658	R317-3-10	AMD	04/20/2005	2005-3/10
wastewater treatment					
Environmental Quality, Water Quality	27656	R317-10-6	AMD	04/20/2005	2005-3/18
water pollution					
Environmental Quality, Water Quality	27659	R317-1	AMD	04/20/2005	2005-3/5
	27658	R317-3-10	AMD	04/20/2005	2005-3/10
	27657	R317-8-3	AMD	04/20/2005	2005-3/12
	27656	R317-10-6	AMD	04/20/2005	2005-3/18
water quality					
Environmental Quality, Drinking Water	27905	R309-225	5YR	05/16/2005	2005-11/97
Environmental Quality, Water Quality	27658	R317-3-10	AMD	04/20/2005	2005-3/10
	27596	R317-7	NSC	02/01/2005	Not Printed
water rights					
Natural Resources, Water Rights	27690	R655-3	5YR	02/01/2005	2005-4/54
	27475	R655-4	NSC	02/01/2005	Not Printed
	27691	R655-4	5YR	02/01/2005	2005-4/55
	27392	R655-4	AMD	01/12/2005	2004-18/30
water system rating					
Environmental Quality, Drinking Water	27909	R309-150	5YR	05/16/2005	2005-11/94
watershed management					
Environmental Quality, Drinking Water	27907	R309-105	5YR	05/16/2005	2005-11/92
well drillers					
Natural Resources, Water Rights	27691	R655-4	5YR	02/01/2005	2005-4/55

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well drilling					
Natural Resources, Water Rights	27475	R655-4	NSC	02/01/2005	Not Printed
	27392	R655-4	AMD	01/12/2005	2004-18/30
wildlife					
Natural Resources, Wildlife Resources	27550	R657-5	AMD	01/15/2005	2004-24/38
	27721	R657-12	AMD	04/15/2005	2005-6/24
	27432	R657-13	CPR	01/03/2005	2004-22/66
	27432	R657-13	AMD	01/03/2005	2004-20/33
	27863	R657-15	5YR	05/05/2005	2005-11/101
	27864	R657-21	5YR	05/05/2005	2005-11/101
	27649	R657-33	AMD	03/04/2005	2005-3/36
	27551	R657-37	AMD	01/15/2005	2004-24/45
	27552	R657-38	AMD	01/15/2005	2004-24/48
	27553	R657-42-4	AMD	01/15/2005	2004-24/53
	27637	R657-47	NSC	03/04/2005	Not Printed
	27639	R657-47	REP	03/04/2005	2005-3/39
wildlife conservation					
Natural Resources, Wildlife Resources	27552	R657-38	AMD	01/15/2005	2004-24/48
wildlife law					
Natural Resources, Wildlife Resources	27721	R657-12	AMD	04/15/2005	2005-6/24
	27432	R657-13	CPR	01/03/2005	2004-22/66
	27432	R657-13	AMD	01/03/2005	2004-20/33
	27864	R657-21	5YR	05/05/2005	2005-11/101
wildlife management					
Natural Resources, Wildlife Resources	27863	R657-15	5YR	05/05/2005	2005-11/101
wildlife permits					
Natural Resources, Wildlife Resources	27637	R657-47	NSC	03/04/2005	Not Printed
	27639	R657-47	REP	03/04/2005	2005-3/39
workers compensation insurance					
Insurance, Administration	27488	R590-231	CPR	05/20/2005	2005-3/55
workers' compensation insurance					
Insurance, Administration	27488	R590-231	NEW	05/20/2005	2004-21/15
	27488	R590-231	CPR	05/20/2005	2005-8/50