

UTAH STATE BULLETIN

OFFICIAL NOTICES OF UTAH STATE GOVERNMENT
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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 63G-3-402.

Inquiries concerning the substance or applicability of an administrative rule that appears in the *Bulletin* should be addressed to the contact person for the rule. Questions about the *Bulletin* or the rulemaking process may be addressed to: Division of Administrative Rules, PO Box 141007, Salt Lake City, Utah 84114-1007, telephone 801-538-3764, FAX 801-537-9240. Additional rulemaking information, and electronic versions of all administrative rule publications are available at: <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

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BY KEYWORD (SUBJECT)..... 113**

SPECIAL NOTICES

Health Health Care Financing, Coverage and Reimbursement Policy

Notice for February 2013 Medicaid Rate Changes

Effective February 1, 2013, Utah Medicaid will adjust its rates consistent with approved methodologies. Rate adjustments include new codes priced consistent with approved Medicaid methodologies, as well as potential adjustments to existing codes. All rate changes are posted to the web and can be viewed at: <http://health.utah.gov/medicaid/stplan/bcrp.htm>

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 December 15, 2012, 12:00 a.m., and December 31, 2012, 11:59 p.m. are included in this, the January 15, 2013 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 between paragraphs (.) indicates that unaffected text from within a section was removed to conserve space. Unaffected sections are not printed. 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 February 14, 2013. The agency may accept comment beyond this date and will indicate 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 hold a hearing on a specific **PROPOSED RULE**. Section 63G-3-302 requires that a hearing request be received by the agency proposing the rule "in writing not more than 15 days after the publication date of the proposed rule."

From the end of the public comment period through May 15, 2013, 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 seven calendar days after the close of the public comment period 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 OF A CHANGE IN PROPOSED RULE**, the **PROPOSED RULE** 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 Section 63G-3-301; 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

Education, Administration
R277-484
 Data Standards

NOTICE OF PROPOSED RULE

(Amendment)

DAR FILE NO.: 37145

FILED: 12/31/2012

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: This rule is amended to remove Section R277-484-9 and place it in another rule so that all provisions regarding student and educator data and confidentiality are within one rule.

SUMMARY OF THE RULE OR CHANGE: Removes Section R277-484-9 from the rule and updates a definition to make it consistent with the definition in other rules.

STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Subsection 53A-1-401(3)

ANTICIPATED COST OR SAVINGS TO:

◆ **THE STATE BUDGET:** There is no anticipated cost or savings to the state budget. The amendment to the rule removes a section and relocates it in another rule which does not result in a cost or savings.

◆ **LOCAL GOVERNMENTS:** There is no anticipated cost or savings to local government. The amendment to the rule removes a section and relocates it in another rule which does not result in a cost or savings.

◆ **SMALL BUSINESSES:** There is no anticipated cost or savings to small businesses. The amendment to the rule applies to public education and does not affect businesses.

◆ **PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES:** There is no anticipated cost or savings to persons other than small businesses, businesses, or local government entities. The amendment to the rule removes a section and relocates it in another rule which does not result in a cost or savings.

COMPLIANCE COSTS FOR AFFECTED PERSONS: There are no compliance costs for affected persons. The amendment to the rule removes a section and relocates it in another rule which does not result in any compliance costs.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: I have reviewed this rule and I see no fiscal impact on businesses.

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 by phone at 801-538-7835, by FAX at 801-538-7768, or by Internet E-mail at carol.lear@schools.utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN AT 5:00 PM ON 02/14/2013

THIS RULE MAY BECOME EFFECTIVE ON: 02/21/2013

AUTHORIZED BY: Carol Lear, Director, School Law and Legislation

R277. Education, Administration.

R277-484. Data Standards.

R277-484-1. Definitions.

A. "Annual Financial Report" means an account of LEA revenue and expenditures by source and fund sufficient to meet the reporting requirements specified in Section 53A-1-301(3)(d) and (e).

B. "Annual Program Report" means an account of LEA revenue and expenditures by source and program sufficient to meet the reporting requirements specified in Section 53A-1-301(3)(d) and (e).

C. "Board" means the Utah State Board of Education.

D. "Comprehensive Administration of Credentials for Teachers in Utah Schools (CACTUS)" means the database maintained on all licensed Utah educators. The database includes information such as:

- (1) personal directory information;
- (2) educational background;
- (3) endorsements;
- (4) employment history;
- (5) professional development information;
- (6) completion of employee background checks; and
- (7) a record of disciplinary action taken against the educator.

E. "Data Clearinghouse File" means the electronic file of student level data submitted by LEAs to the USOE in the layout specified by the USOE. This definition is effective until July 1, 2011.

F. "Data Warehouse" means the database of demographic information, course taking, and test results maintained by the USOE on all students enrolled in Utah schools.

G. "EDEN" means the Education Data Exchange Network, the mechanism by which state education agencies are mandated as of the 2008-09 school year to submit data to the U.S. Department of Education.

H. "ESEA" means the federal Elementary and Secondary Education Act, also known as the No Child Left Behind Act.

I. "LEA" means local education agency, ~~[which may be either a public school district or a charter school]~~ including local

school boards/public school districts, charter schools, and, for purposes of this rule, the Utah Schools for the Deaf and the Blind.

J. "MSP" means Minimum School Program, the set of state support K-12 public school funding programs.

K. "MST" means Mountain Standard Time.

L. "USOE" means Utah State Office of Education.

M. "Utah eTranscript and Record Exchange (UTREx)" means a system that allows individual detailed student records to be exchanged electronically between public education LEAs and the USOE, and allows electronic transcripts to be sent to any post-secondary institution, private or public, in-state or out-of-state, that participates in the e-transcript service. This definition becomes effective on July 1, 2011, the date when UTREx becomes available to all Utah LEAs.

N. "Year" means both the school year and the fiscal year for LEAs in Utah, which runs from July 1 through June 30.

O. "YICISIS" means the Youth In Custody Student Information System.

R277-484-2. Authority and Purpose.

A. This rule is authorized by Utah Constitution Article X, Section 3 which vests general control and supervision of public education in the Board, and by Section 53A-1-401(3) which permits the Board to adopt rules in accordance with its responsibilities and specifically allows the Board to interrupt disbursements of state aid to any LEA which fails to comply with rules.

B. The Board, through its chief executive officer, the State Superintendent of Public Instruction, is required to perform certain data collection related duties essential to the operation of statewide educational accountability and financial systems as mandated in state and federal law.

C. The purpose of this rule is to support the operation of required educational accountability and financial systems by ensuring timely submission of data by LEAs.

R277-484-3. Deadlines for Data Submission.

For the purpose of submission of student level data, each Utah LEA shall participate in UTREx as of July 1, 2011. LEAs shall submit data to the USOE through the following reports by 5:00 p.m. MST on the date and in the format specified by the USOE:

A. February 28 - Community Development and Renewal Agency and/or Redevelopment Agency Taxing Entity Committee Representative List - Business Services.

B. June 15

(1) Immunization Status Report (to Utah Department of Health) - final;

(2) Safe School Incidents Report - for current year.

C. June 29 - CACTUS - final update for current year.

D. July 7

(1) Data Clearinghouse File - final comprehensive update for prior year - Data, Assessment, and Accountability - effective until July 1, 2011;

(2) UTREx - final comprehensive update for prior year - Data, Assessment, and Accountability - effective on July 1, 2011.

E. July 15

(1) Adult Education - final report for prior year;

(2) Classified Personnel Report - for prior year - Business Services;

(3) Driver Education Report - for prior year - Educator Quality;

(4) ESEA Choice and Supplemental Services Report - for prior year;

(5) Fee Waivers Report - for prior year;

(6) Fire Drill Compliance Statement - for prior year;

(7) Home Schooled Students Report - for prior year;

(8) Teacher Benefits Report - for prior year;

(9) Pupil Transportation Statistics - for prior year:

(a) Bus Inventory Report;

(b) Year End Pupil Transportation Statistics Reports.

F. September 15

(1) Membership Audit Report - for prior year;

(2) Adult Education - Financial Audit for prior year.

G. October 1

(1) Annual Financial Report (AFR) - for prior year;

(2) Annual Program Report (APR) - for prior year.

H. October 15

(1) Data Clearinghouse File - update as of October 1 for current year - effective until July 1, 2011;

(2) UTREx - update as of October 1 for current year - effective on July 1, 2011;

(3) YICISIS - update as of October 1 for current year.

I. November 1

(1) Enrollment and Transfer Student Documentation Audit Report - for current year;

(2) Immunization Status Report - for current year;

(3) Pupil Transportation Statistics for state funding:

(a) Schedule A1 (Miles, Minutes, Students Report) - projected for current year;

(b) Schedule B (Miscellaneous Expenditure Report) - for prior year;

(4) Negotiations report - for current year.

J. November 15

(1) CACTUS - update for current year; and

(2) Free and Reduced Price Lunch Enrollment Survey - as of October 31 for current year.

K. November 30 - Financial Audit Report - for prior year.

L. December 15

(1) Data Clearinghouse File - update as of December 1 for current year - effective until July 1, 2011;

(2) Bus Driver Credentials Report - for current year - Business Services.

M. December 15 - UTREx - update as of December 1 for current year - effective on July 1, 2011.

R277-484-4. Adjustments to Deadlines.

A. Deadlines that fall on a weekend or state holiday in a given year shall be moved to the date of the first workday after the date specified in Section 3 for that year.

B. An LEA may seek an extension of a deadline to ensure continuation of funding and provide more accurate input to allocation formulas by submitting a written request to the USOE. The request shall be received by the USOE State Director of School Finance and Statistics at least 24 hours before the specified deadline in Section 3 and include:

(1) The reason(s) why the extension is needed;

(2) The signatures of the LEA business administrator and the district superintendent or charter school director; and

(3) The date by which the LEA shall submit the report.

C. In processing the request for the extension, the USOE State Director of School Finance and Statistics shall:

(1) Take into consideration the pattern of LEA compliance with reporting deadlines and the urgency of the use which depends on the data to be submitted, consult with other USOE staff who have knowledge relevant to the situation of the LEA; and either

(2) Approve the request and allow the MSP fund transfer process to continue; or

(3) Recommend denial of the request and forward it the USOE Associate Superintendent for Business Services for a final decision on whether to stop the MSP fund transfer process.

D. If, after receiving an extension, the LEA fails to submit the report by the agreed date, the MSP fund transfer process shall be stopped and the procedure described in Section 8 shall apply.

E. Extensions shall apply only to the report(s) and date(s) specified in the request.

F. Exceptions - Deadlines for the following reports may not be extended:

(1) June 29 CACTUS Update;

(2) July 7 Final Data Clearinghouse File - final comprehensive update for prior year- Data, Assessment, and Accountability - effective until July 1, 2011;

(3) July 7 UTREx - final comprehensive update for prior year - Data, Assessment, and Accountability - effective on July 1, 2011;

(4) November 15 CACTUS - update for current year.

R277-484-5. Official Data Source and Required LEA Compatibility.

A. The USOE shall load operational data collections into the Data Warehouse as of the submission deadlines specified.

B. The Data Warehouse shall be the sole official source of data for annual:

(1) school performance reports required under Section 53A-3a-602.5;

(2) determination of adequate yearly progress as required under the ESEA; and

(3) submission of data files to the U.S. Department of Education via EDEN.

C. Prior to an LEA acquiring a student information system, replacing an existing student information system, or modifying data elements in an existing student information system, an LEA shall have USOE approval to ensure that the LEA's new or modified student information system maintains compatibility with UTREx.

D. No later than October 1, 2013, all public education LEAs shall begin submitting daily updates to the USOE Clearinghouse using all School Interoperability Framework (SIF) objects defined in the UTREx Clearinghouse specification. Failure to do so shall be a violation of Board reporting rules.

E. All public high school transcripts requested by public education post-secondary schools shall be electronically submitted to those public education post-secondary schools if the post-secondary schools are capable of receiving transcripts through the electronic transcript service designated by the USOE. This process is mandatory for all public high schools after September 1, 2013.

R277-484-6. Use of Data for Allocation of Funds.

The USOE School Finance and Statistics Section shall publish after each general legislative session by June 30 on its website an explicit description of how data shall be used to allocate funds to LEAs in each MSP program in the following fiscal year.

R277-484-7. Adjustments to Summary Statistics Based on Compliance Audits.

A. For the purpose of allocating MSP funds and projecting enrollment, LEA level aggregate membership and fall enrollment counts may be modified by the USOE on the basis of the values in the Membership and Enrollment audit reports, respectively, when an audit report review team comprising at least three members of the Finance and Statistics and Charter School sections agree that an adjustment is warranted by the evidence of an audit:

(1) the audit report review team shall make its determination within five working days of the authorized audit report deadline;

(2) values can only be adjusted downward when audit reports are received after the authorized deadlines.

R277-484-8. Financial Consequences of Failure to Submit Reports on Time.

A. If an LEA fails to submit a report by its deadline as specified in Section 3, the USOE shall stop the MSP fund transfer process on the day after the deadline, unless the LEA has obtained an extension of the deadline in accordance with the procedure described in Section 4, to the following extent:

(1) 10% of the total monthly MSP transfer amount in the first month, 25% in the second month, and 50% in the third and subsequent months for any report other than June 15 Immunization Status report.

(2) Loss of up to 1.0 WPU from Kindergarten or Grades 1-12 programs, depending on the grade level and aggregate membership of the student, in the current year Mid Year Update for each student whose prior year immunization status was not accounted for in accordance with Utah Code 53A-11-301 as of June 15.

B. If the USOE has stopped the MSP fund transfer process for an LEA, the USOE shall:

(1) upon receipt of a late report from that LEA, restart the transfer process within the month (if the report is submitted by 10:00 a.m. on or before the tenth working day of the month) or in the following month (if the report is submitted after 10:00 a.m. on or after the tenth working day of the month); and

(2) inform the appropriate Board Committee at its next regularly scheduled Committee meeting.

(3) inform the chair of the governing board if LEA staff are not responsive in correcting ongoing problems with data.

~~R277-484-9. Disclosure of Data for Research.~~

~~A. The USOE may provide limited or extensive data sets for research and analysis purposes to qualified researchers or organizations.~~

~~(1) A reasonable method shall be used to qualify researchers or organizations to receive data, such as evidence that a research proposal has been approved by a federally recognized Institutional Review Board (IRB).~~

~~_____ (2) A standardized, de-identified research data package shall be prepared each year by the USOE for qualified researchers to systematically protect individual student data.~~

~~_____ (3) The USOE is not obligated to fill every data request and may develop procedures to determine which requests will be filled or to assign priorities to multiple requests. The USOE/Board understands that it will respond in a timely manner to all requests submitted under Section 63G-2-101 et seq., Government Records Access and Management Act.~~

~~_____ (a) In filling data requests, higher priority shall be given to requests that will help improve instruction in Utah's public schools.~~

~~_____ (b) In filling data requests, higher priority shall be given to requests from universities, colleges, schools, faculty, students and government entities residing in Utah.~~

~~_____ (4) A fee may be charged to prepare data or to deliver data, particularly if the preparation requires original work. The USOE shall comply with Section 63G-2-203 in assessing fees.~~

~~_____ (5) The researcher or organization shall provide a copy of the report or publication produced using USOE data to USOE at least 10 business days prior to the public release.~~

~~_____ B. Student information~~

~~_____ (1) Requests for data that disclose student information shall be provided in accordance with the Family Educational Rights and Privacy Act (FERPA), 34 CFR 99-31(a)(6), so that:~~

~~_____ (a) the individual data is de-identified, meaning it is not possible to trace the data to an actual student.~~

~~_____ (b) the recipient of student data shall agree to not report or publish data in a manner that discloses a student's identity. For example, reporting test scores for a race subgroup that has a count, also known as n-size, less than 10 could enable someone to identify the actual students and shall not be published.~~

~~_____ C. Licensed educator information~~

~~_____ (1) The USOE shall provide information about licensed educators maintained in the CACTUS database that is required under Section 63G-2-301(2).~~

~~_____ (2) Additional information/data may be released by the USOE consistent with the purposes of CACTUS, the confidentiality protections accepted by requester(s), and the benefit that the research may provide for public education in Utah, as determined by the USOE.~~

~~_____ D. Recipients of USOE research data shall sign a USOE non-disclosure agreement if required by the USOE.~~

~~_____ E. The Board or the USOE may commission research or may approve research requests.~~

~~_____ F. The USOE may provide personally identifiable data about students or licensed educators consistent with state and federal law. Some data may be provided only if the researcher or contractor agrees to preserve the confidentiality of private and protected data.~~

~~_____]~~

~~**KEY: data standards, reports, deadlines[, research data requests]**~~

~~**Date of Enactment or Last Substantive Amendment: [March 12, 2012]2013**~~

~~**Notice of Continuation: December 31, 2012**~~

~~**Authorizing, and Implemented or Interpreted Law: Art X Sec 3; 53A-1-401(3); 53A-1-301(3)(d) and (e)**~~

**Education, Administration
R277-487
Public School Student Confidentiality**

**NOTICE OF PROPOSED RULE
(Amendment)**

**DAR FILE NO.: 37144
FILED: 12/31/2012**

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: This rule is amended to provide additional provisions regarding disclosure of classroom-level student data, protection of educator evaluation data, and outlining when student data should be publicly available and to whom, and to add new language on public education survey data as required by H.B. 149, 2012 General Legislative Session.

SUMMARY OF THE RULE OR CHANGE: The changes include adding new definitions, revising the authority and purpose to reflect specific statutes regarding student information and public education survey data, and to add two new sections to the rule previously in two other rules so that all provisions of the law related to student and educator data are consistent and adequately addressed in one rule.

STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 53A-1-411 and Subsection 53A-1-401(3) and Subsection 53A-13-301(3)

ANTICIPATED COST OR SAVINGS TO:

♦ **THE STATE BUDGET:** There is no anticipated costs or savings to the state budget. Minimal funding is provided for the state to administer the pilot online school survey system.

♦ **LOCAL GOVERNMENTS:** There is no anticipated costs or savings to local government. The amendments to the rule provide minor clarification for procedures regarding protection of student and educator data within one rule which do not result in a cost or savings.

♦ **SMALL BUSINESSES:** There is no anticipated costs or savings to small businesses. This rule and the amendments to the rule apply to public education and do not affect businesses.

♦ **PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES:** There is no anticipated costs or savings to persons other than small businesses, businesses, or local government entities. This rule and the amendments to the rule affect state and local government and handling of student and educator data and do not affect individuals.

COMPLIANCE COSTS FOR AFFECTED PERSONS: There are no compliance costs for affected persons. Local education agencies should have policies in place and provide appropriate training to employees regarding the confidentiality of student and educator data.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: I have reviewed this rule and I see no fiscal impact on businesses.

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 by phone at 801-538-7835, by FAX at 801-538-7768, or by Internet E-mail at carol.lear@schools.utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN AT 5:00 PM ON 02/14/2013

THIS RULE MAY BECOME EFFECTIVE ON: 02/21/2013

AUTHORIZED BY: Carol Lear, Director, School Law and Legislation

R277. Education, Administration.

R277-487. Public School ~~[Student]~~Data Confidentiality and Disclosure.

R277-487-1. Definitions.

A. "Board" means the Utah State Board of Education.

B. "Comprehensive Administration of Credentials for Teachers in Utah Schools (CACTUS)" means the electronic file maintained and owned by the USOE on all licensed Utah educators. The file includes information such as:

(1) personal directory information;

(2) educational background;

(3) endorsements;

(4) employment history; and

(5) a record of disciplinary action taken against the educator.

C. "Disciplinary action" means any lesser action taken by UPPAC which does not materially affect a licensed educator's license and licensing action taken by the Board for suspension or revocation.

~~[B]~~D. "FERPA" means the Family Educational Rights and Privacy Act of 1974, 20 U.S.C. 1232g, a federal law designed to protect the privacy of students' education records. The law is hereby incorporated by reference.

~~[C]~~E. "LEA" means local education agency, including local school boards/~~charter school governing board,~~ public school districts~~[and schools, and],~~ charter schools, and, for purposes of this rule, the Utah Schools for the Deaf and the Blind.

F. "Student information" means materials, information, records and knowledge that an LEA possesses or maintains, or both, about individual students. Student information is broader than student records and may include information or knowledge that school employees possess or learn in the course of their duties.

~~[D]~~G. "Student record" means a record in any form, including handwriting, print, computer media, video or audio tape, film, microfilm, and microfiche, that is directly related to a student and maintained by an educational agency or institution or by a party acting for an agency or institution. Student records shall be maintained by LEAs consistent with 20 U.S.C. Section 1232g.

R277-487-2. Authority and Purpose.

A. This rule is authorized under Utah Constitution Article X, Section 3 which vests general control and supervision over public education in the Board, ~~[by Section 53A-13-301(3) which requires the Board to make rules to establish standards for public education employees, student aides, and volunteers in public schools regarding the confidentiality of student information and student records, and]~~ by Section 53A-1-401(3) which allows the Board to make rules in accordance with its responsibilities, by Section 53A-13-301(3) regarding confidentiality and required or appropriate disclosure of student records data; by Section 53A-1-411 which directs the Board to establish procedures for administering or making available online surveys to obtain information about public education issues, and Section 53A-6-104 which authorizes the Board to issue licenses to educators and maintain licensing information.

B. The purpose of this rule is to ~~[provide standards and procedures related to public school student confidentiality]~~ ensure the privacy, as directed by law, of individual student information, to provide an online education survey conducted with public funds for Board review and approval, and to provide for appropriate protection and maintenance of educator licensing data.

R277-487-3. ~~[Board Responsibilities]~~Confidentiality of Student Data.

A. Board Responsibilities:

~~[A-]~~(1) The Board shall develop resource materials for LEAs to train employees, ~~[student-]~~aid[~~e~~], and volunteers of an LEA regarding confidentiality of student information and student records, as defined in FERPA.

~~[B-]~~(2) The Board shall make the materials available to each LEA.[

R277-487-4. LEA Responsibilities.]

B. LEA Responsibilities:

~~[A-]~~(1) LEAs shall establish policies and provide appropriate training for employees regarding the confidentiality of student records, including an overview of all federal, state, and local laws that pertain to the privacy of students, their parents, and their families. The policy should address the specific needs or priorities of the LEA.

~~[B-]~~(2) LEAs shall require password protection for all student records maintained electronically.

~~[C-]~~ C. An LEA may adopt policies related to public school student confidentiality to address the specific needs or priorities of the LEA.

R277-487-4. ~~Public Education Employee and Volunteer Responsibilities.~~

~~[C-]~~ C. Public Education Employee and Volunteer Responsibilities:

~~[A-]~~(1) All public education employees, ~~[student-]~~ aid[e]s, and volunteers in public schools shall become familiar with federal, state, and local law regarding the confidentiality of student information and student records.

~~[B-]~~(2) All public education employees, ~~[student-]~~ aid[e]s, and volunteers shall maintain appropriate confidentiality pursuant to federal, state, and local laws with regard to student records.

~~[C-]~~(3) An employee, ~~[student-]~~ aid[e], or volunteer shall maintain student records in a secure and appropriate place as designated by policies of an LEA.

~~[D-]~~(4) An employee, ~~[student-]~~ aid[e], or volunteer accessing student records in electronic format shall comply with policies of an LEA regarding the procedures for maintaining confidentiality of electronic records.

~~[E-]~~(5) An employee, ~~[student-]~~ aid[e], or volunteer shall not share, disclose, or disseminate passwords for electronic maintenance of student records.

~~[G-]~~(6) All public education employees, ~~[student-]~~ aid[e]s and volunteers have a responsibility to protect confidential student information and access records only as necessary for their assignment(s).

~~[F-]~~(7) Public education employees licensed under Section 53A-6-104 shall access and use student information and records consistent with R277-515, Utah Educator Standards. Violations may result in licensing discipline.

R277-487-4. Comprehensive Administration of Credentials for Teachers in Utah Schools (CACTUS) Data, Confidentiality, and Appropriate Disclosure.

A. CACTUS maintains public, protected and private information on licensed Utah educators. Private or protected information includes such items as home address, date of birth, social security number, and any disciplinary action taken against an individual's license.

B. A CACTUS file shall be opened on a licensed Utah educator when:

- (1) the individual initiates a USOE background check, or
- (2) the USOE receives a paraprofessional license application from an LEA.

C. The data in CACTUS may only be changed as follows:

- (1) Authorized USOE staff or authorized LEA staff may change demographic data.
- (2) Authorized USOE staff may update licensing data such as endorsements, degrees, license areas of concentration and licensed work experience.
- (3) Authorized employing LEA staff may update data on educator assignments for the current school year only.

D. A licensed individual may view his own personal data. An individual may not change or add data except under the following circumstances:

- (1) A licensed individual may change his demographic data when renewing his license.
- (2) A licensed individual shall contact his employing LEA for the purpose of correcting demographic or current educator assignment data.
- (3) A licensed individual may petition the USOE for the purpose of correcting any errors in his CACTUS file.

E. Individuals currently employed by public or private schools under letters of authorization or as interns are included in CACTUS.

F. Individuals working in LEAs as student teachers are included in CACTUS.

G. Designated individuals have access to CACTUS data:

(1) Training shall be provided to designated individuals prior to granting access.

(2) Authorized USOE staff may view or change CACTUS files on a limited basis with specific authorization.

(3) For employment or assignment purposes only, authorized LEA staff members may access data on individuals employed by their own LEA or data on licensed individuals who do not have a current assignment in CACTUS.

(4) Authorized LEA staff may also view specific limited information on job applicants if the applicant has provided the LEA with a CACTUS identification number.

(5) CACTUS information belongs solely to the USOE. The USOE shall make the final determination of information included in or deleted from CACTUS.

(6) CACTUS data consistent with Section 63G-2-301(1) under the Government Records Access and Management Act are public information and shall be released by the USOE.

R277-487-5. Public Education Research Data.

A. The USOE may provide limited or extensive data sets for research and analysis purposes to qualified researchers or organizations.

(1) A reasonable method shall be used to qualify researchers or organizations to receive data, such as evidence that a research proposal has been approved by a federally recognized Institutional Review Board (IRB).

(2) Aggregate student assessment data are available through the USOE website. Individual student information are protected.

(3) The USOE is not obligated to fill every request for data and has procedures to determine which requests will be filled or to assign priorities to multiple requests. The USOE/Board understands that it will respond in a timely manner to all requests submitted under Section 63G-2-101 et seq., Government Records Access and Management Act. In filling data requests, higher priority may be given to requests that will help improve instruction in Utah's public schools.

(4) A fee may be charged to prepare data or to deliver data, particularly if the preparation requires original work. The USOE shall comply with Section 63G-2-203 in assessing fees.

(5) The researcher or organization shall provide a copy of the report or publication produced using USOE data to the USOE at least 10 business days prior to the public release.

B. Student information: Requests for data that disclose student information shall be provided in accordance with the Family Educational Rights and Privacy Act (FERPA), 20 U.S.C. Section 1232g; such responses may include:

(1) individual student data that are de-identified, meaning it is not possible to trace the data to individual students;

(2) agreements with recipients of student data where recipients agree not to report or publish data in a manner that discloses students' identities. For example, reporting test scores for

a race subgroup that has a count, also known as n-size, of less than 10 could enable someone to identify the actual students and shall not be published;

(3) release of student data, with appropriate binding agreements, for state or federal accountability or for the purpose of improving instruction to specific student subgroups.

C. Licensed educator information:

(1) The USOE shall provide information about licensed educators maintained in the CACTUS database that is required under Section 63G-2-301(2).

(2) Additional information/data may be released by the USOE consistent with the purposes of CACTUS, the confidentiality protections accepted by requester(s), and the benefit that the research may provide for public education in Utah, as determined by the USOE.

D. Recipients of USOE research data shall sign a USOE non-disclosure agreement if required by the USOE.

E. The Board or the USOE may commission research or may approve research requests.

R277-487-6. Public Education Survey Data.

A. The Board shall approve statewide education surveys administered with public funds through the USOE or through a contract issued by the USOE, as required under Section 53A-1-411.

B. Data obtained from USOE statewide surveys administered with public funds are the property of the Board.

C. Data obtained from USOE statewide surveys administered with public funds shall be made available as follows:

(1) Survey data made available by the Board shall protect the privacy of students in accordance with FERPA.

(2) Survey data about educators shall be available in a manner that protects the privacy of individual educators consistent with State law.

KEY: students, records, confidentiality

Date of Enactment or Last Substantive Amendment:
[November 8, 2011]2013

Notice of Continuation: December 31, 2012

Authorizing, and Implemented or Interpreted Law: Art X Sec 3; 53A-13-301(3); 53A-1-401(3); 53A-1-411

Education, Administration

R277-502

Educator Licensing and Data Retention

NOTICE OF PROPOSED RULE

(Amendment)

DAR FILE NO.: 37146

FILED: 12/31/2012

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: This rule is amended to remove Section R277-502-8 and place it in another rule so that all provisions regarding student and educator data and confidentiality are within one rule.

SUMMARY OF THE RULE OR CHANGE: Removes Section R277-502-8 from the rule and renumbers as appropriate.

STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Subsection 53A-1-401(3)

ANTICIPATED COST OR SAVINGS TO:

♦ **THE STATE BUDGET:** There is no anticipated cost or savings to the state budget. The amendment to the rule removes a section and relocates it in another rule which does not result in a cost or savings to the state.

♦ **LOCAL GOVERNMENTS:** There is no anticipated cost or savings to local government. The amendment to the rule removes a section and relocates it in another rule which does not result in a cost or savings to local government.

♦ **SMALL BUSINESSES:** There is no anticipated cost or savings to small businesses. The amendment to this rule applies to public education and does not affect businesses.

♦ **PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES:** There is no anticipated cost or savings to persons other than small businesses, businesses, or local government entities. The amendment to the rule removes a section and relocates it in another rule which does not result in a cost or savings to individuals.

COMPLIANCE COSTS FOR AFFECTED PERSONS: There are no compliance costs for affected persons. The amendment to this rule removes a section and relocates it in another rule which does not result in any compliance costs.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: I have reviewed this rule and I see no fiscal impact on businesses.

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 by phone at 801-538-7835, by FAX at 801-538-7768, or by Internet E-mail at carol.lear@schools.utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN AT 5:00 PM ON 02/14/2013

THIS RULE MAY BECOME EFFECTIVE ON: 02/21/2013

AUTHORIZED BY: Carol Lear, Director, School Law and Legislation

R277. Education, Administration.**R277-502. Educator Licensing and Data Retention.****R277-502-1. Definitions.**

A. "Accredited" means a Board-approved educator preparation program accredited by the National Council for Accreditation of Teacher Education (NCATE), the Teacher Education Accreditation Council (TEAC) or the Council for Accreditation of Educator Preparation (CAEP).

B. "Accredited school" for purposes of this rule, means public or private school that meets standards essential for the operation of a quality school program and has received formal approval through a regional accrediting association.

C. "Authorized staff" for purposes of this rule means an individual designated by the USOE or an LEA and approved by the USOE and who has completed CACTUS training.

D. "Board" means the Utah State Board of Education.

E. "Comprehensive Administration of Credentials for Teachers in Utah Schools (CACTUS)" means the electronic file maintained on all licensed Utah educators. The file includes information such as:

- (1) personal directory information;
- (2) educational background;
- (3) endorsements;
- (4) employment history; and
- (5) a record of disciplinary action taken against the educator.

F. "ESEA subject" means English, reading or language arts, mathematics, science, foreign languages, civics and government, economics, arts, history, and geography under the Elementary and Secondary Education Act (ESEA).

G. "LEA" means a local education agency, including local school boards/public school districts, charter schools, and, for purposes of this rule, the Utah Schools for the Deaf and the Blind.

H. "Letter of Authorization" means a designation given to an individual for one year, such as an out-of-state candidate or individual pursuing an alternative license, who has not completed the requirements for a Level 1, 2, or 3 license or who has not completed necessary endorsement requirements and who is employed by an LEA.

I. "Level 1 license" means a Utah professional educator license issued upon completion of a Board-approved educator preparation program or an alternative preparation program, or to an applicant that holds an educator license issued by another state or country that has met all ancillary requirements established by law or rule.

J. "Level 2 license" means a Utah professional educator license issued after satisfaction of all requirements for a Level 1 license and:

- (1) satisfaction of requirements under R277-522 for teachers whose employment as a Level 1 licensed educator began after January 1, 2003 in a Utah public LEA or accredited private school;
- (2) at least three years of successful education experience in a Utah public LEA or accredited private school or one year of successful education experience in a Utah public LEA or accredited private school and at least three years of successful education experience in a public LEA or accredited private school outside of Utah;
- (3) additional requirements established by law or rule.

K. "Level 3 license" means a Utah professional educator license issued to an educator who holds a current Utah Level 2 license and has also received National Board Certification or a doctorate in education or in a field related to a content area in a unit of the public education system or an accredited private school, or holds a Speech-Language Pathology area of concentration and has obtained American Speech-Language hearing Association (ASHA) certification.

L. "License areas of concentration" means designations to licenses obtained by completing a Board-approved educator preparation program or an alternative preparation program in a specific area of educational studies to include the following: Early Childhood (K-3), Elementary (K-6), Elementary (1-8), Middle (still valid, but not issued after 1988, 5-9), Secondary (6-12), Administrative/Supervisory (K-12), Career and Technical Education, School Counselor, School Psychologist, School Social Worker, Special Education (K-12), Preschool Special Education (Birth-Age 5), Communication Disorders, Speech-Language Pathologist, Speech-Language Technician. License areas of concentration may also bear endorsements relating to subjects or specific assignments.

M. "License endorsement (endorsement)" means a specialty field or area earned through completing required course work established by the USOE or through demonstrated competency approved by the USOE; the endorsement shall be listed on the Professional Educator License indicating the specific qualification(s) of the holder.

N. "Professional learning plan" means a plan developed by an educator in collaboration with the educator's supervisor consistent with R277-500 detailing appropriate professional learning activities for the purpose of renewing the educator's license.

O. "Renewal" means reissuing or extending the length of a license consistent with R277-500.

P. "State Approved Endorsement Program (SAEP)" means a plan in place developed between the USOE and a licensed educator to direct the completion of endorsement requirements by the educator consistent with R277-520-11.

Q. "USOE" means the Utah State Office of Education.

R277-502-2. Authority and Purpose.

A. This rule is authorized by Utah Constitution Article X, Section 3 which vests general control and supervision of the public school system under the Board, by Section 53A-6-104 which gives the Board power to issue licenses, and Section 53A-1-401(3) which allows the Board to adopt rules in accordance with its responsibilities.

B. This rule specifies the types of license levels and license areas of concentration available and procedures for obtaining a license, required for employment as a licensed educator in the public schools of Utah. The rule provides a process of criteria for educators whose licenses have lapsed and return to the teaching profession. All licensed educators employed in the Utah public schools shall be licensed consistent with this rule in order for the district to receive full funding under Section 53A-17a-107(2).

R277-502-3. Program Approval.

A. The Board shall accept educator license recommendations from educator preparation programs that have

applied for Board approval and have met the requirements described in this rule and the Standards for Program Approval established by the Board in R277-504, R277-505, or R277-506 as determined by USOE.

B. The Board, or its designee, shall establish deadlines and uniform forms and procedures for all aspects of licensing.

C. To be approved for license recommendation the educator preparation program shall:

- (1) be accredited;
- (2) have a physical location in Utah where students attend classes or if the program provides only online instruction:

(a) the program's primary headquarters shall be located in Utah and

(b) the program shall be licensed to do business in Utah through the Utah Department of Commerce;

(3) include coursework designated to ensure that the educator is able to meet the Utah Effective Teaching Standards and Educational Leadership Standards established in R277-530;

(4) in the case of content endorsements, include coursework that is, at minimum, equivalent to the course requirements for the endorsement as established by USOE;

(5) establish entry requirements designed to ensure that only high quality individuals enter the licensure program such as:

- (a) minimum High School/College GPA;
- (b) minimum college entry exam scores (ACT/SAT);
- (c) passing of a basic skills test;
- (d) disposition testing or entrance interview.

(6) require a USOE-cleared fingerprint background check; and

(7) include a student teaching or intern experience that meets the requirements detailed in R277-504, R277-505, and R277-506.

D. USOE representatives shall be a part of the accrediting team for any Board-approved educator preparation program seeking to maintain or receive program approval. USOE representatives shall be responsible for:

- (1) observing and monitoring the accreditation process;
- (2) reviewing of subject specific programs to determine if the program meets state standards for licensure in specific areas;

(3) reviewing of program procedures to ensure that Board requirements for licensure are followed;

(4) reviewing licensure candidate files to determine if Board requirements for licensure are followed by the program.

E. Upon receiving formal accreditation approval, a Board-approved educator preparation program shall prepare a report in conjunction with USOE for the Board that includes:

- (1) program summary;
- (2) accreditation findings;
- (3) program areas of distinction;
- (4) program enrollment;
- (5) program goals and direction.

F. New educator preparation programs that seek Board approval or previously Board-approved educator preparation programs that seek approval for additional license area preparation and endorsements shall submit applications to USOE including:

(1) information detailing the exact license areas of concentration and endorsements that the program intends to award;

(2) detailed course information, including required course lists, course descriptions, and course syllabi for all courses that will be required as part of a program;

(3) detailed information showing how the required coursework will ensure that the educator satisfies all standards in the Utah Effective Teaching Standards and Educational Leadership Standards established in R277-530 and Professional Educator Standards established in R277-515;

(4) information about program timelines and anticipated enrollment.

G. Applications for new educator preparation programs shall be approved by the Board.

H. Applications for previously Board-approved educator preparation programs desiring Board approval for additional license areas and endorsements:

(1) shall be reviewed and approved by USOE;

(2) may receive preliminary approval pending Utah State Board of Regents approval of the new program if the program is within a public institution.

I. An educator preparation program seeking accreditation may apply to the Board for probationary approval not to exceed two years contingent on the completion of the accreditation process.

J. A previously Board-approved educator preparation program shall submit an annual report to USOE by July 1. The report shall include the following:

(1) student enrollment counts designated by anticipated license area of concentration and endorsement and disaggregated by gender and ethnicity;

(2) information regarding any significant changes to course requirements or course content;

(3) the program's response to USOE-identified areas of concern or areas of focus;

(4) information regarding any program-determined areas of concern or areas of focus and the program's planned response.

K. The USOE shall provide reporting criteria to Board-approved educator preparation programs regarding the annual report and USOE-designated areas of concern or focus by January 31 annually.

L. Educator preparation programs that submit inadequate or incomplete information to the USOE may be placed on a probationary status by USOE.

M. Board-approved educator preparation programs on probationary status that continue to fail to meet requirements may have their license recommendation status revoked in full or in part by the Board with at least one year notice.

R277-502-4. License Levels, Procedures, and Periods of Validity.

A. Level 1 License Requirements

(1) An initial license, the Level 1 license, is issued to an individual who is recommended by a Board-approved educator preparation program or approved alternative preparation program, or an educator with a professional educator license from another state.

(a) LEAs and Board-approved educator preparation programs shall cooperate in preparing candidates for the educator Level 1 license. The resources of both may be used to assist candidates in preparation for licensing.

(b) The recommendation indicates that the individual has satisfactorily completed the programs of study required for the preparation of educators and has met licensing standards in the license areas of concentration for which the individual is recommended.

(2) The Level 1 license is issued for three years.

(3) A Level 1 license holder shall satisfy all requirements of R277-522, Entry Years Enhancements (EYE) for Quality Teaching - Level 1 Utah Teachers.

(4) An educator qualified to teach any ESEA subject shall be considered Highly Qualified in at least one ESEA subject prior to moving from Level 1 to Level 2.

(5) A license applicant who has received or completed license preparation activities or coursework inconsistent with this rule may present compelling information and documentation for review and approval by the USOE to satisfy the licensing requirements.

B. Level 2 License Requirements

(1) A Level 2 license may be issued by the Board to a Level 1 license holder upon satisfaction of all USOE requirements for the Level 2 license and upon the recommendation of the employing LEA.

(2) The recommendation shall be made following the completion of three years of successful, professional growth and educator experience, satisfaction of R277-522, Entry Years Enhancements (EYE) for Quality Teaching - Level 1 Utah Teachers, any additional requirements imposed by the employing LEA, and before the Level 1 license expires.

(3) A Level 2 license shall be issued for five years and shall be valid unless suspended or revoked for cause by the Board.

(4) The Level 2 license may be renewed for successive five year periods consistent with R277-500, Educator Licensing Renewal.

C. Level 3 License Requirements

(1) A Level 3 license may be issued by the Board to a Level 2 license holder who:

(a) has achieved National Board Certification; or

(b) has a doctorate in education in a field related to a content area in a unit of the public education system or an accredited private school; or

(c) holds a Speech-Language Pathology area of concentration and has obtained American Speech-Language Hearing Association (ASHA) certification.

(2) A Level 3 license is valid for seven years unless suspended or revoked for cause by the Board.

(3) The Level 3 license may be renewed for successive seven year periods consistent with R277-500.

(4) A Level 3 license shall revert to a Level 2 license if the holder fails to maintain National Board Certification status or fails to maintain a current Certificate of Clinical Competence from the American Speech-Language-Hearing Association.

D. License Renewal Timeline

Licenses expire on June 30 of the year of expiration recorded on CACTUS and may be renewed any time after January of the same year. Responsibility for license renewal rests solely with the holder.

R277-502-5. Professional Educator License Areas of Concentration, and Endorsements and Under-Qualified Employees.

A. Unless excepted under rules of the Board, to be employed in the public schools in a capacity covered by the following license areas of concentration, a person shall hold a valid license issued by the Board in the respective license areas of concentration:

- (1) Early Childhood (K-3);
- (2) Elementary (1-8);
- (3) Elementary (K-6);
- (4) Middle (still valid, and issued before 1988, 5-9);
- (5) Secondary (6-12);
- (6) Administrative/Supervisory (K-12);
- (7) Career and Technical Education;
- (8) School Counselor;
- (9) School Psychologist;
- (10) School Social Worker;
- (11) Special Education (K-12);
- (12) Preschool Special Education (Birth-Age 5);
- (13) Communication Disorders;
- (14) Speech-Language Pathologist;
- (15) Speech-Language Technician.

B. Under-qualified educators:

(1) Educators who are licensed and hold the appropriate license area of concentration but who are working out of their endorsement area(s) shall request and prepare an SAEP to complete the requirements of an endorsement with a USOE education specialist; or

(2) Letters of Authorization

(a) LEAs may request from the Board a Letter of Authorization for educators employed by the local board who have not completed requirements for areas of concentration or endorsements.

(b) An approved Letter of Authorization is valid for one year.

(c) Educators may be approved for no more than three Letters of Authorization throughout their employment in Utah schools. Exceptions to the three Letters of Authorization limitation may be granted by the State Superintendent of Public Instruction or his designee on a case by case basis following specific approval of the request by the LEA governing board. Letters of Authorization prior to the 2000-2001 school year are not counted in this limit.

(d) Following the expiration of the Letter of Authorization, the educator who is still not completely approved for licensing shall be considered under qualified.

C. License areas of concentration may be endorsed to indicate qualification in a subject or content area. An endorsement is not valid for employment purposes without a current license and license area of concentration.

R277-502-6. Returning Educator Relicensure.

A. A previously licensed educator with an expired license may renew an expired license upon satisfaction of the following:

(1) Completion of criminal background check including review of any criminal offenses and approval by the Utah Professional Practices Advisory Commission;

(2) Employment by an LEA;

(3) Completion of a one-year professional learning plan developed jointly by the school principal or charter school director and the returning educator consistent with R277-500 that also considers the following:

(a) previous successful public school teaching experience;

(b) formal educational preparation;

(c) period of time between last public teaching experience and the present;

(d) school goals for student achievement within the employing school and the educator's role in accomplishing those goals;

(e) returning educator's professional abilities, as determined by a formal discussion and observation process completed within the first 30 days of employment; and

(f) completion of additional necessary professional development for the educator, as determined jointly by the principal/school and educator.

(4) Filing of the professional development plan within 30 days of hire;

(5) Successful completion of required Board-approved exams for licensure;

(6) Satisfactory experience as determined by the LEA with a trained mentor; and

(7) Submission to the USOE of the completed and signed Return to Original License Level Application, available on the USOE Educator Quality and Licensing website prior to June 30 of the school year in which the educator seeks to return.

B. The Professional Learning Plan is independent of the License Renewal Point requirements in R277-500-3C.

C. Returning educators who previously held a Level 2 or Level 3 license shall be issued a Level 1 license during the first year of employment. Upon completion of the requirements listed in R277-502-6A and a satisfactory LEA evaluation, if available, the employing LEA may recommend the educator's return to Level 2 or Level 3 licensure.

D. Returning educators who taught less than three consecutive years in a public or accredited private school shall complete the Early Years Enhancement requirements before moving from Level 1 to Level 2 licensure.

R277-502-7. Professional Educator License Reciprocity.

A. Utah is a member of the Compact for Interstate Qualification of Educational Personnel under Section 53A-6-201.

B. A Level 1 license may be issued to an individual holding a professional educator license in another state who has completed preparation equivalent to Board-approved standards and who has completed Board-approved testing, as required by R277-503-3.

(1) If the applicant has three or more continuous years of previous educator experience in a public or accredited private school, a Level 2 license may be issued upon the recommendation of the employing Utah LEA after at least one year.

(2) If the applicant has less than three years of previous educator experience in a public or accredited private school, a Level 2 license may be issued following satisfaction of the requirements of R277-522, Entry Years Enhancements (EYE) for Quality Teaching - Level 1 Utah Teachers.

~~[R277-502-8. Comprehensive Administration of Credentials for Teachers in Utah Schools (CACTUS).~~

~~A. CACTUS maintains public, protected and private information on licensed Utah educators. Private or protected information includes such items as home address, date of birth, social security number, and any disciplinary action taken against an individual's license.~~

~~B. A CACTUS file shall be opened on a licensed Utah educator when:~~

~~(1) the individual initiates a USOE background check, or~~

~~(2) the USOE receives a paraprofessional license application from an LEA.~~

~~C. The data in CACTUS may only be changed as follows:~~

~~(1) Authorized USOE staff or authorized LEA staff may change demographic data.~~

~~(2) Authorized USOE staff may change licensing data such as endorsements, degrees, license areas of concentration and licensed work experience.~~

~~(3) Authorized employing LEA staff may update data on educator assignments for the current school year only.~~

~~D. A licensed individual may view his own personal data. An individual may not change or add data except under the following circumstances:~~

~~(1) A licensed individual may change his demographic data when renewing his license.~~

~~(2) A licensed individual shall contact his employing LEA for the purpose of correcting demographic or current educator assignment data.~~

~~(3) A licensed individual may petition the USOE for the purpose of correcting any errors in his CACTUS file.~~

~~E. Individuals currently employed by public or private schools under letters of authorization or as interns are included in CACTUS.~~

~~F. Individuals working in LEAs as student teachers are included in CACTUS.~~

~~G. Designated individuals have access to CACTUS data:~~

~~(1) Training shall be provided to designated individuals prior to granting access.~~

~~(2) Authorized USOE staff may view or change CACTUS files on a limited basis with specific authorization.~~

~~(3) For employment or assignment purposes only, authorized LEA staff members may access data on individuals employed by their own LEA or data on licensed individuals who do not have a current assignment in CACTUS.~~

~~(4) Authorized LEA staff may also view specific limited information on job applicants if the applicant has provided the LEA with a CACTUS identification number.~~

~~(5) CACTUS information belongs solely to the USOE. The USOE shall make the final determination of information included in or deleted from CACTUS.~~

~~(6) CACTUS data consistent with Section 63G-2-301(1) under the Government Records Access and Management Act are public information and shall be released by the USOE.~~

[R277-502-19]8. Professional Educator License Fees.

A. The Board shall establish a fee schedule for the issuance and renewal of licenses and endorsements consistent with 53A-6-105. All endorsements to which the applicant is entitled may

be issued or renewed with the same expiration date for one licensing fee.

B. A fee may be charged for a valid license to be reprinted or for an endorsement to be added.

C. All costs for testing, evaluation, and course work shall be borne by the applicant unless other arrangements are agreed to in advance by the employing LEA.

D. Costs to review nonresident educator applications may exceed the cost to review resident applications due to the following:

(1) The review is necessary to ensure that nonresident applicants' training satisfies Utah's course and curriculum standards.

(2) The review of nonresident licensing applications is time consuming and potentially labor intensive;

(3) Differentiated fees shall be set consistent with the time and resources required to adequately review all applicants for educator licenses.

KEY: professional competency, educator licensing
Date of Enactment or Last Substantive Amendment: ~~October 22, 2009~~ **2013**

Notice of Continuation: August 14, 2012

Authorizing, and Implemented or Interpreted Law: Art X Sec 3; 53A-6-104; 53A-1-401(3)

Education, Administration
R277-517
Board and UPPAC Disciplinary
Definitions and Actions

NOTICE OF PROPOSED RULE

(New Rule)

DAR FILE NO.: 37147

FILED: 12/31/2012

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: This purpose of this new rule is to provide criteria for Utah State Board of Education (Board) disciplinary actions against educator licenses to ensure protection of students' physical, emotional, academic and social well-being at school by all the adults who work for Utah public schools.

SUMMARY OF THE RULE OR CHANGE: The new rule provides definitions, procedures for Utah Professional Practices Advisory Commission (UPPAC) actions, procedures for Board receipt and review of UPPAC recommendations, and procedures for Board disciplinary actions.

STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Subsection 53A-1-401(3) and Subsection 53A-1-402(1)(a)

ANTICIPATED COST OR SAVINGS TO:

◆ **THE STATE BUDGET:** There is no anticipated cost or savings to the state budget. The changes are procedural for

UPPAC and the Board which do not result in a cost or savings.

◆ **LOCAL GOVERNMENTS:** There is no anticipated cost or savings to local government. This new rule provides procedures for UPPAC and the Board which do not result in a cost or savings to local government.

◆ **SMALL BUSINESSES:** There is no anticipated cost or savings to small businesses. This new rule applies to public education and does not affect businesses.

◆ **PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES:** There is no anticipated cost or savings to persons other than small businesses, businesses, or local government entities. This rule provides procedures for UPPAC and the Board and does not affect individuals.

COMPLIANCE COSTS FOR AFFECTED PERSONS: There are no compliance costs for affected persons. The rule provides procedures for UPPAC and the Board to follow when disciplining licensed educators.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: I have reviewed this rule and I see no fiscal impact on businesses.

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 by phone at 801-538-7835, by FAX at 801-538-7768, or by Internet E-mail at carol.lear@schools.utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN AT 5:00 PM ON 02/14/2013

THIS RULE MAY BECOME EFFECTIVE ON: 02/21/2013

AUTHORIZED BY: Carol Lear, Director, School Law and Legislation

R277. Education, Administration.

R277-517. Board and UPPAC Disciplinary Definitions and Actions.

R277-517-1. Definitions.

A. "Administrative hearing" means a formal adjudicative proceeding consistent with 53A-6-601. The Utah State Board of Education and Utah State Office of Education licensing process is not governed by the Utah Administrative Procedures Act Section 63G-4.

B. "Board" means the Utah State Board of Education.

C. "Comprehensive Administration of Credentials for Teachers in Utah Schools (CACTUS)" means the electronic file owned and maintained on all licensed Utah educators. The file includes information such as:

- (1) personal directory information;
- (2) educational background;
- (3) endorsements;
- (4) employment history; and
- (5) a record of disciplinary action taken against the educator.

D. "Educator paper licensing file" means the file maintained securely by UPPAC on an educator. The file is opened following UPPAC's direction to investigate alleged misconduct. The file contains the original complaint, subsequent correspondence and the final disposition of the case.

E. "Revocation" means a permanent invalidation of a Utah educator license.

F. "Stipulated agreement" means an agreement between a respondent/educator and the Board or between a respondent/educator and UPPAC under which disciplinary action against an educator's license status will be taken, in lieu of a hearing. At any time after an investigative letter has been sent, a stipulated agreement may be negotiated between the parties and becomes binding when approved by the Board.

G. "Suspension" means an invalidation of a Utah educator license. A suspension may include specific conditions that an educator shall satisfy and shall identify a minimum time period that shall elapse before the educator can request a reinstatement hearing before UPPAC.

H. "Utah Professional Practices Advisory Commission (Commission or UPPAC)" means a commission established to assist and advise the Board in matters relating to the professional practices of educators, as established under Section 53A-6-301.

I. "UPPAC disciplinary letters or action" means letters sent or action taken by UPPAC informing the educator of licensing disciplinary action not rising to the level of license suspension. Disciplinary letters and action include the following:

(1) Letter of admonishment is a letter sent by UPPAC to the educator cautioning the educator to avoid or take specific actions in the future;

(2) Letter of warning is a letter sent by UPPAC to an educator for misconduct that was inappropriate or unethical that does not warrant longer term or more serious discipline;

(3) Letter of reprimand is a letter sent by UPPAC to an educator for misconduct that was longer term or more seriously unethical or inappropriate than conduct warranting a letter of warning, but not warranting more serious discipline;

(4) Probation is an action directed by UPPAC for an indefinite or designated time period usually accompanied by a disciplinary letter.

J. "UPPAC investigative letter" means a letter sent by UPPAC to an educator notifying the educator that an allegation of misconduct has been received against him and UPPAC has directed that an investigation of the educator's alleged actions take place.

K. "USOE" means the Utah State Office of Education.

R277-517-2. Authority and Purpose.

A. This rule is authorized by Utah Constitution Article X, Section 3 which vests the general control and supervision of the

public schools in the Board, by Section 53A-1-402(1)(a) which directs the Board to make rules regarding the certification of educators, by Section 53A-6 which establishes provisions related to educator licensing and professional practices, and by Section 53A-1-401(3) which allows the Board to adopt rules in accordance with its responsibilities.

B. The purpose of this rule is to:

(1) provide standards and procedures to ensure protection of students' physical, emotional, academic and social well-being at school by all the adults who work for Utah public schools.

(2) provide definitions and provisions explaining UPPAC actions and recommendations that do not rise to the level of action against an educator's license and to provide definitions and criteria for Board disciplinary actions against educator licenses.

R277-517-3. UPPAC Disciplinary Actions.

A. UPPAC is an advisory body to the Board.

B. Unlike Board action, a UPPAC action does not affect the validity of a Utah educator license.

C. UPPAC may issue the following disciplinary actions:

(1) Letter of admonishment;

(a) sent directly to the educator;

(b) cautioning the educator to avoid or take specific actions in the future;

(c) does not show as a notation on CACTUS;

(d) is maintained permanently in educator's paper licensing file.

(2) Letter of warning;

(a) sent directly to the educator;

(b) warns the educator that specific behavior or conduct was inappropriate or unethical and directs the educator to avoid or take specific actions in the future;

(c) does not show as a notation on CACTUS;

(d) is maintained permanently in educator's paper licensing file;

(e) notice sent by UPPAC to employer or former employer that investigation was closed with a letter of warning.

(3) Letter of reprimand;

(a) sent to educator and to educator's employer or former employer, if the employer is a public or private school;

(b) strongly reprimands the educator that specific behavior or conduct was unethical or unacceptable among professional educators and directing the educator to avoid or take specific action in the future;

(c) shows as a notation on educator's CACTUS file which directs those with CACTUS access to contact USOE for further information;

(d) often, but not always, includes a period of probation during which educator must meet specific conditions;

(e) remains as a notation on educator's CACTUS file for at least two years from the date of UPPAC action unless a different time period is identified by the reprimand letter or in the stipulated agreement for the letter;

(f) is maintained permanently in educator's paper licensing file.

(g) may be removed from educator's active CACTUS file, upon educator's request, following designated time period and satisfaction of conditions by educator. UPPAC shall review the

request, review educator's file and subsequent actions and may require educator to meet with UPPAC prior to granting the request:

(4) probation:

(a) usually, but not always, accompanies a warning or reprimand letter and

(b) designates time period and conditions that educator receiving other UPPAC discipline may be asked to satisfy prior to lifting of the probation or to avoid further UPPAC discipline;

(c) shows as a notation on an educator's CACTUS file and directs those with CACTUS access to contact USOE for further information.

(d) remains on educator's CACTUS file for at least 2 years from the date of UPPAC action unless a different time period is designated;

(e) may be lifted upon educator's request following designated time period and satisfaction of all conditions; UPPAC shall review the request, review educator's file and subsequent action and may require educator to meet with UPPAC prior to granting the request;

(5) other disciplinary action or letter that is appropriate and reasonable to address or remediate educator misconduct, or both, that is not suspension or revocation.

D. UPPAC shall make written recommendations to the Board for disciplinary actions that affect educator licenses including suspension, revocation and reinstatement.

E. UPPAC action is a final administrative action for those disciplinary actions found in R277-517-3C, and the existence of such action is public information under Section 63G-2-201(2)(c). The substance of disciplinary letters is protected under Section 63G-2-305(25), (33) and (34).

F. UPPAC shall send notice of final UPPAC action to an educator no more than 30 days following a final UPPAC action.

G. UPPAC shall not provide information to the public about UPPAC actions until they have been reviewed or acted upon or both by the Board.

R277-517-4. Board Receipt and Review of UPPAC Recommendations.

A. The Board shall review UPPAC recommendations for suspension, revocations, reinstatements, and other disciplinary actions upon request in executive sessions consistent with Section 52-4-204 through 206.

B. UPPAC shall make Hearing Reports and stipulated agreements available for a confidential review by Board members prior to and during the Board's discussion of cases.

C. UPPAC shall make case files, hearing recordings and exhibits available for review by Board members as directed by the Board.

D. UPPAC shall forward the completed UPPAC Recommendation Report Form to the Board for its consideration.

E. If the Board takes final action to accept the recommendations of a UPPAC hearing report, the final hearing report is a public record, but may be redacted prior to release to protect the names of students or information consistent with Section 63G-2-202(3).

F. If the Board does not accept a UPPAC recommendation, the Board shall prepare written findings and conclusions based on the record and take any other action consistent with procedures in R277-514-4C, and provide the findings to the

educator consistent with R277-517-5D and E, below. The Board findings and conclusions are a public record, but may be redacted prior to release to protect the names of students or information consistent with Section 63G-2-202(3).

G. The Board shall initially review UPPAC recommendations at the next regularly scheduled Board meeting following receipt of written recommendations.

R277-517-5. Board Disciplinary Actions.

A. Board disciplinary actions:

(1) The Board may suspend an educator's license consistent with R277-517-1G:

(a) A suspension may be recommended by a Stipulated Agreement negotiated between UPPAC and an educator; or

(b) A suspension may be recommended following an administrative hearing under the provisions of R686-100;

(c) A suspension may include specific conditions which shall be satisfied by the educator prior to requesting a reinstatement hearing from UPPAC under R686-100;

(d) If a complaint is filed against an educator and the educator fails to respond to the complaint, the Board may suspend the educator's license. This action may be taken only if UPPAC has documentation of attempts to contact the educator, consistent with 686-100.

(e) A suspension shall provide a minimum time period after which the educator may request a reinstatement hearing from UPPAC.

(2) The Board may revoke an educator's license:

(a) A revocation is permanent, except as provided under R277-517-4(2)(c) below;

(b) A revocation is required under Section 53A-6-405(2);

(c) An individual whose license has been revoked may seek reinstatement of his license only in the following limited circumstances:

(i) the individual provides evidence of mistake or false information that was critical to the revocation action;

(ii) the individual identifies material procedural UPPAC or Board error in the revocation process.

(3) The Board may reinstate an educator's license:

(a) An educator may request a reinstatement hearing following a license suspension. The reinstatement request shall be made consistent with R686-100.

(b) An educator has a reasonable expectation of a reinstatement hearing, consistent with due process and reinstatement hearing conditions set by UPPAC, but no expectation of license reinstatement by the Board.

(c) An educator whose license has been suspended and the reinstatement denied by the Board may request an additional reinstatement hearing once every 24 months unless otherwise directed by the Board.

(d) An educator requesting a reinstatement hearing shall have a criminal background check, that was conducted not more than six months prior to the requested hearing, on file with the USOE. The background check and review of any offenses must be completed prior to reinstatement.

(e) Prior to sending a reinstatement recommendation to the Board for its consideration, UPPAC shall provide evidence to the Board of its consideration of Board-identified criteria central to the Board's authority to reinstate an educator's license.

D. The Board has sole discretion in final administrative decisions.

E. The Board shall send written notice to an educator of Board action no more than 30 days following the Board's final action.

F. The Board shall send written notice of an educator's license suspension or revocation to an educator's former employer if the employer was a public or private school.

KEY: educator, professional, standards

Date of Enactment or Last Substantive Amendments: 2013

Authorizing, and Implemented or Interpreted Law: Art X Sec 3; 53A-1-402(1)(a); 53A-6; 53A-1-401(3)

Health, Health Care Financing, Coverage and Reimbursement Policy **R414-1-5** Incorporations by Reference

NOTICE OF PROPOSED RULE

(Amendment)

DAR FILE NO.: 37122

FILED: 12/28/2012

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: Subsection 26-18-3(2)(a) requires the Medicaid program to implement policy through administrative rules. The Department, in order to draw down federal funds, must have an approved State Plan with the Centers for Medicare and Medicaid Services (CMS). The purpose of this change, therefore, is to incorporate the most current Medicaid State Plan by reference and to implement by rule both the definitions and the attachment for the Private Duty Nursing Acuity Grid found in the Home Health Agencies Provider Manual, and to implement by rule ongoing Medicaid policy for services described in the Utah Medicaid Provider Manual, Medical Supplies Manual and List; Hospital Services Provider Manual; Speech-Language Services Provider Manual; Audiology Services Provider Manual; Hospice Care Provider Manual; Long Term Care Services in Nursing Facilities Provider Manual; Personal Care Provider Manual; Utah Home and Community-Based Waiver Services for Individuals 65 or Older Provider Manual; Utah Home and Community-Based Waiver Services for Individuals with Acquired Brain Injury Age 18 and Older Provider Manual; Utah Home and Community-Based Waiver Services for Individuals with Intellectual Disabilities or Other Related Conditions Provider Manual; Utah Home and Community-Based Waiver Services for Individuals with Physical Disabilities Provider Manual; Utah Home and Community-Based Waiver Services New Choices Waiver Provider Manual; Utah Home and Community-Based Waiver Services for Technology Dependent, Medically Fragile Individuals Provider Manual; the Office of Inspector General Administrative Hearings

Procedures Manual; the Pharmacy Services Provider Manual; and the Coverage and Reimbursement Code Look-up Tool.

SUMMARY OF THE RULE OR CHANGE: Section R414-1-5 is changed to update the incorporation of the State Plan by reference to 01/01/2013 which includes any approved State Plan Amendments (SPAs). SPAs that became effective during the fourth quarter of Calendar Year 2012 include SPA 12-011-UT, Nursing Facility Evacuation Payments, which adds wording to define how payments to facilities will be administered and what payment limits will be in place during a time of a declared disaster; SPA 12-013-UT, Reimbursement for Optometry Services, which clarifies reimbursement methodology and changes the effective date of rates for optometry from 07/01/2007, to 07/01/2012; SPA 12-014-UT, Reimbursement for Speech Pathology Services, which clarifies reimbursement methodology and changes the effective date of rates for speech pathology from 11/01/2008 to 07/01/2012; SPA 12-015-UT, Reimbursement for Audiology Services, which clarifies reimbursement methodology and changes the effective date of rates for audiology from 11/01/2008, to 07/01/2012; SPA 12-016-UT, Reimbursement for Chiropractic Services, which clarifies reimbursement methodology and changes the effective date of rates for chiropractic services from 11/01/2008, to 07/01/2012; SPA 12-017-UT, Reimbursement for Eyeglasses Services, which clarifies reimbursement methodology and changes the effective date of rates for eyeglasses from 07/01/2007 to 07/01/2012; SPA 12-018-UT, Reimbursement for Clinic Services, which clarifies reimbursement methodology and changes the effective date of rates for clinic services from 05/25/2010 to 07/01/2012. This SPA also clarifies services and limitations in freestanding birth centers; SPA 12-019-UT, Reimbursement for Physical and Occupational Therapy, which changes the effective date of rates for physical therapy and occupational therapy from 07/01/2009 to 07/01/2012; and SPA 12-020-UT, Reimbursement for Rehabilitative Mental Health Services, which clarifies reimbursement methodology and changes the effective date of rates for rehabilitative mental health services from 01/01/2002 to 07/01/2012. This rule change also incorporates by reference the Medical Supplies Manual and List and the hospital services provider manual, effective 01/01/2013; incorporates by reference both the definitions and the attachment for the Private Duty Nursing Acuity Grid found in the Home Health Agencies Provider Manual, effective 01/01/2013; incorporates by reference the Speech-Language Services Provider Manual, effective 01/01/2013; incorporates by reference the Audiology Services Provider Manual, effective 01/01/2013; incorporates by reference the Hospice Care Provider Manual, effective 01/01/2013; incorporates by reference the Long Term Care Services in Nursing Facilities Provider Manual, with its attachments, effective 01/01/2013; incorporates by reference the Utah Home and Community-Based Waiver Services for Individuals 65 or Older Provider Manual, effective 01/01/2013; incorporates by reference the Personal Care Provider Manual, with its attachments, effective 01/01/2013; incorporates by reference the Utah Home and Community-Based Waiver Services for Individuals with Acquired Brain

Injury Age 18 and Older Provider Manual, effective 01/01/2013; incorporates by reference the Utah Home and Community-Based Waiver Services for Individuals with Intellectual Disabilities or Other Related Conditions Provider Manual, effective 01/01/2013; incorporates by reference the Utah Home and Community-Based Waiver Services for Individuals with Physical Disabilities Provider Manual, effective 01/01/2013; incorporates by reference the Utah Home and Community-Based Waiver Services New Choices Waiver Provider Manual, effective 01/01/2013; incorporates by reference the Utah Home and Community-Based Waiver Services for Technology Dependent, Medically Fragile Individuals Provider Manual, effective 01/01/2013; the Office of Inspector General Administrative Hearings Procedures Manual, effective 01/01/2013; the Pharmacy Services Provider Manual with its attachments, effective 01/01/2013; and the Coverage and Reimbursement Code Look-up Tool, effective 01/01/2013.

STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 26-1-5 and Section 26-18-3

MATERIALS INCORPORATED BY REFERENCES:

- ◆ Updates Utah Home and Community-Based Waiver Services for Individuals with Acquired Brain Injury Age 18 and Older Provider Manual, published by Division of Medicaid and Health Financing, 01/01/2013
- ◆ Updates Utah Medicaid State Plan, published by Centers for Medicare and Medicaid Services, 01/01/2013
- ◆ Updates Speech-Language Services Provider Manual, published by Division of Medicaid and Health Financing, 01/01/2013
- ◆ Updates Utah Home and Community-Based Waiver Services New Choices Waiver Provider Manual, published by Division of Medicaid and Health Financing, 01/01/2013
- ◆ Updates Personal Care Provider Manual, with its attachments, published by Division of Medicaid and Health Financing, 01/01/2013
- ◆ Updates Pharmacy Services Provider Manual with its attachments, published by Division of Medicaid and Health Financing, 01/01/2013
- ◆ Updates Utah Home and Community-Based Waiver Services for Individuals with Physical Disabilities Provider Manual, published by Division of Medicaid and Health Financing, 01/01/2013
- ◆ Updates Definitions and the Attachment for the Private Duty Nursing Acuity Grid in the Home Health Agencies Provider Manual, published by Division of Medicaid and Health Financing, 01/01/2013
- ◆ Updates Office of Inspector General Administrative Hearings Procedures Manual, published by Office of Inspector General, 01/01/2013
- ◆ Updates Audiology Services Provider Manual, published by Division of Medicaid and Health Financing, 01/01/2013

- ◆ Updates Utah Home and Community-Based Waiver Services for Individuals with Intellectual Disabilities or Other Related Conditions Provider Manual, published by Division of Medicaid and Health Financing, 01/01/2013
- ◆ Updates Utah Home and Community-Based Waiver Services for Individuals 65 or Older Provider Manual, published by Division of Medicaid and Health Financing, 01/01/2013
- ◆ Updates Long Term Care Services in Nursing Facilities Provider Manual, with its attachments, published by Division of Medicaid and Health Financing, 01/01/2013
- ◆ Updates Hospice Care Provider Manual, published by Division of Medicaid and Health Financing, 01/01/2013
- ◆ Updates Hospital Services Provider Manual, with its attachments, published by Division of Medicaid and Health Financing, 01/01/2013
- ◆ Adds Coverage and Reimbursement Code Look-up Tool, published by Division of Medicaid and Health Financing, 01/01/2013
- ◆ Updates Utah Home and Community-Based Waiver Services for Technology Dependent, Medically Fragile Individuals Provider Manual, published by Division of Medicaid and Health Financing, 01/01/2013
- ◆ Updates Utah Medicaid Provider Manual, Medical Supplies Manual and List, published by Centers for Medicare and Medicaid Services, 01/01/2013

ANTICIPATED COST OR SAVINGS TO:

- ◆ **THE STATE BUDGET:** There is no budget impact because this change only fulfills the requirement to incorporate the State Plan by reference. Implementation of the State Plan is within legislative budget allotments. Further, the rule's incorporation of ongoing Medicaid policy described in the provider manuals does not create costs or savings to the Department or other state agencies.
- ◆ **LOCAL GOVERNMENTS:** There is no budget impact because this change only fulfills the requirement to incorporate the State Plan by reference. Implementation of the State Plan is within legislative budget allotments. Further, the rule's incorporation of ongoing Medicaid policy described in the provider manuals does not create costs or savings to local governments.
- ◆ **SMALL BUSINESSES:** There is no budget impact because this change only fulfills the requirement to incorporate the State Plan by reference. Implementation of the State Plan is within legislative budget allotments. Further, the rule's incorporation of ongoing Medicaid policy described in the provider manuals does not create costs or savings to small businesses.
- ◆ **PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES:** There is no budget impact because this change only fulfills the requirement to incorporate the State Plan by reference. Implementation of the State Plan is within legislative budget allotments. Further, the rule's incorporation of ongoing

Medicaid policy described in the provider manuals does not create costs or savings to other persons or entities.

COMPLIANCE COSTS FOR AFFECTED PERSONS: There are no compliance costs because this change only fulfills the requirement to incorporate the State Plan by reference. Implementation of the State Plan is within legislative budget allotments. Further, the rule's incorporation of ongoing Medicaid policy described in the provider manuals does not create costs or savings to a single Medicaid recipient or provider.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: This rule should not have a direct fiscal impact on business. Incorporation of the State Plan by this rule assures that the Medicaid program is implemented through administrative rule.

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 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 NO LATER THAN AT 5:00 PM ON 02/14/2013

THIS RULE MAY BECOME EFFECTIVE ON: 02/21/2013

AUTHORIZED BY: David Patton, PhD, Executive Director

R414. Health, Health Care Financing, Coverage and Reimbursement Policy.

R414-1. Utah Medicaid Program.

R414-1-5. Incorporations by Reference.

The Department incorporates the [~~October~~]January 1, 201[~~2~~]3 versions of the following by reference:

(1) Utah State Plan, including any approved amendments, under Title XIX of the Social Security Act Medical Assistance Program;

(2) Medical Supplies Manual and List described in the Utah Medicaid Provider Manual, Section 2, Medical Supplies, with its referenced attachment, Medical Supplies List, as applied in Rule R414-70;

(3) Hospital Services Provider Manual with its attachments;

(4) Definitions and the attachment for the Private Duty Nursing Acuity Grid found in the Home Health Agencies Provider Manual;

(5) Speech-Language Services Provider Manual;
(6) Audiology Services Provider Manual;
(7) Hospice Care Provider Manual;
(8) Long Term Care Services in Nursing Facilities Provider Manual with its attachments;

(9) Personal Care Provider Manual with its attachments;
(10) Utah Home and Community-Based Waiver Services for Individuals 65 or Older Provider Manual;

(11) Utah Home and Community-Based Waiver Services for Individuals with Acquired Brain Injury Age 18 and Older Provider Manual;

(12) Utah Home and Community-Based Waiver for Individuals with Intellectual Disabilities or Other Related Conditions Provider Manual;

(13) Utah Home and Community-Based Waiver Services for Individuals with Physical Disabilities Provider Manual;

(14) Utah Home and Community-Based Waiver Services New Choices Waiver Provider Manual;

(15) Utah Home and Community-Based Waiver Services for Technology Dependent, Medically Fragile Individuals Provider Manual;

(16) Office of Inspector General Administrative Hearings Procedures Manual; and

(17) Pharmacy Services Provider Manual with its attachments.

(18) Coverage and Reimbursement Code Look-up Tool found at <http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php>.

KEY: Medicaid

Date of Enactment or Last Substantive Amendment: [~~November 30, 2012~~]2013

Notice of Continuation: March 2, 2012

Authorizing, and Implemented or Interpreted Law: 26-1-5; 26-18-3; 26-34-2

Human Services, Recovery Services
R527-258
Enforcing Child Support When the
Obligor is an Ex-Prisoner or in a
Treatment Program

NOTICE OF PROPOSED RULE

(Amendment)

DAR FILE NO.: 37113

FILED: 12/18/2012

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The purpose of this amendment is to delete the reference to Section 78B-12-212, which deals with medical expenses and add Section 62A-11-326.1, 45 CFR 303.31, and 45 CFR 303.32, which support the office enforcing an order with a medical support provision.

SUMMARY OF THE RULE OR CHANGE: This change deletes the Section 78B-12-212 reference in the Authorizing, and Implemented or Interpreted Law section and adds Section 62A-11-326.1, 45 CFR 303.31, and 45 CFR 303.32.

STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: 45 CFR 303.31 and 45 CFR 303.32 and Section 62A-11-107 and Section 62A-11-326.1 and Subsection 62A-11-320(1)

ANTICIPATED COST OR SAVINGS TO:

◆ THE STATE BUDGET: There are no anticipated costs to the state budget because the change to the rule is only to delete a Utah Code Annotated reference and add one new state law reference and two federal regulations, which support the office enforcing an order with a medical support provision.

◆ LOCAL GOVERNMENTS: Administrative rules of the Office of Recovery Services/Child Support Services (ORS/CSS) do not apply to local government; therefore, there are no anticipated costs or savings for any local businesses due to this amendment.

◆ SMALL BUSINESSES: There are no anticipated costs for small businesses because the change to the rule is only to delete a Utah Code Annotated reference and add one new state law reference and two federal regulations, which support the office enforcing an order with a medical support provision.

◆ PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES: There are no anticipated costs for persons because the change to the rule is only to delete a Utah Code Annotated reference and add one new state law reference and two federal regulations, which support the office enforcing an order with a medical support provision.

COMPLIANCE COSTS FOR AFFECTED PERSONS: There are no costs as the change to the rule is only to delete a Utah Code Annotated reference and add one new state law reference and two federal regulations, which support the office enforcing an order with a medical support provision.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: There is no fiscal impact to businesses as the change to the rule is only to delete a Utah Code Annotated reference and add one new state law reference and two federal regulations, which support the office enforcing an order with a medical support provision.

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:

◆ LeAnn Wilber by phone at 801-536-8950, by FAX at 801-536-8509, or by Internet E-mail at lwilber@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN AT 5:00 PM ON 02/14/2013

THIS RULE MAY BECOME EFFECTIVE ON: 02/21/2013

AUTHORIZED BY: Mark Brasher

**R527. Human Services, Recovery Services.
R527-258. Enforcing Child Support When the Obligor is an Ex-Prisoner or in a Treatment Program.**

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KEY: administrative law, child support
Date of Enactment or Last Substantive Amendment:
[November 3, 2009]2013
Notice of Continuation: June 12, 2012
Authorizing, and Implemented or Interpreted Law: [78B-12-212;]62A-11-107; 62A-11-320(1); 62A-11-326.1; 45 CFR 303.31; 45 CFR 303.32

**Human Services, Services for People
With Disabilities
R539-3
Rights and Protections**

**NOTICE OF PROPOSED RULE
(Amendment)
DAR FILE NO.: 37163
FILED: 12/31/2012**

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: New technology allows for electronic surveillance of persons and programs. In some cases such surveillance is necessary to assure the health and safety of persons in care. The Division wants to assure the maximum amount of privacy is maintained for persons under such surveillance. The rule also reflects the Division's address change and eliminates references to administrative regions that no longer exist.

SUMMARY OF THE RULE OR CHANGE: The additional language in the rule adds privacy protection guidelines for use of electronic surveillance when monitoring persons with disabilities.

STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 62A-5-102 and Section 62A-5-103

ANTICIPATED COST OR SAVINGS TO:

◆ **THE STATE BUDGET:** This rule affects providers by requiring criteria for the use of electronic surveillance should they choose to use such a system. Therefore no cost increase is expected in the state budget.

◆ **LOCAL GOVERNMENTS:** This rule affects providers by requiring criteria for the use of electronic surveillance should they choose to use such a system. Therefore no cost increase is expected for local governments. The disability program is run through private contractor provider networks and imposes no burden on local governments.

◆ **SMALL BUSINESSES:** The Division is not requiring the use of electronic surveillance. While some costs associated with meeting criteria for electronic surveillance privacy measures may be incurred, the rule does not dictate that any electronic surveillance is required. Costs to providers are on an elective basis. Requirements listed in this change are minimal and required for the person's privacy and to meet existing rules and regulations.

◆ **PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES:** This rule provides privacy protections ensuring that persons cannot be electronically surveilled without prior written consent and approval by the Human Rights Committee. Protections are at no cost to the person.

COMPLIANCE COSTS FOR AFFECTED PERSONS: No costs expected to affect persons with disabilities, person's families or guardians as part of this rule change.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: There will be no costs or savings associated with this rule.

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

HUMAN SERVICES
SERVICES FOR PEOPLE WITH DISABILITIES
195 N 1950 W 3RD FLR
SALT LAKE CITY, UT 84116
or at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:

◆ Julene Jones by phone at 801-538-4521, by FAX at 801-538-3942, or by Internet E-mail at jhjones@utah.gov
◆ Nathan Wolfley by phone at 801-538-4154, by FAX at 801-538-4279, or by Internet E-mail at nwolfley@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN AT 5:00 PM ON 02/14/2013

THIS RULE MAY BECOME EFFECTIVE ON: 02/21/2013

AUTHORIZED BY: Paul Smith, Director

R539. Human Services, Services for People with Disabilities.**R539-3. Rights and Protections.****R539-3-1. Purpose.**

(1) The purpose of this rule is to support Persons in exercising their rights as Persons receiving funding from the Division. The procedures of this rule constitute the minimum rights for Persons receiving Division funded services and supports.

R539-3-2. Authority.

(1) This rule establishes procedures and standards for the protection of Persons' constitutional liberty interests as required by Subsection 62A-5-103(2)(b).

R539-3-3. Definitions.

(1) Terms used in this rule are defined in Section 62A-5-101 and R539-1-3.

R539-3-4. Human Rights Committee.

(1) This rule applies to the Division, Persons funded by the Division, Providers, Providers' Human Rights Committees, and the Division Human Rights Council.

(2) All Persons shall have access to a Provider Human Rights Committee with the exception of the following:

- (a) Persons receiving physical disabilities services.
- (b) Families using the Self-Administered Model.
- (c) Persons receiving only family supports or respite.

(3) The Provider Human Rights Committee approves the services agencies provide relating to rights issues, such as rights restrictions and the use of intrusive behavior supports. In addition, the Committee provides recommendations relating to abuse and neglect prevention, rights training, and supporting people in exercising their rights.

(4) Any interested party may request that the rights of a Person be reviewed by a Provider Human Rights Committee by contacting the Person's Provider agency verbally or in writing.

(5) Any interested party may request an appeal of the Provider Human Rights Committee decision by sending a request to the Division, [~~120 North 200 West #411, SLC UT 84103~~]195 North 1950 West, Salt Lake City, UT 84116. The Division shall make a decision whether there will be a review and shall notify the Person, Provider, and Support Coordinator concerning the decision within eight business days. The notification shall contain a statement of the issue to be reviewed and the process and timeline for completing the review.

R539-3-5. Representative Payee Services.

(1) Unless a Person voluntarily signs the Division Voluntary Financial Support Agreement Form 1-3 or a Provider Human Rights Committee has approved restriction on the use and access to personal funds, the Person shall have access to and control over such funds.

(2) The Representative Payee shall follow all Social Security Administration requirements outlined in 20CFR416.601-665.

(3) The Division shall review Provider records for a sample of Representative Payee files on an annual basis.

(4) If the Department does not have guardianship or conservatorship and the Division has not been named as Representative Payee by the Social Security Administration, the Person may sign a Voluntary Financial Support Agreement, Division Form 1-3, allowing the Department to act as Representative Payee.

(5) If the Division is acting as the Representative Payee for a Person, the Division may initiate termination of a Representative Payee relationship through written notification to the Person and the funding agency.

(a) The Division shall initiate termination of a Representative Payee arrangement when:

(i) a Person with a voluntary arrangement requests termination of Representative Payee status;

(ii) a funding agency requests termination of Representative Payee status;

(iii) Person with a Representative Payee becomes ineligible for funding; or

(iv) a Person moves out of the service area.

R539-3-6. Personal Property.

(1) Restrictions to property that are implemented by the Division or Provider shall be part of a written plan or as an Emergency Behavior Intervention in accordance with Division Administrative Rule. Restrictions shall be approved by the Team and Provider Human Rights Committee.

R539-3-7. Privacy.

(1) Persons shall have privacy, including private communications (i.e. mail, telephone calls and private conversations), personal space, personal information, and self-care practices (i.e. dressing, bathing, and toileting).

(2) Restrictions to privacy that are implemented by the Division or Provider shall be part of a written plan and approved by the Team and Provider Human Rights Committee. Circumstances that require assistance in self-care due to functional limitations do not require a written plan.

(3) No Person shall be subject to electronic surveillance of any kind without:

(a) express written consent from the Person to be under surveillance and the Person's guardian;

(b) approval of both the Person's Team and the Provider Human Rights Committee;

(c) certification by the Provider Human Rights Committee that the electronic surveillance meets a necessary health or safety concern and is done in the least intrusive manner possible; and

(d) submission of Electronic Surveillance Certification to DSPD Quality Manager.

(4) Electronic surveillance shall not be placed in common areas without:

(a) express written consent from all Persons who live at the site, and the guardians of those Persons;

(b) approval of the Provider Human Rights Committee;

(c) certification by the Provider Human Rights Committee that the electronic surveillance meets a necessary health or safety concern and is done in the least intrusive manner possible; and

(d) submission of Electronic Surveillance Certification to DSPD Quality Manager.

(5) Under no circumstances shall electronic surveillance be used by administrative or supervisory staff as a substitute for direct supervision of Persons or employees providing direct care to Persons.

(6) Visitors shall be provided with notice of electronic surveillance upon entering the premises.

(a) Notice shall be provided by placing a sign of substantial size, in a conspicuous location, so as to attract the attention of visitors as they enter.

(7) The Person's Team and the Provider Human Rights Committee shall conduct reviews of electronic surveillance:

(a) at least annually; and

(b) in response to specific requests for review from the Person under surveillance or that Person's guardian.

(8) Electronic surveillance at the Utah State Developmental Center shall comply with federal regulations outlined in 42 C.F.R. 483.420(a)(7) (2011), 42 C.F.R. 483.440(f)(3) (i)-(iii) (2011) and 42 C.F.R. 483.470(d)(2) (2011).

R539-3-8. Notice of Agency Action and Administrative Hearings.

(1) Persons have the right to receive adequate written Notice of Agency Action and to present grievances about agency action by requesting a formal or informal administrative hearing in accordance with R497-100 for Persons receiving non-Waiver services, and R410-14 for Persons receiving Waiver services.

(2) Pursuant to Utah Code Annotated, Title 63G, Chapter 4, the Division shall notify a Person in writing before taking any agency action, such as changes in funding, eligibility, or services.

(3) At least 30 calendar days before the Division [~~or the Region~~]terminates or reduces a Person's services or benefits, the Division [~~or Region~~]shall send the Person a written Notice of Agency Action.

(4) The Notice of Agency Action shall comply with Subsection 63G-4-201 and R497-100-4(2)(a).

(5) To assist a Person in requesting an administrative hearing, the Division [~~or Region~~]shall send the Person a Hearing Request Form 490S when the Division [~~or Region~~]sends the Notice of Agency Action Form 522.

(6) To request an informal hearing with the Department of Human Services for non-waiver services, the Person must file a Hearing Request Form 490S with the Division within 30 calendar days of the mailing date shown on the Notice of Agency Action Form 522.

(7) To request a formal hearing with the Department of Health for Waiver services, the Person must file the Medicaid Standard Hearing Request Form with the Division and Department of Health, Division of Health Care Finance within 30 calendar days of the mailing date shown on the Notice of Agency Action Form 522.

(8) This 30-day deadline for formal and informal hearings applies regardless of whether the Person also wishes to participate in the Division's conflict resolution process.

(a) If the Person files the Hearing Request within ten calendar days of the mailing date of the Notice of Agency Action, the Person's services shall continue unchanged during the formal or informal hearing process.

(b) If the Person files the Hearing Request Form between 11 and 30 calendar days after the mailing date of the Notice of Agency Action, the Person is entitled to an administrative hearing, but the Person's services and benefits shall be discontinued or reduced according to the Notice of Agency Action during the formal or informal hearing process.

(9) A Person may file a Request for Hearing Form for a formal or informal hearing and choose to still participate in the

Division's conflict resolution process prior to the formal or informal hearing.

(10) If the Person requests an informal hearing and also chooses the conflict resolution process, the conflict resolution process must be completed before the informal hearing can begin, unless the Person submits a written request to the Division to end the conflict resolution process prematurely.

R539-3-9. Participation in Hospice Services.

(1) Persons expected by their physicians to live fewer than six months have the right to pursue hospice services as their choice of end-of-life care. A Person who is expected by two physicians to live fewer than six months and who receives Division funding for services and supports may request to continue to receive their Division-funded services and supports while participating in hospice services.

(2) If a Person has not executed a Durable Power of Attorney for Health Care and is incapable of making an informed decision about hospice services or signing a Hospice Agreement, choices related to end-of-life care shall be made on behalf of the Person by the Team upon approval of the Provider Human Rights Committee unless a guardian has been appointed by the Court with the legal authority to make end-of-life decisions for the Person.

(3) If a Person receives Waiver services through the Division and elects the Medicaid hospice benefit and meets the program eligibility requirements in accordance with R414-14A-3, hospice shall become the primary service delivery program, including the primary case management program, for the care of the Person. All other Medicaid programs serving the Person at the time of hospice election, including Waivers, shall coordinate with the hospice case management team to determine the full scope of services that shall be provided from that point forward.

(a) Pursuant to R414-14A-7(A), a Person can continue to receive Division services through the Waiver program that are necessary to prevent institutionalization, are not duplicative of services covered by the hospice benefit, and do not conflict with the hospice plan of treatment.

(b) The Medicaid hospice benefit shall determine the actual number of times a Person can revoke and re-elect hospice services, which hospice Providers and services are available, and which Waiver services may continue concurrently with hospice services.

(c) If the Division wishes to initiate disenrollment of a Medicaid-funded Person from the Waiver based on the Person's election of hospice services, it shall be considered an involuntary disenrollment and will be subject to review and approval by the Department of Health, Division of Health Care Finance.

R539-3-10. Prohibited Procedures.

(1) The following procedures are prohibited for Division staff and Providers, including staff hired for Self-Administered Services, in all circumstances in supporting Persons receiving Division funding:

(a) Physical punishment, such as slapping, hitting, and pinching.

(b) Demeaning speech to a Person that ridicules or is abusive.

(c) Locked confinement in a room.

(d) Denial or restriction of access to assistive technology devices, except where removal prevents injury to self, others, or property as outlined in Section R539-3-6.

(e) Withholding or denial of meals, or other supports for biological needs, as a consequence or punishment for problems.

(f) Any Level II or Level III Intervention, as defined in R539-4-3(n) and R539-4-3(o), used as coercion, as convenience to staff, or in retaliation.

(g) Any procedure in violation of R495-876, R512-202, R510-302, 62A-3-301 thru 62A-3-321, and 62A-4a-402 thru 62A-4a-412 prohibiting abuse.

KEY: people with disabilities, rights

Date of Enactment or Last Substantive Amendment: [~~May 17, 2005~~]**2013**

Notice of Continuation: August 17, 2009

Authorizing, and Implemented or Interpreted Law: 62A-5-102; 62A-5-103

**Insurance, Administration
R590-164
Uniform Health Billing Rule**

**NOTICE OF PROPOSED RULE
(Amendment)**

DAR FILE NO.: 37118

FILED: 12/21/2012

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The rule is being updated to incorporate new standards for electronic billing of health insurance claims submitted by health care providers to insurers. Additionally, the revisions adopt the uniform standards for eligibility and coordination of benefits information as required by H.B. 52, Health Reform -- Uniform Electronic Standards, passed in the 2010 General Session.

SUMMARY OF THE RULE OR CHANGE: The rule is being updated to incorporate new standards for electronic billing of health insurance claims submitted by health care providers to insurers. Additionally, the revisions adopt the uniform standards for eligibility and coordination of benefits information as required by H.B. 52 (2010).

STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 31A-22-614.5

ANTICIPATED COST OR SAVINGS TO:

♦ **THE STATE BUDGET:** The changes to this rule will not change the work load of the Insurance Department nor will they change the revenues or expenses of the department or state. The changes deal with the billing process between insurance companies and health care providers.

♦ **LOCAL GOVERNMENTS:** The changes to this rule will not impact local government since they deal with the relationship between insurance companies and health care providers.

♦ **SMALL BUSINESSES:** The changes to this rule may impact health care providers and insurers that have not kept

pace with changes taking place in the uniform medical billing process. These employers may be small, as well as large employer groups. Those not keeping pace with the changes will incur costs to update their existing electronic programs. It should not require the addition or deletion of employees.

◆ PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES: The changes to this rule may impact health care providers and insurers that have not kept up with the changes taking place in the uniform medical billing process. These employers may be small, as well as large employer groups. Those not keeping pace with the changes will incur costs to update their existing electronic programs. It should not require the addition or deletion of employees.

COMPLIANCE COSTS FOR AFFECTED PERSONS: Insurance company and health care provider employers that have not kept pace with changes in uniform medical billing will need to pay to update their existing electronic programs to comply with the new requirements.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: Many of those affected by this rule are keeping up with the changes as they occur. Those that have not will need to catch up by updating their existing electronic computer programs to comply with the new requirements. The cost will vary from employer to employer.

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 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 NO LATER THAN AT 5:00 PM ON 02/14/2013

THIS RULE MAY BECOME EFFECTIVE ON: 02/21/2013

AUTHORIZED BY: Neal Gooch, Commissioner

R590. Insurance, Administration.
R590-164. Uniform Health Billing Rule.
R590-164-1. Authority.

This rule is promulgated by the Insurance Commissioner pursuant to Subsection 31A-22-614.5 which authorizes the commissioner to adopt uniform claim forms, billing codes, and compatible systems of electronic billing.

R590-164-2. Purpose.

The purpose of this rule is to designate uniform claim forms, billing codes and compatible electronic data interchange standards for use by health payers and providers.

R590-164-3. Applicability and Scope.

[A-](1) This rule applies to health claims, health encounters, and electronic data interchange between payers and providers.

[B-](2) Except as otherwise specifically provided, the requirements of this rule apply to payers and providers.

[C-](3) This rule does not prohibit a payer from requesting additional information required to determine eligibility of the claim under the terms of the policy or certificate issued to the claimant.

[D-](4) This rule does not prohibit a payer or provider from using alternative forms or procedures specified in a written contract between the payer and provider.

[E-](5) This rule does not exempt a payer or provider from data reporting requirements under state or federal law or regulation.

R590-164-4. Definitions.

As used in this rule:

[A-](1) Uniform Claim Forms are defined as:

[1(a)] ~~"UB-92 HCFA-1450" means the health insurance claim form maintained by HCFA for use by institutional care providers. Currently this form is known as the UB92. This form will not be used after 01/01/2008.~~

~~_____ (b)(a) "UB-04" means the health insurance claim form maintained by NUBC for use by institutional care providers.~~

[~~_____ (2)(a) "Form HCFA-1500 (12-90)" means the health insurance claim form maintained by HCFA for use by health care providers. This form will not be used after 06/01/2008.~~

] (b) "Form CMS 1500[~~(-08-05)~~]" means the health insurance claim form maintained by NUCC for use by health care providers. [~~This form will not be used after 06/01/2008.~~

~~_____ (3)(c) "[American Dental Association, 1999 Version 2000]400" means the uniform dental claim form approved by the American Dental Association for use by dentists.~~

[4](d) "NCPDP" means the National Council for Prescription Drug Program's Claim Form or its electronic counterpart.

[B-](2) Uniform Claim Codes are defined as:

[1(a)] "ASA Codes" means the codes contained in the ASA Relative Value Guide developed and maintained by the American Society of Anesthesiologists to describe anesthesia services and related modifiers.

[2](b) "CDT Codes" means the current dental terminology prescribed by the American Dental Association.

[3](c) "CPT Codes" means the current physicians procedural terminology, published by the American Medical Association.

(d) "DRG Codes" means Diagnosis Related Group codes. DRG's are universal grouping that are used to clarify the type of inpatient care received. The DRG code, along with a diagnosis code and the length of the inpatient stay, are used to determine payment and reimbursement for claims.

[4](e) "HCPCS" means HCFA's Common Procedure Coding System, a coding system that describes products, supplies, procedures and health professional services and includes, the American Medical Association's (AMA's) Physician Current Procedural

Terminology, codes, alphanumeric codes, and related modifiers. This includes:

~~[(a)](i)~~ "HCPCS Level 1 Codes" which are the AMA's CPT codes and modifiers for professional services and procedures.

~~[(b)](ii)~~ "HCPCS Level 2 Codes" which are national alphanumeric codes and modifiers for health care products and supplies, as well as some codes for professional services not included in the AMA's CPT codes.

~~[(5)](f)~~ "ICDCM Codes" means the diagnosis and procedure codes in the International Classification of Diseases, clinical modifications published by the U.S. Department of Health and Human Services.

~~[(6)](g)~~ "NDC" means the National Drug Codes of the Food and Drug Administration.

~~[(7)](h)~~ "UB04 Rate Codes" means the code structure and instructions established for use by the National Uniform Billing Committee.

~~[(C)](3)~~ "Electronic Data Interchange Standard" means the:

~~[(+)](a)~~ ASC X12N standard format developed by the Accredited Standards Committee X12N Insurance Subcommittee of the American National Standards Institute and the ASC X12N implementation guides as modified by the Utah Health Information Network (UHIN) Standards Committee;

~~[(2)](b)~~ other standards developed by the UHIN Standards Committee at the request of the commissioner; and

~~[(3)](c)~~ as adopted by the commissioner by rule.

~~(4)~~ "HPID" means Health Plan Identifier. HPID is the national unique health plan identifier assigned to identify individual health plans.

~~(5)~~ "NPI" means National Provider Identifier. A NPI is a unique ten digit identification number required by HIPAA for all health care providers in the United States. Providers must use their NPI to identify themselves in all HIPAA transactions.

~~[(D)](6)~~ "Payer" means an insurer or third party administrator that pays for, or reimburses for the costs of health care expense.

~~[(E)](7)~~ "Provider" means any person, partnership, association, corporation or other facility or institution that renders or causes to be rendered health care or professional services, and officers, employees or agents of any of the above acting in the course and scope of their employment.

~~[(F)]~~ "HCFA" means ~~the Health Care Financing Administration of the U.S. Department of Health and Human Services. HCFA is no longer an active division of the Department of Health and Human Services.~~

~~[(G)](8)~~ "UHIN Standards Committee" means the Standards Committee of the Utah Health Information Network.

~~[(H)](9)~~ "CMS" means the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services. CMS replaced HCFA.

~~[(I)](10)~~ "HIPAA" means the federal Health Insurance Portability and Accountability Act.

~~[(J)](11)~~ "NUBC" means the National Uniform Billing Committee.

~~[(K)](12)~~ "NUCC" means the National Uniform Claim Committee.

R590-164-5. Paper Claim Transactions.

Payers shall accept and may require the applicable uniform claim forms completed with the uniform claim codes.

R590-164-6. Electronic Data Interchange Transactions.

~~[(A)](1)~~ The commissioner shall use the UHIN Standards Committee to develop electronic data interchange standards for use by payers and providers transacting health insurance business electronically. In developing standards for the commissioner, the UHIN Standards Committee shall consult with national standard setting entities including but not limited to Centers for Medicare and Medicaid Services (CMS), the National Uniform Claim Form Committee, ASC X12, NCPDP, and the National Uniform Billing Committee.

~~[(B)](2)~~ Standards developed and adopted by the UHIN Standards Committee shall not be required for use by payers and providers, until adopted by the commissioner by rule.

~~[(C)](3)~~ Payers shall accept the applicable electronic data if transmitted in accordance with the adopted electronic data interchange standard. Payers may reject electronic data if not transmitted in accordance with the adopted electronic data interchange standard.

~~[(D)](4)~~ The following HIPAA+ electronic data interchange standards developed and adopted by the UHIN Standards Committee and adopted by the commissioner are hereby incorporated by reference with this rule and are available for public inspection at the department during normal business hours or at www.insurance.utah.gov/rules/index.htm.

~~(a)~~ "Administrative Transaction Acknowledgements Standard v3.0." Purpose: To create a process for acknowledging all electronic transactions between trading partners based on the communication, syntax semantic and business process specifications.

~~[(1) - #1 - "Anesthesia v2.0."](b)~~ "Anesthesia Standard v3.0." Purpose: to standardize the transmission of anesthesia data for health care services. This standard does not alter any contractual agreement between providers and payers. [Effective date: 07-12-2003.]

~~(c)~~ "Benefits Enrollment and Maintenance Standard v3.0." Purpose: To detail the standard transactions for the transmission of health care benefits enrollment and maintenance.

~~(d)~~ "CMS 1500 Paper Claim Form Box 17 and 17A Standard v3.1." Purpose: To establish a standard approach to reporting referring provider name and identifier number on the claim form. This standard also provides the cross walk to the ASCX12 837 Professional Claim version 005010x222A1.

~~(e)~~ "CMS 1500 Paper Claim Form Standard v3.0." Purpose: To clearly describe the standard use of each Box, for print images, and its crosswalk to the HIPAA 837 005010X222A1 Professional implementation guide.

~~(f)~~ "Claim Acknowledgement Standard v3.1." Purpose: To provide a standardized claim acknowledgement in response to a claim submission. This transaction is used to report on the status of a claim/encounter at the pre-adjudication processing stage, for example, before the payer is legally required to keep a history of the claim or encounter.

~~(g)~~ "Claim Status Inquiry and Response Standard v3.1." Purpose: To detail the standard transactions for the transmission of health care claim status inquiries and response after January 1, 2012.

The transaction is intended to allow the provider to reduce the need for claim follow-up and facilitate the correction of claims.

(h) "Coordination of Benefits Standard v3.0." Purpose: To streamline the coordination of benefits process between payers and providers or payer to payers. The standard is to define the data to be exchanged for coordination of benefits and to increase effective communications.

(i) "Dental Claim Billing Standard v3.1." Purpose: To describe the standard use of each item number, for print images, and its crosswalk to the HIPAA 837 005010X0224A1 dental implementation guide.

(j) "Electronic Remittance Advice Standard v 3.4." Purpose: To detail the standard transaction for the reporting of transmission receipt and transaction or functional group X12 and implementation guide errors. This standard adopts the use of the ASC X12 999 transaction.

(k) "Eligibility Inquiry and Response Standard v3.1." Purpose: To detail the standard transactions for the transmission of health care eligibility inquiries and responses.

(l) "Health Care Claim Encounter Standard v3.2." Purpose: To detail the standard transactions for the transmission of health care claims and encounters and associated transactions.

(m) "Health Identification Card Standard v1.2." Purpose: To standardize the patient health identification card information. This identification card addresses the human-readable appearance and machine-readable information used by the healthcare industry to obtain eligibility.

(n) "Home Health Standard v3.0." Purpose: To provide a uniform standard of billing for home health care claims and encounters.

(o) "Implementation Acknowledgement For Health Care Insurance v3.2." Purpose: To detail the standard transaction for the reporting of transmission receipt and transaction or functional group X12 and implementation guide error. This standard adopts the use of the ASC X12 999 transaction.

(p) "Individual Name Standard v2.0." Purpose: To provide guidance for entering names into provider, payer or sponsor systems for patients, enrollees, as well as all other people associated with these records.

(q) "Medicaid Enrollment Implementation Guide v3.0." Purpose: This standard establishes the use of the ASC X12 834 enrollment transaction for Medicaid enrollments.

(r) "Metabolic Dietary Products Standard v3.0." Purpose: To provide a uniform standard for billing of metabolic dietary products for those providers and payers using the UB04, the CMS 1500, the NCPDP, or an electronic equivalent.

(s) "National Provider Identifier Standard v3.0." Purpose: To inform providers of the national provider identifier requirements and the usage within the transactions.

(t) "Pain Management Standard v3.0." Purpose: To provide a uniform method of submitting pain management claims, encounters, pre-authorizations, and notifications.

(u) "Patient Identification Number Standard v3.0." Purpose: To describe the standard for the patient identification number.

(v) "Premium Payment Standard v3.0." Purpose: To detail the standard transactions for the transmission of premium payments.

(w) "Prior Authorization/Referral Standard v3.0." Purpose: To provide general recommendations to payers and providers about handling electronic prior authorization and referrals.

(x) "Required Unknown Values Standard v 3.0." Purpose: To provide guidance for the use of common data values that can be used within the HIPAA transactions when a required data element is not known by the provider, payer or sponsor for patients, enrollees, as well as all other people associated with these transactions. These data values should only be used when the data is truly not available or known. These values should not be used to replace known data.

(y) "Telehealth Standard v3.0." Purpose: To provide a uniform standard of billing for health care claims and encounters delivered via telehealth.

(z) "Transparency Administration Performance Standard v 1.0." Purpose: To establish performance measures that report the average telephone answer time and claim turnaround time.

(aa) "Transparency Denial Standard v 1.1." Purpose: To establish performance measures that report the number and cost of an insurer's denied health claims and to provide guidance pertaining to the reporting method and timeline.

(bb) "UB04 Form Locator Elements Standard v3.0." Purpose: To clearly describe the use of each form locator in the UB04 claim billing form and its crosswalk to the HIPAA 837 005010X223A2 institutional implementation guide.

~~(2) #2A - "UB92 Form Locator Elements v2.0." Purpose: to clearly describe the use of each form locator in the UB-92 (HCFA 1450) claim billing form and its crosswalk to the HIPAA 837-004010X096A1 Institutional implementation guide. This standard creates a uniform billing method for institutional claims. Effective date: 07-12-2003.~~

~~(3) #2B - "HCFA 1500 Box Elements v2.0." Purpose: to clearly describe the standard use of each box (for print images) and its crosswalk to the HIPAA 837 004010X098A1 Professional implementation guide. This standard creates a uniform billing method for professional claims. Effective date: 07/12/03.~~

~~(4) #2D - "Dental Form Locator Elements v2.0." Purpose: to clearly describe the standard use of each Form Locator (for print images) and its crosswalk to the HIPAA 837 004010X097A1 Dental implementation guide. This standard creates a uniform billing method for dental claims. Effective date: 12/12/03.~~

~~(5) #3 - "837 Health Care Claim Standard v2.1." Purpose: to detail the standard transactions for the transmission of health care claims and encounters and associated transactions in the state of Utah. Effective date: 01/17/03.~~

~~(6) #4 - "Provider Remittance Advice v2.0." Purpose: to detail the standard transactions for the transmission of health care remittance advices in the state of Utah. Effective date: 01/17/03.~~

~~(7) #8 - "Patient Identification Number v2.0." Purpose: to describe the standard for the patient identification number in Utah. Effective date: 09/11/98.~~

~~(8) #9 - "Professional Common Edits v2.0." Purpose: to detail common edits used in all professional claims. Effective date: 10/17/97.~~

~~(9) #10 - "Facilities Common Edits v2.0." Purpose: to detail common edits used in all facility claims. Effective date: 9/10/99.~~

— (10) #11 - "Medicaid Enrollment Standard v2.0." Purpose: to describe the standard for the transmission of a Medicaid enrollment transaction in the state of Utah. Effective date: 04/12/03.

— (11) #12 - "HCFA Box 17 / 17A." Purpose: to establish a standard approach to reporting referring provider name and identifier number on the HCFA 1500 claim form. This Standard also provides the cross walk to the ASC X12 837 Professional Claim version 4010A. Effective date: 09/04/04.

— (12) #18 - "Acknowledgements v2.3." Purpose: to detail the standard transaction for the reporting of transmission receipt and transaction and/or functional group X12 standard syntactical errors. This standard adopts the use of the ASC X12 997 transaction. Effective date: 07/08/06.

— (13) #20 - "Front-End Acknowledgement Standard v2.2." Purpose: to delineate a standardized front-end encounter acknowledgement transaction. This transaction will be used only to report on the status of a claim/encounter at the level of the payers "front end" claim/encounter edits, i.e., before the payer is legally required to keep a history of the claim/encounter. Effective date: 12/02/05.

— (14) #26 - "Telehealth v2.1." Purpose: to provide a uniform standard of billing for a health care claim/encounter delivered via telehealth. Two types of telehealth technology have been identified to deliver health care. Effective date: 9/13/03.

— (15) #27 - "Metabolic and Dietary Foods v2.1." Purpose: to provide a uniform standard for billing of metabolic dietary products for those providers and payers that use the UB92 and the HCFA 1500 or the electronic equivalent. Effective date: 09/11/04.

— (16) #28 - "Home Health v2.1." Purpose: to provide a uniform standard of billing for a home health care claim/encounter. Effective date: 06/12/04.

— (17) #30 - "Pain Management v2.0." Purpose: to provide a uniform method of submitting a pain management claim/encounter, pre-authorization, and notification. Effective date: 10/19/02.

— (18) #31 - "Eligibility Inquiry and Response Standard v2.3." Purpose: to detail the Standard transactions for the transmission of health care eligibility inquiries and responses in the state of Utah. Effective date: 06/02/07.

— (19) #32 - "Benefits Enrollment and Maintenance Standard v2.1." Purpose: to mandate the use of the ASC X12 834 HHPAA-addenda transaction for health care benefits enrollment and maintenance transactions. Effective date: 12/06/04.

— (20) #34 - "Psychiatric Day Treatment Standard v2.0." Purpose: to provide a uniform standard for submitting a psychiatric day treatment claim/encounter, pre-authorization, and notification. Effective date: 10/09/02.

— (21) #35 - "Prior Authorization/Referral Standard v2.0." Purpose: to (1) lay out general recommendations to payers and providers about handling the UHN Internet based prior authorization/referral (termed the 278) system, (2) set out the minimum data set that providers will submit in the 278 request, and (3) set out the minimum data set that payers will return on the 278 response. Effective date: 10/08/02.

— (22) #36 - "Claim Status Inquiry v2.2." Purpose: to detail the Standard transactions for the transmission of health care claim status inquiries and response in the state of Utah. Effective date: 07/08/06.

— (23) #37 - "Individual Name v2.0." Purpose: to provide guidance for entering names into any Utah provider, payer or sponsor systems for patients, enrollees, as well as all other people associated with these records. Effective Date: 07/12/03.

— (24) #46 - "Required 'Unknown' Values v2.0." Purpose: to provide guidance for the use of common data values that can be used within the HIPAA transactions when a required data element is not known by the provider, payer or sponsor for patients, enrollees, as well as all other people associated with these transactions. These data values should only be used when the data is truly not available or known. These values are not to be used to replace known data. Effective Date: 06/12/04.

— (25) #50 - "Coordination of Benefits v2.0." Purpose: to streamline the coordination of benefits process between payers and providers. The over all goal of this standard is to define the data to be exchanged for Coordination of Benefits (COB) and increase effective communications. Effective Date: 07/08/06.

— (26) #51 - "National Provider Identifier v2.1." Purpose: to describe the agreed upon requirements surrounding the National Provider Identifier and its usage for providers and payers in the State of Utah during the transition period of May 23, 2005 through May 22, 2007. Effective Date: 09/01/2007.

— (27) #56 - "CMS 1500 Paper Claim Form v2.2." Purpose: to clearly describe the use of each form locator in the CMS 1500 claim billing form and its crosswalk to the HIPAA 837-004010X096A1-Institutional implementation guide. This standard applies to professional providers. Effective Date: 09/01/2007.

— (28) #57 - "UB04 Paper Claim Form v2.0." The purpose of this standard is to describe the use of each form locator in the UB04 (CMS1450) claim billing form and its crosswalk to the HIPAA-004010X096A1 Institutional implementation guide. This standard applies to institutional providers. Effective Date: 04/07/2007.

]

R590-164-7. Separability.

If any provision of this rule or the application to any person or circumstance is for any reason held to be invalid, the remainder of the rule and the application of the provision to other persons or circumstances may not be affected.

[R590-164-8. Enforcement Date.

— The commissioner will begin enforcing the revised portions of this rule 45 days from the rule's effective date.

]

KEY: insurance law

Date of Enactment or Last Substantive Amendment: [August 26, 2008]2013

Notice of Continuation: March 11, 2010

Authorizing, and Implemented or Interpreted Law: 31A-22-614.5

Labor Commission, Industrial Accidents **R612-1** Workers' Compensation Rules - Procedures

NOTICE OF PROPOSED RULE

(Repeal)

DAR FILE NO.: 37129

FILED: 12/28/2012

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The Labor Commission proposes to repeal this and other Industrial Accident Division rules in order to consolidate, reorganize, and reenact the substance of those rules in a format that is more logical and user friendly.

SUMMARY OF THE RULE OR CHANGE: The existing Rule R612-1 will be repealed in its entirety. The substance of the existing rule will be reenacted in new Rules R612-100 and R612-200. (DAR NOTE: The proposed new Rule R612-100 is under DAR No. 37124, and the proposed new Rule R612-200 is under DAR No. 37125 in this issue, January 15, 2013, of the Bulletin.)

STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 34A-1-104 et seq. and Section 34A-2-101 et seq. and Section 34A-3-101 et seq. and Section 63G-4-102 et seq.

ANTICIPATED COST OR SAVINGS TO:

- ◆ **THE STATE BUDGET:** Because the substantive provisions of the existing rule will be reenacted as a new rule, repeal of the existing rule will not result in costs or savings to the state budget.
- ◆ **LOCAL GOVERNMENTS:** Because the substantive provisions of the existing rule will be reenacted as a new rule, repeal of the existing rule will not result in costs or savings to local government.
- ◆ **SMALL BUSINESSES:** Because the substantive provisions of the existing rule will be reenacted as a new rule, repeal of the existing rule will not result in costs or savings to small businesses.
- ◆ **PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES:** Because the substantive provisions of the existing rule will be reenacted as a new, repeal of the existing rule will not result in costs or savings to other affected persons.

COMPLIANCE COSTS FOR AFFECTED PERSONS: The repeal of existing Rule R612-1 and reenactment of its substantive provisions in Rules R612-100 and R612-200 will not change interested parties' rights or duties and will not impose any compliance costs on affected persons.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: The repeal of existing Rule R612-1, coupled with reenactment of the rule's substantive provisions in the new Rules R612-100 and R612-200, is intended to make the rule easier to find and use by businesses and all other stakeholders in the workers' compensation system. The Commission does not anticipate that the improved

organization of these rules will result in any fiscal impact on businesses.

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:

◆ Ron Dressler by phone at 801-530-6841, by FAX at 801-530-6804, or by Internet E-mail at rdressler@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN AT 5:00 PM ON 02/14/2013

THIS RULE MAY BECOME EFFECTIVE ON: 02/21/2013

AUTHORIZED BY: Sherrie Hayashi, Commissioner

R612. Labor Commission, Industrial Accidents.

~~[R612-1. Workers' Compensation Rules - Procedures.~~

~~R612-1-1. Definitions.~~

- ~~_____ A. "Commission" means the Labor Commission.~~
- ~~_____ B. "Division" means the Division of Industrial Accidents within the Labor Commission.~~
- ~~_____ C. "Applicant/Plaintiff" means an injured employee or his/her dependent(s) or any person seeking relief or claiming benefits under the Workers' Compensation and/or Occupational Disease and Disability Laws.~~
- ~~_____ D. "Defendant" means an employer, insurance carrier, self-insurer, the Employers' Reinsurance Fund, and/or the Uninsured Employers' Fund.~~
- ~~_____ E. "Administrative Law Judge" means a person duly designated by the Commission to hear and determine disputed or other cases under the provisions of Title 34A, Chapters 2 and 3, and of Title 63, Chapter 46b.~~
- ~~_____ F. "Insurance Carrier" includes all insurance companies writing workers' compensation and occupational disease and disability insurance, the Workers' Compensation Fund, and self-insurers who are granted self-insuring privileges by the Commission. In all cases involving no insurance coverage by the employer, the term "Insurance Carrier" includes the employer.~~
- ~~_____ G. "Medical Panel" means a panel appointed by an Administrative Law Judge pursuant to the standards set forth in Section 34A-2-601, which is responsible to make findings regarding disputed medical aspects of a compensation claim, and may make any additional findings, perform any tests, or make any inquiry as the Administrative Law Judge may require.~~
- ~~_____ H. "Award" means the finding or decision of the Commission or Administrative Law Judge as to the amount of compensation or benefits due any injured employee or the dependent(s) of a deceased employee.~~

R612-1-2. Authority.

~~This rule is enacted under the authority of Section 34A-1-104.~~

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 time 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 - Forms 221(a) Spine, 221(b) Upper Extremity, and 221(c) Lower Extremity" - These forms are 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 the appropriate 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 benefits.~~

~~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 ease 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.

R612-1-4. Discount.

Eight percent shall be used for any discounting or present value calculations. Lump sums ordered by the Commission or for any attorney fees paid in a single up-front amount, or of any other sum being paid earlier than normally paid under a weekly benefit method shall be subject to the 8% discounting. The Commission shall create and make available a precise discount or present value table based on a 365 day year. For those instances where discount calculations are not routinely utilized or where the Commission's precise table is not available, the following table, which is a shortened version of the precise table, may be utilized by interpolating between the stated weeks and the related discount.

TABLE

Unaccrued Weeks	X Weekly Benefit \$	X Cumulative Discount	= Discount \$
1		.001475	
10		.008076	
20		.015343	
30		.022538	
40		.029663	
50		.036719	
60		.043706	
70		.050626	
80		.057478	
90		.064264	
100		.070984	
110		.077639	
120		.084229	
130		.090756	
140		.097221	
150		.103623	
160		.109963	
170		.116243	
180		.122463	
190		.128623	
200		.134724	
210		.140767	
220		.146752	
230		.152680	
240		.158552	
250		.164368	
260		.170129	
270		.175835	
280		.181488	
290		.187087	
300		.192633	
312		.199219	

R612-1-5. Interest.

A. Interest must be paid on each benefit payment which comprises the award from the date that payment would have been due and payable at the rate of 8% per annum.

B. For the purpose of interest calculation, benefits shall become "due and payable" as follows:

1. Temporary total compensation shall be due and payable within 21 days of the date of the accident.

2. Permanent partial compensation shall be due and payable on the next day following the termination of a temporary total disability. However, where the condition is not fixed for rating purposes, the interest shall commence from the date the permanent partial impairment can be medically determined.

3. Permanent partial or permanent total disability compensation payable by the Employers' Reinsurance Fund or the Uninsured Employers' Fund shall be due and payable as soon as reasonably practical after an order is issued.

R612-1-6. Issuance of Checks.

A. Any entity issuing compensation checks or drafts must make those checks/drafts payable directly to the injured worker and must mail them directly to the last known mailing address of the injured worker, with the following exceptions:

1. If the employer provides full salary to the injured worker in return for the worker's compensation benefits, the check may be mailed to the worker at the place of employment;

2. If the employer coordinates other benefits with the worker's compensation benefits, the check may be mailed to the worker at the place of employment.

B. In no case may the check be made out to the employer.

C. Where attorney fees are involved, a separate check should be issued to the worker's attorney in the amount approved or ordered by the Commission, unless otherwise directed by the Commission. Payment of the worker's attorney by issuing a check payable to the worker and his attorney jointly constitutes a violation of this rule.

R612-1-7. Acceptance/Denial of a Claim.

A. Upon receiving a claim for workers' compensation benefits, the insurance carrier or self-insured employer shall promptly investigate the claim and begin payment of compensation within 21 days from the date of notification of a valid claim or the insurance carrier or self-insured employer shall send the claimant and the division written notice on a division form or letter containing similar information, within 21 days of notification, that further investigation is needed stating the reason(s) for further investigation. Each 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 division in writing that the claim is denied and the reason(s) why the claim is being denied.

B. The payment of compensation shall be considered overdue if not paid within 21 days of a valid claim or within the 45 days of investigation unless denied.

C. Failure to make payment or to deny a claim within the 45 day time period without good cause shall result in a referral of the insurance company to the Insurance Department for appropriate disciplinary action and may be cause for revocation of the self-insurance certification for a self-insured employer. Good cause is defined as:

1. Failure by an employee claiming benefits to sign requested medical releases;

2. Injury or occupational disease did not occur within the scope of employment;

3. Medical information does not support the claim;

4. Claim was not filed within the statute of limitations;

5. Claimant is not an employee of the employer he/she is making a claim against;

6. Claimant has failed to cooperate in the investigation of the claim;

7. A pre-existing condition is the sole cause of the medical problem and not the claimed work-related injury or occupational disease;

8. Tested positive for drugs or alcohol; or

9. Other - a very specific reason must be given.

D. If an insurance carrier or self-insured employer begins payment of benefits on an investigation basis so as to process the claim in a timely fashion, a later denial of benefits based on newly discovered information may be allowed.

R612-1-8. Insurance Carrier/Employer Liability.

A. This rule governs responsibility for payment of workers' compensation benefits for industrial accidents when:

1. The worker's ultimate entitlement to benefits is not in dispute; but

2. There is a dispute between self-insured employers and/or insurers regarding their respective liability for the injured worker's benefits arising out of separate industrial accidents which are compensable under Utah law.

B. In cases meeting the criteria of subsection A, the self-insured employer or insurer providing workers' compensation coverage for the most recent compensable injury shall advance workers' compensation benefits to the injured worker. The benefits advanced shall be limited to medical benefits and temporary total disability compensation. The benefits advanced shall be paid according to the entitlement in effect on the date of the earliest related injury.

1. The self-insured employer or insurance carrier advancing benefits shall notify the non-advancing party(s) within the time periods as specified in rule R612-1-7, that benefits are to be advanced pursuant to this rule.

2. The self-insured employers or insurers not advancing benefits, upon notification from the advancing party, shall notify the advancing party within 10 working days of any potential defenses or limitations of the non-advancing party(s) liability.

C. The parties are encouraged to settle liabilities pursuant to this rule, however, any party may file a request for agency action with the Commission for determination of liability for the workers' compensation benefits at issue.

D. The medical utilization decisions of the self-insured employer or insurer advancing benefits pursuant to this rule shall be presumed reasonable with respect to the issue of reimbursement.

R612-1-9. Compensation Agreements.

A. An applicant, insurance company, and/or employer may enter into a compensation agreement for the purpose of resolving a worker's compensation claim. Compensation agreements must be approved by the Commission. The compensation agreement must be that contained on Form 019 of the Commission forms and shall include the following information:

1. Signatures of the parties involved;
2. Form 122 - Employer's First Report of Injury;
3. Doctor's report of impairment rating;
4. Form 141 - Payment of Benefits Statement.

B. Failure to provide any of the above documentation and forms may result in the return of the compensation agreement to the carrier or self-insured employer without approval.

R612-1-10. Permanent Total Disability.

A. This rule applies to claims for permanent total disability compensation under the Utah Workers' Compensation Act.

1. Subsection B applies to permanent total disability claims arising from accident or disease prior to May 1, 1995.

2. Subsection C applies to permanent total disability claims arising from accident or disease on or after May 1, 1995.

B. For claims arising from accident or disease on or after July 1, 1988 and prior to May 1, 1995, the Commission is required under Section 34A-2-413, to make a finding of total disability as measured by the substance of the sequential decision-making process of the Social Security Administration under Title 20 of the Code of Federal Regulations, amended April 1, 1993. The use of the term "substance of the sequential decision-making process" is deemed to confer some latitude on the Commission in exercising a degree of discretion in making its findings relative to permanent total disability.

The Commission does not interpret the code section to eliminate the requirement that a finding by the Commission in permanent and total disability shall in all cases be tentative and not final until rehabilitation training and/or evaluation has been accomplished.

1. In the event that the Social Security Administration or its designee has made, or is in the process of making, a determination of disability under the foregoing process, the Commission may use this information in lieu of instituting the process on its own behalf.

2. In evaluating industrial claims in which the injured worker has qualified for Social Security disability benefits, the Commission will determine if a significant cause of the disability is the claimant's industrial accident or some other unrelated cause or causes.

3. To make a tentative finding of permanent total disability the Commission incorporates the rules of disability determination in 20 CFR 404.1520, amended April 1, 1993. The sequential decision-making process referred to requires a series of questions and evaluations to be made in sequence. In short, these are:

a. Is the claimant engaged in a substantial gainful activity?

b. Does the claimant have a medically severe impairment?

c. Does the severe impairment meet or equal the duration requirement in 20 CFR 404.1509, amended April 1, 1993, and the listed impairments in 20 CFR Subpart P Appendix 1, amended April 1, 1993?

d. Does the impairment prevent the claimant from doing past relevant work?

e. Does the impairment prevent the claimant from doing any other work?

4. After the Commission has made a tentative finding of permanent total disability:

a. In those cases arising after July 1, 1994, the Commission shall order initiation of payment of permanent total disability compensation;

b. the Commission shall review a summary of reemployment activities undertaken pursuant to the Utah Injured Worker Reemployment Act, as well as any qualified reemployment plan submitted by the employer or its insurance carrier; and

c. unless otherwise stipulated, the Commission shall hold a hearing to consider the possibility of rehabilitation and reemployment of the claimant pending final adjudication of the claim.

5. After a hearing, or waiver of the hearing by the parties, the Commission shall issue an order finding or denying permanent total disability based upon the preponderance of the evidence and with due consideration of the vocational factors in combination with the residual functional capacity which the commission incorporates as published in 20 CFR 404 Subpart P Appendix 2, amended April 1, 1993.

C. For permanent total disability claims arising on or after May 1, 1995, Section 34A-2-413 requires a two-step adjudicative process. First, the Commission must make a preliminary determination whether the applicant is permanently and totally disabled. If so, the Commission will proceed to the second step, in which the Commission will determine whether the applicant can be reemployed or rehabilitated.

1. First Step - Preliminary Determination of Permanent Total Disability: On receipt of an application for permanent total disability compensation, the Adjudication Division will assign an Administrative Law Judge to conduct evidentiary proceedings to determine whether the applicant's circumstances meet each of the elements set forth in Subsections 34A-2-413(1)(b) and (c).

(a) If the ALJ finds the applicant meets each of the elements set forth in Subsections 34A-2-413(1)(b) and (c), the ALJ will issue a preliminary determination of permanent total disability and shall order the employer or insurance carrier to pay permanent total disability compensation to the applicant pending completion of the second step of the adjudication process. The payment of permanent total disability compensation pursuant to a preliminary determination shall commence as of the date established by the preliminary determination and shall continue until otherwise ordered.

(b) A party dissatisfied with the ALJ's preliminary determination may obtain additional agency review by either the Labor Commissioner or Appeals Board pursuant to Subsection 34A-2-801(3). If a timely motion for review of the ALJ's preliminary determination is filed with either the Labor Commissioner or Appeals Board, no further adjudicative or enforcement proceedings shall take place pending the decision of the Commissioner or Board.

(c) A preliminary determination of permanent total disability by the Labor Commissioner or Appeals Board is a final agency action for purposes of appellate judicial review.

(d) Unless otherwise stayed by the Labor Commissioner, the Appeals Board or an appellate court, an appeal of the Labor Commissioner or Appeals Board's preliminary determination of permanent total disability shall not delay the commencement of "second step" proceedings discussed below or payment of permanent total disability compensation as ordered by the preliminary determination.

(e) The Commissioner or Appeals Board shall grant a request for stay if the requesting party has filed a petition for judicial review and the Commissioner or Appeals Board determine that:

(i) the requesting party has a substantial possibility of prevailing on the merits;

(ii) the requesting party will suffer irreparable injury unless a stay is granted; and

(iii) the stay will not result in irreparable injury to other parties to the proceeding.

2. Second Step - Reemployment and Rehabilitation: Pursuant to Subsection 34A-2-413(6), if the first step of the adjudicatory process results in a preliminary finding of permanent total disability, an additional inquiry must be made into the applicant's ability to be reemployed or rehabilitated, unless the parties waive such additional proceedings:

(a) The ALJ will hold a hearing to consider whether the applicant can be reemployed or rehabilitated.

(i) As part of the hearing, the ALJ will review a summary of reemployment activities undertaken pursuant to the Utah Injured Worker Reemployment Act;

(ii) The employer or insurance carrier may submit a reemployment plan meeting the requirements set forth in Subsection 34A-2-413(6)(a)(ii) and Subsections 34A-2-413(6)(d)(i) through (iii).

(b) Pursuant to Subsection 34A-2-413(4)(b) the employer or insurance carrier may not be required to pay disability compensation for any combination of disabilities of any kind in excess of the amount of compensation payable over the initial 312 weeks at the applicable permanent total disability compensation rate.

(i) Any overpayment of disability compensation may be recouped by the employer or insurance carrier by reasonably offsetting the overpayment against future liability paid before or after the initial 312 weeks.

(ii) An advance of disability compensation to provide for the employee's subsistence during the rehabilitation process is subject to the provisions of Subsection 34A-2-413(4)(b), described in subsection 2.(b) above, but can be funded by reasonably offsetting the advance of disability compensation against future liability normally paid after the initial 312 weeks.

(iii) To fund an advance of disability compensation to provide for an employee's subsistence during the rehabilitation process, a portion of the stream of future weekly disability compensation payments may be discounted from the future to the present to accommodate payment. Should this be necessary, the employer or insurance carrier shall be allowed to reasonably offset the amounts paid against future liability payable after the initial 312 weeks. In this process, care should be exercised to reasonably minimize adverse financial impact on the employee.

(iv) In the event the parties cannot agree as to the reasonableness of any proposed offset, the matter may be submitted to an ALJ for determination.

(c) Subsections 34A-2-413(7) and (9) require the applicant to fully cooperate in any evaluation or reemployment plan. Failure to do so shall result in dismissal of the applicant's claim or reduction or elimination of benefit payments including disability compensation and subsistence allowance amounts, consistent with the provisions of Section 34A-2-413(7) and (9).

(d) Subsection 34A-2-413(6) requires the employer or its insurance carrier to diligently pursue any proffered reemployment plan. Failure to do so shall result in a final award of permanent total disability compensation to the applicant.

(e) If, after the conclusion of the foregoing "second step" proceeding, the ALJ concludes that successful rehabilitation is not possible, the ALJ shall enter a final order for continuing payment of permanent total disability compensation. The period for payment of such compensation shall be commence on the date the employee became permanently and totally disabled, as determined by the ALJ.

(f) Alternatively, if after the conclusion of the "second step" proceeding, the ALJ concludes that successful rehabilitation and/or reemployment is possible, the ALJ shall enter a final order to that effect, which order shall contain such direction to the parties as the ALJ shall deem appropriate for successful implementation and continuation of rehabilitation and/or reemployment. As necessary under the particular circumstances of each case, the ALJ's final order shall provide for reasonable offset of payments of any disability compensation that constitute an overpayment under Subsection 34A-2-413(4)(b).

(g) The ALJ's decision is subject to all administrative and judicial review provided by law.

D. For purposes of this rule, the following standards and definitions apply:

1. Other work reasonably available: Subject to medical restrictions and other provisions of the Act and rules, other work is reasonably available to a claimant if such work meets the following criteria:

a. The work is either within the distance that a resident of the claimant's community would consider to be a typical or acceptable commuting distance, or is within the distance the claimant was traveling to work prior to his or her accident;

b. The work is regular, steady, and readily available; and

c. The work provides a gross income at least equivalent to:

~~_____ (1) The current state average weekly wage, if at the time of the accident the claimant was earning more than the state average weekly wage then in effect; or~~

~~_____ (2) The wage the claimant was earning at the time of the accident, if the employee was earning less than the state average weekly wage then in effect.~~

~~_____ 2. Cooperation: As determined by an administrative law judge, an employee is not entitled to permanent total disability compensation or subsistence benefits unless the employee fully cooperates with any evaluation or reemployment plan. The ALJ will evaluate the cooperation of the employee using, but not limited to, the following factors: attendance, active participation, effort, communication with the plan coordinator, and compliance with the requirements of the vocational plan. In determining if these factors were met, the ALJ shall consider relevant changes in the employee's documented medical condition.~~

~~_____ 3. Diligent Pursuit: The employer or its insurance carrier shall diligently pursue the reemployment plan. The ALJ will evaluate the employer or insurance carrier's diligent pursuit of the plan using, but not limited to, the following factors: timely payment of expenses and benefits outline in the vocational plan, and as required by the educational institution providing the vocational training, communication with the employee, compliance with the requirements of the vocational plan, and timely modification of the plan as required by documented changes in the employee's medical condition.~~

~~_____ 4. Resolution of disputes regarding "cooperation" and "diligent pursuit": If a party believes another party is not cooperating with or diligently pursuing either the evaluations necessary to establish a plan, or the requirements of an approved reemployment or rehabilitation plan, the aggrieved party shall submit to the workers' compensation mediation unit an outline of the specific instances of non-cooperation or lack of diligence. Other parties may submit a reply. The Mediation Unit will promptly schedule mediation to reestablish cooperation among the parties necessary to evaluate or comply with the plan. If mediation is unsuccessful, a party may request the Adjudication Division resolve the dispute. The Adjudication Division will conduct a hearing on the matter within 30 days and shall issue a written decision within 10 days thereafter.~~

R612-1-11. Burial Expenses.

~~_____ (1) Pursuant to Section 34A-2-418 if death results from an industrial injury or occupational disease, burial expenses in ordinary cases shall be paid by the employer or insurance carrier up to \$8,000. Unusual cases may result in additional payment, either voluntarily by the employer or insurance carrier or through commission order.~~

~~_____ (2) Beginning in the year 2004 and every two years thereafter, the Commission shall review this rule and shall make such adjustments as are necessary so that the burial expense provided by this rule remains equitable when compared to the average cost of burial in this state.~~

~~**KEY:** workers' compensation, time, administrative procedures, filing deadlines~~

~~**Date of Enactment or Last Substantive Amendment:** October 22, 2012~~

~~**Notice of Continuation:** June 19, 2012~~

~~**Authorizing, and Implemented or Interpreted Law:** 34A-2-101 et seq.; 34A-3-101 et seq.; 34A-1-104 et seq.; 63G-4-102 et seq.]~~

Labor Commission, Industrial Accidents **R612-2** Workers' Compensation Rules - Health Care Providers

NOTICE OF PROPOSED RULE

(Repeal)

DAR FILE NO.: 37130

FILED: 12/28/2012

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The Labor Commission proposes to repeal this and other Industrial Accident Division rules in order to consolidate, reorganize, and reenact the substance of those rules in a format that is more logical and user friendly.

SUMMARY OF THE RULE OR CHANGE: The existing Rule R612-2 will be repealed in its entirety. The substance of the existing rule will be reenacted in new Rules R612-100 and R612-300. (DAR NOTE: The proposed new Rule R612-100 is under DAR No. 37124, and the proposed new Rule R612-300 is under DAR No. 37126 in this issue, January 15, 2013, of the Bulletin.)

STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 34A-1-104 and Section 34A-2-101 et seq. and Section 34A-3-101 et seq.

MATERIALS INCORPORATED BY REFERENCES:

- ◆ Removes Medical Fee Guidelines, published by Utah Labor Commission, 12/01/2012
- ◆ Removes Current Procedural Terminology, published by American Medical Association, 2012
- ◆ Removes Optum Essential RBRVS, published by Optum, 2012 1st Quarter

ANTICIPATED COST OR SAVINGS TO:

◆ **THE STATE BUDGET:** Because the substantive provisions of the existing rule will be reenacted as a new rule, repeal of the existing rule will not result in costs or savings to the state budget.

◆ **LOCAL GOVERNMENTS:** Because the substantive provisions of the existing rule will be reenacted as a new rule, repeal of the existing rule will not result in costs or savings to local government.

◆ **SMALL BUSINESSES:** Because the substantive provisions of the existing rule will be reenacted as a new rule, repeal of the existing rule will not result in costs or savings to small businesses.

◆ **PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES:** Because the substantive provisions of the existing rule will be reenacted as a new rule, repeal of the existing rule will not result in costs or savings to other affected persons.

COMPLIANCE COSTS FOR AFFECTED PERSONS: The repeal of existing Rule R612-2 and reenactment of its substantive provisions in new Rules R612-100 and R612-300 will not change interested parties' rights or duties and will not impose any compliance costs on affected persons.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: The repeal of existing Rule R612-2, coupled with reenactment of the rule's substantive provisions in new Rules R612-100 and R612-300, is intended to make the rule easier to find and use by businesses and all other stakeholders in the workers' compensation system. The Commission does not anticipate that the improved organization of these rules will result in any fiscal impact on businesses.

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:

◆ Ron Dressler by phone at 801-530-6841, by FAX at 801-530-6804, or by Internet E-mail at rdressler@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN AT 5:00 PM ON 02/14/2013

THIS RULE MAY BECOME EFFECTIVE ON: 02/21/2013

AUTHORIZED BY: Sherrie Hayashi, 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.~~

~~R612-2-2. Authority:~~

~~_____ This rule is enacted under the authority of Section 34A-1-104 and Section 34A-2-407.~~

~~R612-2-3. Filings:~~

~~_____ A. Within one week following the initial examination of an industrial patient, nurse practitioners, 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 practitioner 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.

R612-2-4. Hospital or Surgery Pre-Authorization.

Any ambulatory surgery or inpatient hospitalization other than a life or limb threatening admission, allegedly related to an industrial injury or occupational disease, shall require pre-authorization by the employer/insurance carrier. Within two working days of a telephone request for pre-authorization, the employer/carrier shall notify the physician and employee of approval or denial of the surgery or hospitalization, or that a medical examination or review is going to be obtained. The medical examination/review must be conducted without undue delay which in most circumstances would be considered less than thirty days. If the request for pre-authorization is made in writing, the employer/carrier shall have four days from receipt of the request to notify the physician and employee. If the employee chooses to be hospitalized and/or to have the surgery prior to such pre-authorization or medical examination/review, the employee may be personally responsible for the bills incurred and may not be reimbursed for the time lost unless a determination is made in his/her favor.

R612-2-5. Regulation of Medical Practitioner Fees.

Pursuant to Section 34A-2-407(9):

A. The Labor Commission of Utah:

1. Establishes and regulates fees and other charges for medical provider services as required for the treatment of a work-related injury or illness.

2. Adopts and by this reference incorporates the Ingenix Essential RBRVS, 2011 1st Quarter Emergency Update ("RBRVS"), as the method for calculating reimbursement and the Ingenix 2011 Current Procedural Coding Expert ("CPT").

a. 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.

b. The CPT coding guidelines and 2011 First Quarter RBRVS, 1761 Edition, are subject to the Utah Labor Commission's Medical Fee Guidelines and the following Labor Commission conversion factors for medical care rendered for a work-related injury or illness, effective December 1, 2011: (Conversion Rates below EFFECTIVE December 1, 2011, to be used with the RBRVS procedural Unit value as per specialty.)

Anesthesiology \$40.00 (1 unit per 15 minutes of anesthesia);

Medicine, E and M \$44.00;

Evaluation and Management codes 99201 - 99204 and 99211 - 99214 \$44.00;

Pathology and Laboratory \$50.00;

Radiology \$51.00;

Restorative Services \$44.00;

Surgery \$36.00;

All 20000 codes, codes 49505 thru 49525 and all 60000 codes of the CPT-4 coding guidelines \$56.00.

3. Adopts and incorporates by this reference the Utah Labor Commission's 2012 Medical Fee Guidelines, effective December 1, 2011. The Utah Medical Fee Guidelines 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 <http://laborecommission.utah.gov/Provider%20Page.html#WorkersCompensation>.

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.

G. For procedures not covered by other provisions of this rule, medical providers have three options:

1. Medical providers may request preauthorization for a procedure from the insurance carrier.

2. Medical providers may present evidence to Medical Fee Committee for incorporating a procedure into the Commission's fee schedule. However, such incorporation will have prospective effect only.

3. Medical providers may apply for hearing before the Commission's Adjudication Division pursuant to Subsection 34A-2-801(1)(c) to establish a reasonable fee for the procedure.

R612-2-6. Fees in Cases Requiring Unusual Treatment.

The RBRVS scheduled fees are maximum fees except that fees higher than RBRVS scheduled may be authorized by the Commission when extraordinary difficulties encountered by the physician justify increased charges and are documented by written reports.

R612-2-7. Insurance Carrier's Privilege to Examine.

The employer or the employer's insurance carrier or a self-insured employer shall have the privilege of medical examination of an injured employee at any reasonable time. A copy of the medical examination report shall be made available to the Commission at any time upon request of the Commission.

R612-2-8. Who May Attend Industrial Patients.

_____A. The employer has first choice of physicians; but if the employer fails or refuses to provide medical attention, the employee has the choice of physicians.

_____B. An employee of an employer with an approved medical program may procure the services of any qualified practitioner for emergency treatment if a physician employed in the program is not available for any reason.

R612-2-9. Changes of Doctors and Hospitals.

_____A. It shall be the responsibility of the insurance carrier or self-insured employer to notify each claimant of the change of doctor rules. Those rules are as follows:

_____1. If a company doctor, designated facility or PPO is named; the employee must first treat with that designated provider. The insurance carrier or self-insured employer shall be responsible for payment for the initial visit, less any health insurance copays and subject to any health insurance reimbursement, if the employee was directed to and treated by the employer's or insurance carrier's designated provider, and liability for the claim is denied and if the treating physician provided treatment in good faith and provided the insurance carrier or self-insured employer a report necessary to make a determination of liability. Diagnostic studies beyond plain x-rays would need prior approval unless the claimed industrial injury or occupational illness required emergency diagnosis and treatment.

_____2. The employee may make one change of doctor without requesting the permission of the carrier, so long as the carrier is promptly notified of the change by the employee.

_____ (a) Physician referrals for treatment or consultation shall not be considered a change of doctor.

_____ (b) Changes from emergency room facilities to private physicians, unless the emergency room is named as the "company doctor", shall not be considered a change of doctor. However, once private physician care has begun, emergency room visits are prohibited except in cases of:

_____ (i) Private physician referral, or

_____ (ii) Threat to life.

_____3. Regardless of prior changes, a change of doctor shall be automatically approved if the treating physician fails or refuses to rate permanent partial impairment.

_____B. Any changes beyond those listed above made without the permission of the carrier/self-insurer may be at the employee's own expense if:

_____1. The employee has received notification of rules, or

_____2. A denial of request is made.

_____C. An injured employee who knowingly continues care after denial of liability by the carrier may be individually responsible for payment. It shall be the burden of the carrier to prove that the patient was aware of the denial.

_____D. It shall be the responsibility of the employee to make the proper filings with the division when changing locale and doctor. Those forms can be obtained from the division.

_____E. Except in special cases where simultaneous attendance by two or more medical care practitioners has been approved by the carrier/employer or the division, or specialized services are being provided the employee by another physician under the supervision and/or by the direct referral of the treating physician, the injured employee may be attended by only one practitioner and fees will not

be paid to two practitioners for similar care during the same period of time.

_____F. The Director of the Division of Industrial Accidents may authorize an injured worker to be examined by another physician for the purpose of obtaining a further medical examination or evaluation pertaining to the medical issues involved, and to obtain a report addressing these medical issues in all cases where:

_____1. The treating physician has failed or refused to give an impairment rating, and/or

_____2. A substantial injustice may occur without such further evaluation.

_____G. The Commission has jurisdiction to decide liability for medical care allegedly related to an industrial accident.

R612-2-10. One Fee Only to be Paid in Global Fee Cases.

_____In a global fee case which is transferred from one doctor to another doctor, one fee only will be paid, apportioned at the discretion of the Commission. Adequate remuneration shall also be paid to the medical practitioner who renders first aid treatment where the circumstances of the case require such treatment.

R612-2-11. Surgical Assistants' Fees.

_____Fees, in accordance with the Commission's adopted Resource-Based Relative Value Scale (RBRVS), in addition to the global fee for surgical services, will be paid surgical assistants only when specifically authorized by the employer or insurance carrier involved, or in hospitals where interns and residents are not available and the complexity of the surgery makes a surgical assistant necessary.

R612-2-12. Separate Bills.

_____Separate bills must be presented by each surgeon, assistant, anesthetist, consultant, hospital, special nurse, or other medical practitioner within 30 days of treatment on a HCFA 1500 billing form so that payment can be made to the medical practitioner who rendered the service. All bills must contain the federal ID number of the person submitting the bill.

R612-2-13. Interest for Medical Services.

_____A. All hospital and medical bills must be paid promptly on an accepted liability claim. All bills which have been submitted properly on an accepted liability claim are due and payable within 45 days of being billed unless the bill or a portion of the bill is in dispute. Any portion of the bill not in dispute is payable within 45 days of the billing.

_____B. Per Section 34A-2-420, any award for medical treatment made by the Commission shall include interest at 8% per annum from the date of billing for the medical service.

R612-2-14. Hospital Fees Separate.

_____Fees covering hospital care shall be separate from those for professional services and shall not extend beyond the actual necessary hospital care. When it becomes evident that the patient needs no further hospital treatment, he/she must be discharged. All billings must be submitted on a UB92 form and be properly itemized and coded and shall include all appropriate documentation to support the billing. There shall not be a separate fee charged for the necessary documentation in billing for payment of hospital services. The documentation of hospital services shall include at a minimum the

discharge summary. The insurance carrier may request further documentation if needed in order to determine liability for the bill.

R612-2-15. Charges for Ordinary Supplies, Materials, or Drugs.

Fees covering ordinary dressing materials or drugs used in treatment shall not be charged separately but shall be included in the amount allowed for office dressings or treatment.

R612-2-16. Charges for Special or Unusual Supplies, Materials, or Drugs.

A. Charges for special or unusual supplies, materials, or drugs not included as a normal and usual part of the service or procedure shall, upon receipt of an itemized and coded billing, be paid at cost plus 15% restocking fees.

B. For purposes of part A above, the amount to be paid shall be calculated as follows:

1. Applicable shipping charges shall be added to the purchase price of the product;

2. The 15% restocking fee shall then be added to the amount determined in sub part 1;

3. The amount of taxes paid on the purchase of the supplies, materials, or drugs shall then be added to the amount determined in sub part 2, which sum shall constitute the total amount to be paid.

R612-2-17. Fees for Unscheduled Procedures.

Fees for medical or surgical procedures not appearing in the Commission's adopted RBRVS current fee schedule are subject to the Commission's approval and should be submitted to the Commission when the physician and employer or insurance carrier do not agree on the value of the service. Such fees shall be in proportion as nearly as practicable to fees for similar services appearing in the RBRVS.

R612-2-18. Dental Injuries.

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.

R612-2-19. Ambulance Charges.

Ambulance charges must not exceed the rates adopted by the State Emergency Medical Service Commission for similar services.

R612-2-20. Travel Allowance and Per Diem.

A. An employee who, based upon his/her physician's advice, requires hospital, medical, surgical, or consultant services for injuries arising out of and in the course of employment and who is authorized by the self-insurer, the carrier, or the Commission to obtain such services from a physician and/or hospital shall be entitled to:

1. Subsistence expenses of \$6 per day for breakfast, \$9 per day for lunch, \$15 per day for dinner, and actual lodging expenses as per the state of Utah's in-state travel policy provided:

(a) The employee travels to a community other than his/her own place of residence and the distance from said community and the employee's home prohibits return by 10:00 p.m., and

(b) The absence from home is necessary at the normal hour for the meal billed.

2. Reasonable travel expenses regardless of distance that are consistent with the state of Utah's travel reimbursement rates, or actual reasonable costs of practical transportation modes above the state's travel reimbursement rates as may be required due to the nature of the disability.

B. This rule applies to all travel to and from medical care with the following restrictions:

1. The carrier is not required to reimburse the injured employee more often than every three months, unless:
 - (a) More than \$100 is involved, or
 - (b) The case is about to be closed.
2. All travel must be by the most direct route and to the nearest location where adequate treatment is reasonably available.
3. Travel may not be required between the hours of 10:00 p.m. and 6:00 a.m., unless approved by the Commission.
4. Requests for travel reimbursement must be submitted to the carrier for payment within one year of the authorized medical care.
5. Travel allowance shall not include picking up prescriptions unless documentation is provided substantiating a claim that prescriptions cannot be obtained locally within the injured worker's community.
6. The Commission has jurisdiction to resolve all disputes.

R612-2-21. Notice to Health Care Providers.

Any notice from a carrier denying further liability must be mailed to the Commission and the patient on the same day as it is mailed to the health care provider. Where it can be shown, in fact, that a medical care provider and the injured employee have received a denial of further care by the insurance carrier or self-insured employer, further treatment may be performed at the expense of the employee. Any future ratification of the denial by the Commission will not be considered a retroactive denial but will serve to uphold the force and effect of the previous denial notice.

R612-2-22. Medical Records.

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 extent 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, a designated person(s) within the Industrial Accidents Division or an administrative law judge if the claim is being adjudicated.

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 and 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.

R612-2-23. Adjusting Resource-Based Relative Value Scale (RBRVS) Codes.

A. When adjusting any medical provider's bill who has billed per the Commission's adopted RBRVS the adjusting entity shall provide one or more of the following explanations as applies to the down coding when payment is made to the medical provider:

1. Code 99202, 99203, 99204 or 99205 - the submitted documentation for a new patient did not meet the three key components lacking in the level of history for the code billed.

2. Code 99202, 99203, 99204 or 99205 - the submitted documentation for a new patient did not meet the three key components lacking in the level of examination for the code billed.

3. Code 99202, 99203, 99204 or 99205 - the submitted documentation for a new patient did not meet the three key components lacking in the level of medical decision making for the code billed.

4. Code 99202, 99203, 99204, or 99205 - the submitted documentation for a new patient did not meet the three key components lacking in the level of history and exam for the code billed.

5. Code 99213, 99214 or 99215 - the submitted documentation for an established patient did not meet the two key components lacking in the level of history and exam that the code billed.

6. Code 99213, 99214 or 99215 - the submitted documentation for an established patient did not meet the two key components lacking in the level of history and medical decision making for the code billed.

7. Code 99213, 99214 or 99215 - the submitted documentation for the established patient did not meet the two key components lacking in the level of exam and medical decision making for the code billed.

B. The above explanations may be abbreviated, with a legend provided, to accommodate the space of computerized messages.

R612-2-24. Review of Medical Payments.

A. Health care providers and payors are primarily responsible to resolve disputes over fees for medical services between themselves. However, in some cases it is necessary to submit such disputes to the Division for resolution. The Commission therefore establishes the following procedure for submission and review of fees for medical services:

1. The provider shall submit a bill for services rendered, with supporting documentation, to the payor within one year of the date of service;

2. The payor shall evaluate the bill according to the guidelines contained in the Commission's Medical Fee Guidelines and RBRVS and shall pay the provider the appropriate fee within 45 days as required by Rule R612-2-13.

3. If the provider believes that the payor has improperly computed the fee under the RBRVS, the provider or designee shall request the payor to re-evaluate the fee. The provider's request for re-evaluation shall be in writing, shall describe the specific areas of disagreement and shall include all appropriate documentation. The provider shall submit all requests for re-evaluation to the payor within one year of the date of the original payment.

4. Within 30 days of receipt of the written request for re-evaluation, the payor shall either pay the additional fee due the provider or respond with a specific written explanation of the basis for its denial of additional fees. The payor shall maintain proof of transmittal of its response.

B. If the provider continues to disagree with the payor's determination of the appropriate fee, the provider shall submit the matter to the Division by filing with the Division a written explanation of the disagreement. The provider's explanation shall include copies of:

1. The provider's original bill and supporting documentation;

2. The payor's initial payment of that bill;

3. The provider's request for re-evaluation and supporting documentation; and

4. The payor's written explanation or its denial of additional fees.

C. The Division will evaluate the dispute according to the requirements of the Medical Fee Guidelines and RBRVS and, if necessary, by consulting with the provider, payor, or medical specialists. Within 45 days from the date the Division receives the provider's request, the Division will mail its determination to both parties.

D. Any party aggrieved by the Division's determination may file an application for hearing with the Division of Adjudication to obtain formal adjudication of the dispute.

E. A payor seeking reimbursement from a provider for overpayment of a bill shall submit a written request to the provider detailing the circumstances of the payment requested within one year of submission of the bill.

1. Providers should make appropriate reimbursements, or respond in writing detailing the reasons why repayment will not be made, within 90 days of receipt of a written request from a payor.

2. If a dispute as to reimbursement occurs, an aggrieved party may request resolution of the dispute by the Labor Commission.

R612-2-25. Injured Worker's Right to Privacy.

A. No agent of the employer or the employer's insurance carrier shall be present during an injured worker's visit with a medical provider, unless agreed upon by the claimant.

B. If an agent of the employer or the employer's insurance carrier is excluded from the medical visit, the medical provider and the injured worker shall meet with the agent at the conclusion of the visit so as to communicate regarding medical care and return to work issues.

R612-2-26. Utilization Review Standards.

A. As used in this subsection:

1. "Payor" means a workers' compensation insurance carrier, a self-insured employer, third-party administrator, uninsured employer or the Uninsured Employers' Fund, which is responsible for payment of the workers' compensation claim.

2. "Health Care Provider" means a provider of medical services, including an individual provider, a health service plan, a health care organization, or a preferred provider organization.

3. "Request for Authorization" means any request by a physician for assurance that appropriate payment will be made for a course of proposed medical treatment, including surgery or hospitalization, or any diagnostic studies beyond plain X-rays.

4. "Utilization Review," as authorized in Section 34A-2-111, is a process used to manage medical costs, improve patient care, and enhance decision-making. Utilization review includes, but is not limited to, the review of requests for authorization to treat, and the review of bills, for the purpose of determining whether the medical services provided were or would be necessary, to treat the effects of the injury/illness. Utilization review does not include bill review for the purpose of determining whether the medical services rendered were accurately billed. Nor does it include any system, program, or activity in connection with making decisions concerning whether a person has sustained an injury or illness which is compensable under Section 34A-2 or 34A-3.

5. "Reasonable Attempt" is defined as at least two phone calls and a fax, or three phone calls, within five business days from date of the payor's receipt of the physician's request for review.

B. Any utilization review system shall establish an appeals process which utilizes a physician(s) for a final decision by the insurer, should an initial review decision be contested. The payor may establish levels of review that meet the following criteria:

1. Level I-Initial Request and Review. A payor may use medical or non-medical personnel to initially apply medically-based criteria to a request for authorization for payment of a specific treatment. The treating physician must send all the necessary documentation for the payor to make a decision regarding the treatment recommended. The payor must then notify the physician within five business days of the request for authorization of payment for the treatment, by a method which provides certification of transmission of the document, of either an acceptance or a denial of the request. A denial for authorization of payment for a recommended treatment utilizing the Commission's form, Form 223, must be sent to the provider with the criteria used in making the determination to deny payment for the treatment. A copy of the denial must also be mailed to the claimant. Level I-Request and Review does not include authorization requests for services billed from the Restorative section of the Resource-Based Relative Value Scale (RBRVS). Requests for authorization for restorative services are governed by rule R612-2-3(B).

2. Level II-Review. A physician, who has been denied authorization of payment for treatment, or has received no response within five business days from the request for authorization for payment at Level I review, may request a physician's review by sending the completed portion of the Commission form 223 to the payor. Such a request for review may be filed by any physician who has been denied authorization for payment for restorative services beyond the initial eight visits as authorized by Rule R612-2-3(B). The requesting physician must include the times and days that he/she is

available to discuss the case with the reviewing physician, and must be reasonably available during normal business hours. The payor's physician representative must complete the review within five business days of the treating physician's request for review. Before the insurer's physician representative may issue a denial of an authorization for payment to treat, a reasonable effort must have been made to contact the requesting treating physician to discuss the differing aspects of the case. Failure by the payor to respond within five business days, by a method which provides certification of transmission, to a denial for authorization for payment for treatment, shall constitute an authorization for payment of the treatment. The payor's denial to pay for the recommended treatment must be issued on Commission's form 223, and the denial must be accompanied by the criteria that was used in making the decision to deny authorization, along with the name and speciality of the reviewing physician. The denial to authorize payment for treatment must then be sent to the physician, the claimant, and the Commission. The payor shall notify the Commission if an additional five days is needed in order to contact the treating physician or to review the case. An additional extension of time may be requested from the Commission to accommodate highly unusual circumstances or particularly difficult cases.

C. Upon receipt of denial of authorization for payment for medical treatment at Level II, the Commission will facilitate, upon the request of the claimant, the final disposition of the case. If the parties agree, the medical dispute may be resolved by the Commission through binding mediation or medical review. If there is not agreement among the parties, the Commission will resolve the dispute through formal adjudication. The payor shall be responsible for sending the claimant the Commission appeals information when the denial for authorization for payment for medical treatment is sent to the claimant.

D. If the medical treatment requested is not an emergency, and treatment is rendered by the physician after receiving notice of the utilization standards encompassed in this rule, the following shall apply:

1. The Commission shall, if the disputed medical treatment is ultimately determined to be compensable as an expense necessary to treat the industrial injury or occupational disease, order that the physician be reimbursed at only 75% of the of the amount otherwise payable had appropriate authorization been timely obtained. The injured worker shall not be liable for any additional payment to the physician above the 75%.

2. Neither the worker's employer or its workers' compensation insurer shall be liable for any portion of the cost of disputed medical treatment, if that treatment is ultimately determined not to be compensable as an expense necessary to treat an industrial injury or occupational disease.

3. A worker may become liable for the cost of the disputed medical treatment, if that treatment is ultimately determined not to be compensable as an expense necessary to treat the industrial injury or occupational disease.

4. Except for any co-pays or deductibles under the worker's health insurance plan, the penalty provision in D(1) and D(3) shall not apply if the physician performs the medical treatment in question, having been preauthorized in writing to do the same by a health insurer or other non-worker's compensation insurance payor.

5. The penalty provisions in D(1) shall not apply to medical treatment rendered in emergency situations, which are defined as a threat to life or limb.

6. The Commission shall notify a physician, in writing, of reported violations of this rule. Repeated violations of this rule by a physician may result in a report from the Commission to the Department of Commerce, Division of Occupational/Professional Licensing.

~~R612-2-27. Commission Approval of Health Care Treatment Protocol.~~

A. Authority. Pursuant to authority granted by Section 34A-2-111(2)(c)(i)(B)(VII) of the Utah Workers' Compensation Act, the Utah Labor Commission establishes the following standards and procedures for Commission approval of medical treatment and quality care guidelines:

B. Standards:

1. Scientifically based: Section 34A-2-111(2)(c)(i)(B)(VII) (Aa) of the Act requires that guidelines be scientifically based. The Commission will consider a guideline to be "scientifically based" when it is supported by medical studies and/or research.

2. Peer reviewed: Section 34A-2-111(2)(c)(i)(B)(VII)(Bb) of the Act requires that guidelines be peer reviewed. The Commission will consider a guideline to be "peer reviewed" when the medical study's content, methodology, and results have been reviewed and approved prior to publication by an editorial board of qualified experts.

3. Other standards: Pursuant to its rulemaking authority under Section 34A-2-111(2)(c)(i)(B)(VII), the Utah Labor Commission establishes the following additional standards for medical treatment and quality care guidelines:

a. The guidelines must be periodically updated and, subject to Commission discretion, may not be approved for use unless updated in whole or in part at least biannually;

b. Guideline sources must be identified;

c. The guidelines must be reasonably priced;

d. The guidelines must be easily accessible in print and electronic versions.

C. Procedure: Pursuant to Section 34A-2-111(2)(c)(i)(B) (VII) of the Utah Workers' Compensation Act, a party seeking Commission action to approve or disapprove a guideline shall file a petition for such action with the Labor Commission.

KEY: workers' compensation, fees, medical practitioner

Date of Enactment or Last Substantive Amendment: November 21, 2011

Notice of Continuation: April 28, 2008

Authorizing, and Implemented or Interpreted Law: 34A-2-101 et seq.; 34A-3-101 et seq.; 34A-1-104]

Labor Commission, Industrial Accidents **R612-3** Workers' Compensation Rules - Self-Insurance

NOTICE OF PROPOSED RULE

(Repeal)

DAR FILE NO.: 37131

FILED: 12/28/2012

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The Labor Commission proposes to repeal this and other Industrial Accident Division rules in order to consolidate, reorganize, and reenact the substance of those rules in a format that is more logical and user friendly.

SUMMARY OF THE RULE OR CHANGE: The existing Rule R612-3 will be repealed in its entirety. The substance of the existing rule will be reenacted in new Rules R612-100 and R612-400. (DAR NOTE: The proposed new Rule R612-100 is under DAR No. 37124, and the proposed new Rule R612-400 is under DAR No. 37127 in this issue, January 15, 2013, of the Bulletin.)

STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 34A-1-104 and Section 34A-2-201

ANTICIPATED COST OR SAVINGS TO:

- ◆ **THE STATE BUDGET:** Because the substantive provisions of the existing rule will be reenacted as a new rule, repeal of the existing rule will not result in costs or savings to the state budget.
- ◆ **LOCAL GOVERNMENTS:** Because the substantive provisions of the existing rule will be reenacted as a new rule, repeal of the existing rule will not result in costs or savings to local government.
- ◆ **SMALL BUSINESSES:** Because the substantive provisions of the existing rule will be reenacted as a new rule, repeal of the existing rule will not result in costs or savings to small businesses.
- ◆ **PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES:** Because the substantive provisions of the existing rule will be reenacted as a new rule, repeal of the existing rule will not result in costs or savings to other affected persons.

COMPLIANCE COSTS FOR AFFECTED PERSONS: The repeal of existing Rule R612-3 and reenactment of its substantive provisions in Rules R612-100 and R612-400 will not change interested parties' rights or duties and will not impose any compliance costs on affected persons.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: The repeal of existing Rule R612-3, coupled with reenactment of the rule's substantive provisions in the new Rules R612-100 and R612-400, is intended to make the rule easier to find and use by businesses and all other stakeholders in the workers' compensation system. The Commission does not anticipate that the improved organization of these rules will result in any fiscal impact on businesses.

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:

◆ Ron Dressler by phone at 801-530-6841, by FAX at 801-530-6804, or by Internet E-mail at rdressler@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN AT 5:00 PM ON 02/14/2013

THIS RULE MAY BECOME EFFECTIVE ON: 02/21/2013

AUTHORIZED BY: Sherrie Hayashi, Commissioner

R612. Labor Commission, Industrial Accidents.**[R612-3. Workers' Compensation Rules - Self-Insurance.****R612-3-1. Definitions.**

A. "Reserve" is defined as the amount necessary to satisfy all debts, past, present, and future, incurred by reason of industrial accidents or occupational diseases, the origins of which commenced prior to the date of reserve determination.

B. "Aggregate Excess Insurance" is defined as the amount of insurance required to cover the total accumulated workers' compensation benefits for all claims payable for a given period of time with the employer retaining an obligation for a designated amount as a deductible and the insurance company paying all amounts due thereafter up to a maximum total obligation.

C. "Specific Excess Insurance" is defined as the amount of insurance required to cover the workers' compensation benefits arising out of a specific occurrence (accident) or occupational disease under the Workers' Compensation Law with the employer retaining an obligation for a designated amount as a deductible and the insurance company assuming the obligation for all amounts due thereafter up to a maximum total obligation.

D. In addition to the foregoing definitions, all definitions in Rule R612-1 apply to this section.

R612-3-2. Authority.

This rule is enacted under the authority of Section 34A-1-104.

R612-3-3. Application.

A. An employer seeking authorization to become self-insured under the provision of Section 34A-2-201 of the Utah Workers' Compensation Act must apply to the division through the use of a form entitled "Application for Self Insurance."

B. The division will require annual renewals for continuing self-insurance. Renewal, through the use of a form entitled "Renewal Application for Self Insurance", will require an update of the initial information. Renewal information must be submitted at least 60 days

before the self-insurance anniversary date. Failure to file a renewal application on time may result in an interruption or cancellation of self-insurance privileges.

C. The initial and all renewal applications must be completed and signed by the employer's duly authorized representative.

R612-3-4. Qualifying Requirements.

A. To qualify, an employer must be in business for a period of not less than five years and shall demonstrate sufficient financial strength and liquidity of the business to assure that all obligations will be promptly met. An employer in business less than five years will be considered only if a pre-existing parent corporation (in business more than five years) guarantees the liability. In cases of merger or name-identification change, the history of the pre-existing entity will be considered for the five year requirement. Upon applying for self-insurance privileges, the applicant must forward a current, certified financial statement or other proof of financial ability to pay direct compensation and other expenses as provided by Section 34A-2-201. Mergers occurring after an entity is self-insured will require a new application by the merged entity. However, entities whose financial information can be obtained from Dunn and Bradstreet will not be required to file financial statements unless clarification or supplemental statements are deemed appropriate or necessary.

B. Specific or aggregate excess insurance with policy limits and retention amounts acceptable are required as a condition of approval and continuation of self-insurance privileges.

C. Excess Insurance policies shall include a bankruptcy and insolvency endorsement (Form 303) for each self-insured entity. The endorsement adds the Uninsured Employer's Fund to the excess insurance policy and specifies the conditions of the Utah bankruptcy and insolvency endorsement for individual self-insureds.

D. A minimum \$100,000 surety bond.

E. No corporate surety shall be eligible to write self-insurers' surety bonds or excess insurance unless authorized to transact such business in this state.

F. Surety bonds must be issued on a prescribed form entitled "Self-Insurance Aggregate Surety Bond" and shall be exchanged or replaced with another surety bond only if a 60-day notice of termination of liability is given by the bonding company. The replacement bond must be issued on a form as prescribed by the Commission. No replacements will be authorized by the Commission unless the new surety accepts the liability of the previous surety(ies) or a guarantee is filed by both (all) sureties acknowledging their respective liabilities and periods of time covering such liabilities.

G. All subsidiary companies must have the parent company guarantee liability for payment of benefits (unless such requirement is waived by the division). The form and substance of such guarantees are to be approved by the division.

H. The division may utilize services such as Dunn and Bradstreet credit ratings for the purpose of evaluating a company's financial ability to pay.

I. Entities that fall within the top two composite credit appraisal ratings by Dunn and Bradstreet (or information from an equivalent service) and their top two ratings on estimated financial strength may qualify for self-insurance in Utah with the minimum requirements as set forth in Rule R612-3-4C. Companies with a 5A or

4A estimated financial strength rating and falling within the fair-composite credit appraisal of Dunn and Bradstreet may qualify for self-insurance with higher security requirements as determined by the division. The provisions herein are to be construed as optional, with the division having the option.

J. Self-insured entities, or their parent company if such is a guarantor, that fall below either the 5A or 4A estimated financial strength rating or the top three composite credit appraisal ratings of Dunn and Bradstreet will not be allowed to self-insure. A company already self-insured that falls in the aforementioned disqualifying categories will not be allowed to continue self-insurance privileges. However, at the discretion of the division continuation of self-insurance will be considered if the following steps are taken:

1. An independent actuarial study satisfactory to the division and the employer is made of the reserve requirements of the self-insured entity, said study to be at the employer's expense. Selection of the actuary will be mutually agreed upon by the division and the employer. However, should the parties fail to agree, the division will make the final selection.

2. Satisfactory security is obtained for the reserves plus the aggregate excess retention amount.

3. Any company whose self-insurance privileges are revoked under the provisions of these rules will be required to obtain security for their reserve requirements under the foregoing two-step process regardless of whether or not self-insurance privileges are continued.

4. Companies whose privileges are to be revoked will be allowed 60 days from notice to comply with steps 1 through 3 above.

5. Quarterly financial reviews will be taken of entities which retain their self-insurance privileges by following 1, 2, and 3 above.

K. Security requirements for all entities requiring security will be determined by a review of past incurred losses and application of exposure, loss, and contingency factors. The minimum acceptable bond amount is \$100,000.

L. Public and eleemosynary entities are classified as special categories requiring separate consideration for self-insurance privileges and security requirements.

R612-3-5. Administration of the Self-Insurance Program.

A. A self-insurer must procure the services of an insurance carrier or adjusting company to administer the self-insurance program with regard to claims, setting up of reserves, and safety programs; or

B. The self-insurer must show proof of sufficient and competent staff to administer the self-insurance program and provide safety engineering. The division reserves the right to train and test adjusters and administrators of self-insurance programs.

C. Whether a self-insurer hires their own adjuster or contracts with an insurance carrier or service organization, the following conditions must be met:

1. A knowledgeable contact concerning claims will be located in the state of Utah;

2. The self-insurer will maintain a toll free number or accept during office hours a reasonable number of collect calls from injured employees if either employees of the company or the division offices are in a different city than that of the adjuster.

~~_____ D. The self-insurer will comply with all rules of the Commission and with the Workers' Compensation Act.~~

R612-3-6. Notice of Certification for Self-Insurance or Denial and Renewal.

~~_____ Upon meeting the requirements set forth in these rules, an employer shall receive a formal certificate approving self-insured status. The privilege may be renewed from year to year with renewal procedure as required by these rules. An employer whose original or renewal application for self-insurance has been denied or revoked, or who takes exception to insurance or reserve requirements, may request a review or reconsideration by the Commission. The request must be made within 20 days of the notice of Commission action issued to the employer. A request for review will not automatically extend the authorization to self-insure. However, the Commission may extend the privilege pending review. Without such an extension, the privilege is revoked on the anniversary date.~~

R612-3-7. Revocation of Right to Self-Insure.

~~_____ The right to self-insure may be revoked by the division for failure to comply with the rules contained herein.~~

~~**KEY:** self insurance plans, workers' compensation, benefits~~

~~**Date of Enactment or Last Substantive Amendment:** October 22, 2012~~

~~**Notice of Continuation:** April 28, 2008~~

~~**Authorizing, and Implemented or Interpreted Law:** 34A-1-104; 34A-2-201]~~

Labor Commission, Industrial Accidents **R612-4** Premium Rates

NOTICE OF PROPOSED RULE

(Repeal)

DAR FILE NO.: 37132

FILED: 12/28/2012

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The Labor Commission proposes to repeal this and other Industrial Accident Division rules in order to consolidate, reorganize, and reenact the substance of those rules in a format that is more logical and user friendly.

SUMMARY OF THE RULE OR CHANGE: The exiting Rule R612-4 will be repealed in its entirety. The substance of the existing rule will be reenacted in new Rules R612-100 and R612-400. (DAR NOTE: The proposed new Rule R612-100 is under DAR No. 37124, and the proposed new Rule R612-400 is under DAR No. 37127 in this issue, January 15, 2013, of the Bulletin.)

STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Subsection 59-9-101(2)

ANTICIPATED COST OR SAVINGS TO:

◆ **THE STATE BUDGET:** Because the substantive provisions of the existing rule will be reenacted as a new rule, repeal of the existing rule will not result in costs or savings to the state budget.

◆ **LOCAL GOVERNMENTS:** Because the substantive provisions of the existing rule will be reenacted as a new rule, repeal of the existing rule will not result in costs or savings to local government.

◆ **SMALL BUSINESSES:** Because the substantive provisions of the existing rule will be reenacted as a new rule, repeal of the existing rule will not result in costs or savings to small businesses.

◆ **PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES:** Because the substantive provisions of the existing rule will be reenacted as a new rule, repeal of the existing rule will not result in costs or savings to other affected persons.

COMPLIANCE COSTS FOR AFFECTED PERSONS: The repeal of existing Rule R612-4 and reenactment of its substantive provisions in new Rules R612-100 and R612-400 will not change interested parties' rights or duties and will not impose any compliance costs on affected persons.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: The repeal of existing Rule R612-4, coupled with reenactment of the rule's substantive provisions in new Rules R612-100 and R612-400, is intended to make the rule easier to find and use by businesses and all other stakeholders in the workers' compensation system. The Commission does not anticipate that the improved organization of these rules will result in any fiscal impact on businesses.

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:

◆ Ron Dressler by phone at 801-530-6841, by FAX at 801-530-6804, or by Internet E-mail at rdressler@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN AT 5:00 PM ON 02/14/2013

THIS RULE MAY BECOME EFFECTIVE ON: 02/21/2013

AUTHORIZED BY: Sherrie Hayashi, Commissioner

R612. Labor Commission, Industrial Accidents.

~~[R612-4. Premium Rates:~~

~~R612-4-1. Authority.~~

~~_____ This rule is enacted under the authority of Section 34A-1-104 and 59-9-101.~~

~~R612-4-2. Premium Rates for the Uninsured Employers' Fund and the Employers' Reinsurance Fund.~~

~~_____ A. Pursuant to Section 59-9-101(2), Section 59-9-101.3 and 34A-2-202 the workers' compensation premium rates effective January 1, 2012, as established by the Labor Commission, shall be:~~

~~_____ 1. 0.05% for the Uninsured Employers' Fund;~~

~~_____ 2. 3.0% for the Employers' Reinsurance Fund;~~

~~_____ B. The premium rates are a percentage of the total workers' compensation insurance premium income as detailed in Section 59-9-101(2)(a).~~

~~KEY: workers' compensation, rates~~

~~Date of Enactment or Last Substantive Amendment: January 1, 2012~~

~~Notice of Continuation: December 8, 2010~~

~~Authorizing, and Implemented or Interpreted Law: 59-9-101(2)]~~

Labor Commission, Industrial Accidents
R612-5
Employee Leasing Company Workers'
Compensation Insurance Policy
Endorsements

NOTICE OF PROPOSED RULE

(Repeal)

DAR FILE NO.: 37133

FILED: 12/28/2012

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The Labor Commission proposes to repeal this and other Industrial Accident Division rules in order to consolidate, reorganize, and reenact the substance of those rules in a format that is more logical and user friendly.

SUMMARY OF THE RULE OR CHANGE: The existing Rule R612-5 will be repealed in its entirety. The substance of the existing rules will be reenacted in new Rules R612-100 and R612-400. (DAR NOTE: The proposed new Rule R612-100 is under DAR No. 37124, and the proposed new Rule R612-400 is under DAR No. 37127 in this issue, January 15, 2013, of the Bulletin.)

STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 34A-2-103

ANTICIPATED COST OR SAVINGS TO:

◆ THE STATE BUDGET: Because the substantive provisions of the existing rule will be reenacted as a new rule, repeal of the existing rule will not result in costs or savings to the state budget.

◆ LOCAL GOVERNMENTS: Because the substantive provisions of the existing rule will be reenacted as a new rule, repeal of the existing rule will not result in costs or savings to local government.

◆ SMALL BUSINESSES: Because the substantive provisions of the existing rule will be reenacted as a new rule, repeal of the existing rule will not result in costs or savings to small businesses.

◆ PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES: Because the substantive provisions of the existing rule will be reenacted as a new rule, repeal of the existing rule will not result in costs or savings to other affected persons.

COMPLIANCE COSTS FOR AFFECTED PERSONS: The repeal of existing Rule R612-5 and reenactment of its substantive provisions in Rules R612-100 and R612-400 will not change interested parties' rights or duties and will not impose any compliance costs on affected persons.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: The repeal of existing Rule R612-5, coupled with reenactment of the rule's substantive provisions in new Rules R612-100 and R612-400, is intended to make the rule easier to find and use by businesses and all other stakeholders in the workers' compensation system. The Commission does not anticipate that the improved organization of these rules will result in any fiscal impact on businesses.

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:

◆ Ron Dressler by phone at 801-530-6841, by FAX at 801-530-6804, or by Internet E-mail at rdressler@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN AT 5:00 PM ON 02/14/2013

THIS RULE MAY BECOME EFFECTIVE ON: 02/21/2013

AUTHORIZED BY: Sherrie Hayashi, Commissioner

R612. Labor Commission, Industrial Accidents.**~~R612-5. Employee Leasing Company Workers' Compensation Insurance Policy Endorsements.~~****~~R612-5-1. Authority.~~**

~~This rule is enacted under the authority of Sections 34A-1-104 and 34A-2-103.~~

~~R612-5-2. Definition.~~

~~A. For the purposes of this rule an employee leasing company is as defined per Title 58, Chapter 59.~~

~~B. In addition to the foregoing definition, all definitions in Rule R612-1 apply to this section.~~

~~R612-5-3. Workers' Compensation Coverage for Client Companies Under an Endorsement Arrangement.~~

~~An insurance company licensed to write workers' compensation coverage in the state of Utah underwriting an employee leasing company as the named insured shall insure all of the primary insured's client companies under an umbrella policy and shall provide a separate endorsement for each client company unless the client company provides workers' compensation coverage under a separate policy.~~

~~R612-5-4. Notification of a New Policy and Endorsements.~~

~~A. Any insurance carrier underwriting a new policy naming an employee leasing company as the primary insured shall notify the division in writing or by electronic means within ten working days of the new policy including all client companies covered under the policy. The notification shall include all the information as specified in this rule.~~

~~B. The insurance carrier shall subsequently notify the division in writing or by electronic means within ten working days of any new client company endorsements covered under a leasing company's umbrella policy after the initial policy is written giving all information as specified in this rule.~~

~~R612-5-5. Cancellations.~~

~~Any insurance carrier underwriting an employee leasing company as the primary insured shall:~~

~~A. Give the division a 30 day advance notice in writing or by electronic means of a proposed cancellation of an employee leasing company or any client company written as an endorsement under an employee leasing company's policy.~~

~~B. Give the division notice in writing or through electronic means within ten working days after cancellation of a policy underwritten naming the employee leasing company as the primary insured and any cancellation of an endorsement of a client company covered under the primary insured.~~

~~C. Failure by an insurance carrier to notify the division of the cancellation of either the primary insured employee leasing company or a client company will result in the continuation of coverage by the insurance carrier until the division receives notification as specified in this rule.~~

~~R612-5-6. Required Information.~~

~~The following information is required on any notice sent to the division on a policy underwritten by the insurance carrier naming an employee leasing company as the primary insured.~~

~~A. Name and both mailing and physical address of the employee leasing company.~~

~~B. The policy number and effective dates of coverage for the employee leasing company.~~

~~C. Each client company's DBA's (doing business as) names(s) and mailing and physical location(s).~~

~~D. The Standard Industrial Classification (SIC) for each client company.~~

~~E. The effective dates of coverage on the endorsement for each client company.~~

~~R612-5-7. Reporting of Injuries.~~

~~The reporting of injuries as required in Section 34A-2-407 shall be in the name of the client company.~~

KEY: workers' compensation, employer, insurance

Date of Enactment or Last Substantive Amendment: 1993

Notice of Continuation: April 28, 2008

Authorizing, and Implemented or Interpreted Law: 34A-2-103]

Labor Commission, Industrial Accidents**R612-6****Notification of Workers' Compensation Insurance Coverage****NOTICE OF PROPOSED RULE**

(Repeal)

DAR FILE NO.: 37134

FILED: 12/28/2012

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The Labor Commission proposes to repeal this and other Industrial Accident Division rules in order to consolidate, reorganize, and reenact the substance of those rules in a format that is more logical and user friendly.

SUMMARY OF THE RULE OR CHANGE: The existing Rule R612-6 will be repealed in its entirety. The substance of the existing rule will be reenacted in new Rule R612-400. (DAR NOTE: The proposed new Rule R612-400 is under DAR No. 37127 in this issue, January 15, 2013, of the Bulletin.)

STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 34A-2-205

ANTICIPATED COST OR SAVINGS TO:

♦ **THE STATE BUDGET:** Because the substantive provisions of the existing rule will be reenacted as a new rule, repeal of the existing rule will not result in costs or savings to the state budget.

♦ **LOCAL GOVERNMENTS:** Because the substantive provisions of the existing rule will be reenacted as a new rule, repeal of the existing rule will not result in costs or savings to the local government.

◆ **SMALL BUSINESSES:** Because the substantive provisions of the existing rule will be reenacted as a new rule, repeal of the existing rule will not result in costs or savings to small businesses.

◆ **PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES:** Because the substantive provisions of the existing rule will be reenacted as a new rule, repeal of the existing rule will not result in costs or savings to other affected persons.

COMPLIANCE COSTS FOR AFFECTED PERSONS: The repeal of existing Rule R612-6 and reenactment of its substantive provision in Rule R612-400 will not change interested parties' rights or duties and will not impose any compliance costs on affected persons.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: The repeal of existing Rule R612-6, coupled with reenactment of the rule's substantive provisions in the new Rule R612-400, is intended to make the rule easier to find and use by businesses and all other stakeholders in the workers' compensation system. The Commission does not anticipate that the improved organization of these rules will result in any fiscal impact on businesses.

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:
◆ Ron Dressler by phone at 801-530-6841, by FAX at 801-530-6804, or by Internet E-mail at rdressler@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN AT 5:00 PM ON 02/14/2013

THIS RULE MAY BECOME EFFECTIVE ON: 02/21/2013

AUTHORIZED BY: Sherrie Hayashi, Commissioner

R612. Labor Commission, Industrial Accidents.
~~[R612-6. Notification of Workers' Compensation Insurance Coverage.~~
~~R612-6-1. Notification of Workers' Compensation Insurance Coverage.~~

~~Any insurance carrier subject to the policy reporting requirements of Section 34A-2-205 may satisfy such reporting requirements by either of the following methods:~~

~~1. The insurance carrier may directly file the required information electronically with the Industrial Accidents Division in~~

~~accordance with the International Association of Industrial Accidents Boards and Commissions (IAIABC) standards and format.~~

~~2. Alternatively, the insurance carrier may use an agent to file the required information electronically with the Industrial Accidents Division in accordance with IAIABC standards and format, provided that the agent has been authorized by the Labor Commission as meeting its electronic filing standards.~~

~~**KEY: workers' compensation**
Date of Enactment or Last Substantive Amendment: October 16, 2001
Notice of Continuation: September 3, 2010
Authorizing, and Implemented or Interpreted Law: 34A-2-205]~~

Labor Commission, Industrial Accidents **R612-7** Impairment Ratings for Industrial Injuries and Diseases

NOTICE OF PROPOSED RULE (Repeal)

DAR FILE NO.: 37135
FILED: 12/28/2012

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The Labor Commission proposes to repeal this and other Industrial Accident Division rules in order to consolidate, reorganize, and reenact the substance of those rules in a format that is more logical and user friendly.

SUMMARY OF THE RULE OR CHANGE: The existing Rule R612-6 will be repealed in its entirety. The substance of the existing rule will be reenacted in new Rules R612-100 and R612-300. (DAR NOTE: The proposed new Rule R612-100 is under DAR No. 37124, and the proposed new Rule R612-300 is under DAR No. 37126 in this issue, January 15, 2013, of the Bulletin.)

STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 34A-1-104 and Section 34A-2-412

ANTICIPATED COST OR SAVINGS TO:

◆ **THE STATE BUDGET:** Because the substantive provisions of the existing rule will be reenacted as a new rule, repeal of the existing rule will not result in costs or savings to the state budget.

◆ **LOCAL GOVERNMENTS:** Because the substantive provisions of the existing rule will be reenacted as a new rule, repeal of the existing rule will not result in costs or savings to local government.

◆ **SMALL BUSINESSES:** Because the substantive provisions of the existing rule will be reenacted as a new rule, repeal of the existing rule will not result in costs or savings to small businesses.

◆ PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES: Because the substantive provisions of the existing rule will be reenacted as a new rule, repeal of the existing rule will not result in costs or savings to other affected persons.

COMPLIANCE COSTS FOR AFFECTED PERSONS: The repeal of existing Rule R612-6 and reenactment of its substantive provisions in Rules R612-100 and R612-300 will not change interested parties' rights or duties and will not impose any compliance costs on affected persons.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: The repeal of existing Rule R612-6, coupled with reenactment of the rule's substantive provisions in the new Rules R612-100 and R612-300, is intended to make the rule easier to find and use by businesses and all other stakeholders in the workers' compensation system. The Commission does not anticipate that the improved organization of these rules will result in any fiscal impact on businesses.

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:

◆ Ron Dressler by phone at 801-530-6841, by FAX at 801-530-6804, or by Internet E-mail at rdressler@utah.gov

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THIS RULE MAY BECOME EFFECTIVE ON: 02/21/2013

AUTHORIZED BY: Sherrie Hayashi, Commissioner

R612. Labor Commission, Industrial Accidents.

[R612-7. Impairment Ratings for Industrial Injuries and Diseases. R612-7-1. Authority.

_____ This rule is enacted under the authority of Sections 34A-1-104 and 34A-2-412.

R612-7-2. Definition.

_____ The definition of impairment in Section 34A-2-102 applies to this rule.

R612-7-3. Method for Rating.

_____ A. For rating all impairments, which are not expressly listed in Section 34A-2-412, the Commission incorporates by reference "Utah's 2006 Impairment Guides" as published by the Commission for

all injuries rated on or after July 11, 2006. For those conditions not found in "Utah's 2006 Impairment Guides," the American Medical Association's "Guides to the Evaluation of Permanent Impairment, Fifth Edition" are to be used.

KEY: workers' compensation, impairment ratings

~~Date of Enactment or Last Substantive Amendment: July 11, 2006~~

~~Notice of Continuation: April 28, 2008~~

~~Authorizing, and Implemented or Interpreted Law: 34A-1-104; 34A-2-412]~~

Labor Commission, Industrial Accidents **R612-8** Procedural Guidelines for the Reemployment Act

NOTICE OF PROPOSED RULE

(Repeal)

DAR FILE NO.: 37136

FILED: 12/28/2012

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The Labor Commission proposes to repeal this and other Industrial Accident Division rules in order to consolidate, reorganize, and reenact the substance of those rules in a format that is more logical and user friendly.

SUMMARY OF THE RULE OR CHANGE: The existing Rule R612-8 will be repealed in its entirety. The substance of the existing rule will be reenacted in new Rules R612-100 and R612-500. (DAR NOTE: The proposed new Rule R612-100 is under DAR No. 37124, and the proposed new Rule R612-500 is under DAR No. 37128 in this issue, January 15, 2013, of the Bulletin.)

STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 34A-1-104 and Section 34A-8-109

ANTICIPATED COST OR SAVINGS TO:

◆ THE STATE BUDGET: Because the substantive provisions of the existing rule will be reenacted as a new rule, repeal of the existing rule will not result in costs or savings to the state budget.

◆ LOCAL GOVERNMENTS: Because the substantive provisions of the existing rule will be reenacted as a new rule, repeal of the existing rule will not result in costs or savings to local government.

◆ SMALL BUSINESSES: Because the substantive provisions of the existing rule will be reenacted as a new rule, repeal of the existing rule will not result in costs or savings to small businesses.

◆ PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES: Because the substantive provisions of the existing rule will be

reenacted as a new rule, repeal of the existing rule will not result in costs or savings to other affected persons.

COMPLIANCE COSTS FOR AFFECTED PERSONS: The repeal of existing Rule R612-8 and reenactment of its substantive provisions in Rules R612-100 and R612-500 will not change interested parties' rights or duties and will not impose any compliance costs on affected persons.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: The repeal of existing Rule R612-8, coupled with reenactment of the rule's substantive provisions in the new Rules R612-100 and R612-500, is intended to make the rule easier to find and use by businesses and all other stakeholders in the workers' compensation system. The Commission does not anticipate that the improved organization of these rules will result in any fiscal impact on businesses.

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 LABOR COMMISSION
 INDUSTRIAL ACCIDENTS
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 SALT LAKE CITY, UT 84111-2316
 or at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
 ♦ Ron Dressler by phone at 801-530-6841, by FAX at 801-530-6804, or by Internet E-mail at rdressler@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN AT 5:00 PM ON 02/14/2013

THIS RULE MAY BECOME EFFECTIVE ON: 02/21/2013

AUTHORIZED BY: Sherrie Hayashi, Commissioner

**R612. Labor Commission, Industrial Accidents.
 [R612-8. Procedural Guidelines for the Reemployment Act.
 R612-8-1. Purpose, Authority and Definitions.**

- ~~_____ A. These rules guide insurance carriers and employers in complying with reporting and other requirements of the Utah Injured Workers Reemployment Act, Title 34A, Chapter 8a, Utah Code Annotated.~~
- ~~_____ B. The Utah Labor Commission enacts these rules under the authority of section 34A-8a-202 and section 34A-8a-203.~~
- ~~_____ C. Definitions established by section 34A-8a-102, section 34A-8a-203(1) and rule R612-1 apply to this rule. The following definitions also apply to this rule:~~
 - ~~_____ 1. "Insurance Carrier" includes insurance carriers providing workers' compensation coverage and the Uninsured Employers Fund;~~
 - ~~_____ 2. "Employer" includes self-insured employers and uninsured employers that are paying an injured workers' claim for benefits.~~

- ~~_____ 3. "disabled Injured Worker" means an injured worker who:~~
 - ~~_____ a. because of the injury or disease that is the basis for the employee being an injured worker:~~
 - ~~_____ i. is or will be unable to return to work in the injured worker's usual and customary occupation; or~~
 - ~~_____ ii. is unable to perform work for which the injured worker has previous training and experience; and~~
 - ~~_____ b. reasonably can be expected to attain gainful employment after an evaluation provided for in accordance with the Utah Injured Worker Reemployment Act, Title 34A, Chapter 8a.~~

R612-8-2. Form 206 – Insurer/Employer Initial Reemployment Report for Injured Worker.

- ~~_____ A. Pursuant to section 34A-8a-301, a worker who has suffered a work-related injury or disease must be provided an initial written report (Form 206) that assesses the injured worker's need for vocational reemployment assistance. Form 206 is only required in those instances in which:~~
 - ~~_____ 1. it appears the injured worker is or will be a "disabled injured worker"; or~~
 - ~~_____ 2. the duration of the injured workers' temporary total disability compensation exceeds 90 days.~~
- ~~_____ B. If the injured worker was covered by workers' compensation insurance at the time of injury or disease or the claim is being paid by the Uninsured employers' Fund (UEF), the insurance carrier or UEF must prepare and submit Form 206. If the injured worker's claim is being paid by a self-insured employer or an uninsured employer, the employer must prepare and submit Form 206.~~
- ~~_____ C. Form 206 must be mailed or otherwise delivered to the injured worker and to the Division within 30 days after the insurance carrier or employer knows or should know that the injured worker's circumstances satisfy either of the conditions described in subsection A. (1) of A. (2).~~

R612-8-3. Referral of Disabled Injured Worker for Evaluation; Permission to Waive or Postpone Referral.

- ~~_____ A. If Form 206 determines that an injured worker satisfies the definition of a "disabled injured worker", the insurance carrier or employer shall refer the injured worker to the Utah State Office of Rehabilitation or to a private rehabilitation or reemployment service for evaluation and development of a reemployment plan. This referral must be made within 10 days after the insurance carrier or employer submits Form 206 to the Division unless the Division grants a waiver or postponement as provided in the following subsection B of this rule.~~
- ~~_____ B. Section 34A-8a-302(3) authorizes the Labor Commission through the Division of Industrial Accidents to waive or postpone an insurance carrier or employer's referral obligation. An insurance carrier or employer shall make its request by completing and submitting "Form 215 – Insurer/Employer Request to Waive/Postpone Reemployment Referral" to the Division and mailing a copy of the completed form to the injured worker. The Division will consider such requests on a case-by-case basis. The Division will generally grant requests for waiver or postponement for the following reasons, or for other reasons similarly establishing good cause:~~
 - ~~_____ 1. the injured worker was not medically stable;~~
 - ~~_____ 2. the injured worker's physical capacity has not been determined; or~~
 - ~~_____ 3. liability for the injured worker's claim is under review provided, however, that the Division may require the insurance carrier~~

or employer to refer the injured worker for the free services offered by the Utah State Office of Rehabilitation.

~~R612-8-4. Form 239 – Insurer/Employer Quarterly Report on Reemployment Efforts to the Division; Penalties.~~

~~A. Beginning with the calendar quarter commencing on July 1, 2009, and continuing for each quarter thereafter, section 34A-8a-203(2) requires insurance carriers and employers (referred to as "reporting entities") to file quarterly reports enumerating their efforts to return injured workers to gainful employment.~~

~~B. Reporting entities shall submit their quarterly reports by completing Form 239 – Insurer/Employer Quarterly Report on Reemployment Efforts," and filing the form with the Division no later than 45 days after the end of each calendar quarter.~~

~~C. Section 34A-8a-203(4) requires the Commission to impose a civil penalty of up to \$500 against a reporting entity that fails to file Form 206. Initial proceedings to assess such penalty are hereby designated as informal adjudicatory proceedings, while all subsequent proceedings with respect to assessment of such penalty are hereby designated as formal proceedings.~~

~~R612-8-5. Administrative Review.~~

~~An injured worker, insurance carrier or employer may submit any dispute arising from the provisions of the Utah Injured Worker Reemployment Act or these rules to the Labor Commission's Adjudication Division for resolution according to the procedures established by the Utah Administrative Procedures Act, Title 63G, Chapter 4, Utah Code Annotated.~~

~~KEY: reemployment workers' compensation guidelines~~

~~Date of Enactment or Last Substantive Amendment: December 9, 2009~~

~~Notice of Continuation: September 17, 2009~~

~~Authorizing, and Implemented or Interpreted Law: 34A-1-104; 34A-8-109]~~

Labor Commission, Industrial Accidents
R612-9

Designation of the Initial Assessment of
Noncompliance Penalties as an
"Informal" Proceeding

NOTICE OF PROPOSED RULE

(Repeal)

DAR FILE NO.: 37137

FILED: 12/28/2012

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The Labor Commission proposes to repeal this and other Industrial Accident Division rules in order to consolidate, reorganize, and reenact the substance of those rules in a format that is more logical and user friendly.

SUMMARY OF THE RULE OR CHANGE: The existing Rule R612-9 will be repealed in its entirety. The substance of the existing rule will be reenacted in new Rule R612-100. (DAR NOTE: The proposed new Rule R612-100 is under DAR No. 37124 in this issue, January 15, 2013, of the Bulletin.)

STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 34A-1-104 and Subsection 63G-3-301(3)(c) and Subsection 63G-4-201(1)

ANTICIPATED COST OR SAVINGS TO:

♦ THE STATE BUDGET: Because the substantive provisions of the existing rule will be reenacted as a new rule, repeal of the existing rule will not result in costs or savings to the state budget.

♦ LOCAL GOVERNMENTS: Because the substantive provisions of the existing rule will be reenacted as a new rule, repeal of the existing rule will not result in costs or savings to local government.

♦ SMALL BUSINESSES: Because the substantive provisions of the existing rule will be reenacted as a new rule, repeal of the existing rule will not result in costs or savings to small businesses.

♦ PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES: Because the substantive provisions of the existing rule will be reenacted as a new rule, repeal of the existing rule will not result in costs or savings to other affected persons.

COMPLIANCE COSTS FOR AFFECTED PERSONS: The repeal of existing Rule R612-9 and reenactment of its substantive provisions as Rule R612-100 will not change interested parties' rights or duties and will not impose any compliance costs on affected persons.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: The repeal of existing Rule R612-9, coupled with reenactment of the rule's substantive provisions in the new Rule R612-100, is intended to make the rule easier to find and use by businesses and all other stakeholders in the workers' compensation system. The Commission does not anticipate that the improved organization of these rules will result in any fiscal impact on businesses.

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:

♦ Ron Dressler by phone at 801-530-6841, by FAX at 801-530-6804, or by Internet E-mail at rdressler@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN AT 5:00 PM ON 02/14/2013

THIS RULE MAY BECOME EFFECTIVE ON: 02/21/2013

AUTHORIZED BY: Sherrie Hayashi, Commissioner

R612. Labor Commission, Industrial Accidents.

~~[R612-9. Designation of the Initial Assessment of Noncompliance Penalties as an "Informal" Proceeding.~~

~~R612-9-1. Authority.~~

~~— This rule is enacted under authority of Section 34A-1-104 and Section 63G-4-202(1) and is applicable to proceedings under Section 34A-2-211 to assess penalties against employers who have failed to obtain workers compensation insurance coverage.~~

~~R612-9-2. Designation as Informal Proceedings.~~

~~— Initial proceedings to assess such penalty are hereby designated as informal adjudicatory proceeding, while all subsequent proceedings with respect to assessment of such penalty are hereby designated as formal proceedings.~~

~~KEY: penalties, worker's compensation, uninsured employers, informal adjudicative proceedings~~

~~Date of Enactment or Last Substantive Amendment: November 14, 1995~~

~~Notice of Continuation: December 1, 2009~~

~~Authorizing, and Implemented or Interpreted Law: 63G-3-301(3) (e); 63G-4-202(1); 34A-1-104]~~

Labor Commission, Industrial Accidents
R612-10
HIV, Hepatitis B and C Testing and Reporting for Emergency Medical Services Providers

NOTICE OF PROPOSED RULE

(Repeal)

DAR FILE NO.: 37138

FILED: 12/28/2012

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The Labor Commission proposes to repeal this and other Industrial Accident Division rules in order to consolidate, reorganize, and reenact the substance of those rules in a format that is more logical and user friendly.

SUMMARY OF THE RULE OR CHANGE: The existing Rule R612-10 will be repealed in its entirety. The substance of the existing rule will be reenacted in new Rule R612-300. (DAR NOTE: The proposed new Rule R612-300 is under DAR No. 37126 in this issue, January 15, 2013, of the Bulletin.)

STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 34A-1-104 et seq. and Section 34A-2-101 et seq. and Section 34A-3-101 et seq. and Section 78B-8-402 and Section 78B-8-404

ANTICIPATED COST OR SAVINGS TO:

◆ THE STATE BUDGET: Because the substantive provisions of the existing rule will be reenacted as a new rule, repeal of the existing rule will not result in costs or savings to the state budget.

◆ LOCAL GOVERNMENTS: Because the substantive provisions of the existing rule will be reenacted as a new rule, repeal of the existing rule will not result in costs or savings to local government.

◆ SMALL BUSINESSES: Because the substantive provisions of the existing rule will be reenacted as a new rule, repeal of the existing rule will not result in costs or savings to small businesses.

◆ PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES: Because the substantive provisions of the existing rule will be reenacted as a new rule, repeal of the existing rule will not result in costs or savings to other affected persons.

COMPLIANCE COSTS FOR AFFECTED PERSONS: The repeal of existing Rule R612-10 and reenactment of its substantive provisions in Rule R612-300 will not change interested parties' rights or duties and will not impose any compliance costs on affected persons.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: The repeal of existing Rule R612-10, coupled with reenactment of the rule's substantive provisions in the new Rule R612-300, is intended to make the rule easier to find and use by businesses and all other stakeholders in the workers' compensation system. The Commission does not anticipate that the improved organization of these rules will result in any fiscal impact on businesses.

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:

◆ Ron Dressler by phone at 801-530-6841, by FAX at 801-530-6804, or by Internet E-mail at rdressler@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN AT 5:00 PM ON 02/14/2013

THIS RULE MAY BECOME EFFECTIVE ON: 02/21/2013

AUTHORIZED BY: Sherrie Hayashi, Commissioner

R612. Labor Commission, Industrial Accidents.

~~**[R612-10. HIV, Hepatitis B and C Testing and Reporting for Emergency Medical Services Providers.**~~

~~**R612-10-1. HIV, Hepatitis B and C Testing and Reporting for Emergency Medical Services Providers.**~~

~~_____ A. Authority - The HIV, Hepatitis B and C Testing and Reporting for Emergency Medical Services Providers rule is established under the authority of U.C.A. Section 78B-8-404.~~

~~_____ B. Purpose - To establish procedures pursuant to U.C.A. Section 78B-8-401 for source patient testing and reporting following a significant exposure of an emergency medical services provider.~~

~~_____ C. Definitions~~

~~_____ 1. Department means the Utah Labor Commission.~~

~~_____ 2. Contact means designated person(s) within the emergency medical services agency or the employer of the emergency medical services provider.~~

~~_____ 3. Disease means Human Immunodeficiency Virus, acute or chronic Hepatitis B or Hepatitis C infections.~~

~~_____ 4. Emergency medical services provider means Emergency Medical personnel as defined in Section 26-8a-102, a public safety officer, local fire department personnel, or personnel employed by the Department of Corrections or by a county jail, who provide prehospital Emergency medical care for an emergency medical services agency either as an employee or a volunteer.~~

~~_____ 5. Emergency medical services (EMS) agency means an agency, entity, or organization that employs or utilizes emergency medical services providers as defined in (4) as employees or volunteers.~~

~~_____ 6. Source Patient means any individual cared for by a prehospital emergency medical services provider, including but not limited to victims of accidents or injury, deceased persons, and prisoners or persons in the custody of the Department of Corrections.~~

~~_____ 7. Receiving facility means a hospital, health care or other facility where the patient is delivered by the emergency medical services provider for care.~~

~~_____ 8. "Significant Exposure" and "Significantly Exposed" mean:~~

~~_____ a. exposure of the body of one person to the blood or body fluids visibly contaminated by blood of another person by:~~

~~_____ 1. percutaneous injury, including a needle stick or cut with a sharp object or instrument; or~~

~~_____ 2. contact with an open wound, mucous membrane, or nonintact skin because of a cut, abrasion, dermatitis, or other damage; or~~

~~_____ b. exposure that occurs by any other method of transmission defined by the Department of Health as a significant exposure.~~

~~_____ D. Emergency Medical Services Provider Responsibility:~~

~~_____ 1. The EMS provider shall document and report all significant exposures to the receiving facility and contact as defined in (C)(2).~~

~~_____ 2. The reporting process is as follows:~~

~~_____ a. The exposed EMS provider shall complete the Exposure Report Form (ERF) at the time the patient is delivered to the receiving facility and provide a copy to the person at the receiving facility authorized by the facility to receive the form. In the event the exposed~~

~~EMS provider does not accompany the source patient to the receiving facility, he/she may report the exposure incident, with information requested on the ERF, by telephone to a person authorized by the facility to receive the form. In this event, the exposed EMS provider shall nevertheless submit a written copy of the ERF within three days to an authorized person of the receiving facility.~~

~~_____ b. The exposed EMS provider shall, within three days of the incident, submit a copy of the ERF to the contact as defined in (C)(2).~~

~~_____ E. Receiving Facility Responsibility:~~

~~_____ 1. The receiving facility shall establish a system to receive ERFs as well as telephoned reports from exposed EMS providers on a 24-hour per day basis. The facility shall also have available on call, trained pre-test counselors for the purpose of obtaining consent and counseling of source patients when HIV testing has been requested by EMS providers. The receiving facility shall contact the source patient prior to release from the facility to provide the individual with counseling or, if unable to provide counseling, provide the source patient with phone numbers for a trained counselor to provide the counseling within 24 hours.~~

~~_____ 2. Upon notification of exposure, the receiving facility shall request permission from the source patient to draw a blood sample for disease testing, as defined in (C)(3). In conjunction with this request, the source patient must be advised of his/her right to refuse testing and be advised that if he/she refuses to be tested that fact will be forwarded to the EMS agency or employer of EMS provider. The source patient shall also be advised that if he/she refuses to be tested, the EMS agency or provider may seek a court order to compel the source patient to submit to a blood draw for the disease testing.~~

~~_____ Testing is authorized only when the source patient, his/her next of kin or legal guardian consents to testing, with the exception that consent is not required from an individual who has been convicted of a crime and is in the custody or under the jurisdiction of the Department of Corrections, or if the source patient is dead. If consent is denied, the receiving facility shall complete the ERF and send it to the EMS agency or employer of the EMS provider. If consent is received, the receiving facility shall draw a sample of the source patient's blood and send it, along with the ERF, to a qualified laboratory for testing.~~

~~_____ 3. The laboratory that the receiving facility has sent source patient's blood draw to shall send the disease test results, by Case ID number, to the EMS agency or employer of the EMS provider.~~

~~_____ F. EMS Agency/Employer Responsibility:~~

~~_____ 1. The EMS agency/employer, upon receipt of the disease tests, from the receiving facility laboratory, shall immediately report the result, by case number, not name, to the exposed EMS provider.~~

~~_____ 2. The EMS agency/employer, upon the receipt of refusal of testing by the source, shall report that refusal to the EMS provider.~~

~~_____ 3. The agency/employer or its insurance carrier shall pay for the EMS provider and the source patient testing for the covered diseases per the Labor Commission fee schedule.~~

~~_____ 4. The EMS agency/employer shall maintain the records of any disease exposures contained in this rule per the OSHA Blood Borne Pathogen standards.~~

~~**KEY: workers' compensation, administrative procedures, reporting, settlements**~~

~~**Date of Enactment or Last Substantive Amendment: December 2, 2005**~~

~~Notice of Continuation: November 4, 2010~~

~~Authorizing, and Implemented or Interpreted Law: 34A-2-101 et seq.; 34A-3-101 et seq.; 34A-1-104; 78B-8-402; 78B-8-404~~

Labor Commission, Industrial Accidents R612-11 Prohibition of Direct Payments by Insured Employer

NOTICE OF PROPOSED RULE

(Repeal)

DAR FILE NO.: 37139

FILED: 12/28/2012

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The Labor Commission proposes to repeal this and other Industrial Accident Division rules in order to consolidate, reorganize, and reenact the substance of those rules in a format that is more logical and user friendly.

SUMMARY OF THE RULE OR CHANGE: The existing Rule R612-11 will be repealed in its entirety. The substance of the existing rule will be reenacted in new Rule R612-100. (DAR NOTE: The proposed new Rule R612-100 is under DAR No. 37124 in this issue, January 15, 2013, of the Bulletin.)

STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 34A-1-104 et seq. and Section 34A-2-101 et seq. and Section 34A-3-101 et seq. and Section 78B-8-402 and Section 78B-8-404

ANTICIPATED COST OR SAVINGS TO:

◆ **THE STATE BUDGET:** Because the substantive provisions of the existing rule will be reenacted as a new rule, repeal of the existing rule will not result in costs or savings to the state budget.

◆ **LOCAL GOVERNMENTS:** Because the substantive provisions of the existing rule will be reenacted as a new rule, repeal of the existing rule will not result in costs or savings to local government.

◆ **SMALL BUSINESSES:** Because the substantive provisions of the existing rule will be reenacted as a new rule, repeal of the existing rule will not result in costs or savings to small businesses.

◆ **PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES:** Because the substantive provisions of the existing rule will be reenacted as a new rule, repeal of the existing rule will not result in costs or savings to other affected persons.

COMPLIANCE COSTS FOR AFFECTED PERSONS: The repeal of existing Rule R612-11 and reenactment of its

substantive provisions in Rule R612-100 will not change interested parties' rights or duties and will not impose any compliance costs on affected persons.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: The repeal of existing Rule R612-11, coupled with reenactment of the rule's substantive provisions in the new Rule R612-100, is intended to make the rule easier to find and use by businesses and all other stakeholders in the workers' compensation system. The Commission does not anticipate that the improved organization of these rules will result in any fiscal impact on businesses.

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:

◆ Ron Dressler by phone at 801-530-6841, by FAX at 801-530-6804, or by Internet E-mail at rdressler@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN AT 5:00 PM ON 02/14/2013

THIS RULE MAY BECOME EFFECTIVE ON: 02/21/2013

AUTHORIZED BY: Sherrie Hayashi, Commissioner

R612. Labor Commission, Industrial Accidents.

~~[R612-11. Prohibition of Direct Payments by Insured Employer.~~

~~R612-11-1. Authority.~~

~~———— This rule is enacted under the authority of U.C.A. Sections 34A-1-104, 34A-2-201.3, and 63G-4-202(1) and is applicable to proceedings under section 34A-2-201.3 to assess a penalty for direct payment of workers' compensation benefits by an insured employer.~~

~~R612-11-2. Designation as Informal Proceedings.~~

~~———— Initial proceedings to assess such penalty are hereby designated as informal adjudicatory proceedings, while all subsequent proceedings with respect to assessment of such penalty are hereby designated as formal proceedings.~~

~~KEY: workers' compensation, administrative procedures, reporting, settlements~~

~~Date of Enactment or Last Substantive Amendment: August 11, 2008~~

~~Authorizing, and Implemented or Interpreted Law: 34A-2-101 et seq.; 34A-3-101 et seq.; 34A-1-104; 78B-8-402; 78B-8-404~~

Labor Commission, Industrial Accidents
R612-12
 Workers' Compensation Coverage
 Waivers

NOTICE OF PROPOSED RULE

(Repeal)

DAR FILE NO.: 37140

FILED: 12/28/2012

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The Labor Commission proposes to repeal this and other Industrial Accident Division rules in order to consolidate, reorganize, and reenact the substance of those rules in a format that is more logical and user friendly.

SUMMARY OF THE RULE OR CHANGE: The existing Rule R612-12 will be repealed in its entirety. The substance of the existing rule will be reenacted in new Rules R612-100 and R612-400. (DAR NOTE: The proposed new Rule R612-100 is under DAR No. 37124, and the proposed new Rule R612-400 is under DAR No. 37127 in this issue, January 15, 2013, of the Bulletin.)

STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 34A-1-104 et seq. and Section 34A-2-101 et seq. and Section 34A-3-101 et seq. and Section 78B-8-402 and Section 78B-8-404

ANTICIPATED COST OR SAVINGS TO:

◆ **THE STATE BUDGET:** Because the substantive provisions of the existing rule will be reenacted as a new rule, repeal of the existing rule will not result in costs or savings to the state budget.

◆ **LOCAL GOVERNMENTS:** Because the substantive provisions of the existing rule will be reenacted as a new rule, repeal of the existing rule will not result in costs or savings to local government.

◆ **SMALL BUSINESSES:** Because the substantive provisions of the existing rule will be reenacted as a new rule, repeal of the existing rule will not result in costs or savings to small businesses.

◆ **PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES:** Because the substantive provisions of the existing rule will be reenacted as a new rule, repeal of the existing rule will not result in costs or savings to other affected persons.

COMPLIANCE COSTS FOR AFFECTED PERSONS: The repeal of existing Rule R612-12 and reenactment of its substantive provisions in Rules R612-100 and R612-400 will not change interested parties' rights or duties and will not impose any compliance costs on affected persons.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: The repeal of existing Rule R612-12, coupled with reenactment of the rule's substantive provisions in the new Rules R612-100 and R612-400, is intended to make the rule easier to find and use by businesses and all other stakeholders in the workers' compensation system. The Commission does not anticipate that the improved organization of these rules will result in any fiscal impact on businesses.

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:

◆ Ron Dressler by phone at 801-530-6841, by FAX at 801-530-6804, or by Internet E-mail at rdressler@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN AT 5:00 PM ON 02/14/2013

THIS RULE MAY BECOME EFFECTIVE ON: 02/21/2013

AUTHORIZED BY: Sherrie Hayashi, Commissioner

R612. Labor Commission, Industrial Accidents.

[R612-12. Workers' Compensation Coverage Waivers.

R612-12-1. Authority and Purpose.

~~————— This rule is enacted under authority of 34A-1-104 of the Utah Labor Commission Act and Title 34A, Chapter Two, Part One, the Workers' Compensation Coverage Waivers Act ("the Act"). The purpose of this rule is to establish procedures for workers' compensation coverage waivers ("coverage waivers"). The rule also addresses the effect of coverage waivers and the adjudicative procedures to be followed by the Division in granting, denying, or revoking coverage waivers.~~

R612-12-2. Administration by Industrial Accidents Division.

~~————— Except as otherwise provided, the Utah Labor Commission's Division of Industrial Accidents ("Division") shall administer the provisions of the Act and this rule.~~

R612-12-3. Procedure for Application and Issuance of Certificate.

~~————— A. A business entity may apply for a coverage waiver by completing a form provided by the Commission, submitting required supporting documents, and paying a fee of \$50. The Division's determination of whether to grant or deny a request for coverage waiver shall be conducted as informal proceedings under the Utah Administrative Procedures Act.~~

~~B. Supporting documents. 34A-2-1004 of the Workers' Compensation Coverage Waivers Act requires a business entity to submit the following documentation to support its request for a coverage waiver:~~

- ~~(1) a copy of two or more of the following:~~
- ~~(a) the business entity's federal or state income tax return that shows business income for the complete taxable year that immediately precedes the day on which the business entity submits the information;~~
 - ~~(b) a valid business license;~~
 - ~~(c) a license to engage in an occupation or profession, including a license under Title 58, Occupations and Professions; or~~
 - ~~(d) documentation of an active liability insurance policy that covers the business entity's activities; or~~
- ~~(2) a copy of one item listed in Subsection (1) and a copy of two or more of the following:~~
- ~~(a) proof of a bank account for the business entity;~~
 - ~~(b) proof that for the business entity there is:~~
 - ~~(i) a telephone number; and~~
 - ~~(ii) a physical location; or~~
 - ~~(c) an advertisement of services in a newspaper of general circulation or telephone directory showing the business entity's:~~
 - ~~(i) name; and~~
 - ~~(ii) contact information.~~

~~C. Fee. A business entity applying for a workers' compensation coverage waiver certificate shall submit payment of a fee of \$50.00. Such fees are used to defray the costs of processing and evaluating the application and are nonrefundable. If payment of the fee is made by check, the Division may delay issuance of a coverage waiver until it has verified that the check will be honored.~~

~~D. Issuance or Denial of Certificate. If the Division determines that a business entity has satisfied each requirement for a coverage waiver, the Division will issue the coverage waiver. If the Division determines that a business entity has not satisfied each requirement for a workers' compensation insurance waiver, the Division will issue a written denial to the business entity, stating the basis for denial and setting forth the business entity's appeal rights.~~

R612-12-4. Duration, Renewal and Revocation.

~~A. Duration. Subject to revocation of a coverage waiver as provided by subparagraph C. of this section, a coverage waiver remains in effect for the following time periods:~~

~~1. A coverage waiver issued by a licensed workers' compensation insurance company prior to July 1, 2011, the effective date of the Workers' Compensation Coverage Waivers Act, shall remain effective for the period shown on the coverage waiver.~~

~~2. A coverage waiver issued by the Division after July 1, 2011, shall be effective for one year from the date the coverage waiver is issued.~~

~~B. Renewal. The Division will renew a business entity's coverage waiver if:~~

- ~~1. The business entity requests renewal; and~~
- ~~2. The business entity satisfies all requirements in effect at the time of the renewal request.~~

~~C. Revocation. If the Division has reason to believe that a business entity no longer qualifies for a coverage waiver, the Division shall institute proceedings to determine whether the business entity's~~

~~coverage waiver should be revoked. Such proceedings shall be conducted as informal proceedings under the Utah Administrative Procedures Act. If the Division concludes that the business entity does not satisfy each requirement for a workers' compensation insurance waiver, the Division will issue a written order revoking the waiver certificate, stating the basis for revocation, and setting forth the business entity's appeal rights. The Division may also initiate other proceedings authorized by the Utah Workers' Compensation Act to compel the business entity to obtain workers' compensation coverage for its employees.~~

R612-12-5. Review of Division Decisions to Deny or Revoke Waiver Certificate.

~~A business entity may challenge a Division decision to deny or revoke the business entity's coverage waiver by filing an appeal of the decision with the Commission's Adjudication Division. Such appeal proceedings shall be assigned to an administrative law judge and conducted as de novo formal adjudicatory proceedings pursuant to the Utah Administrative Procedures Act.~~

R612-12-6. Effect, Verification and Limitation of Coverage Waiver.

~~A. Effect of coverage waiver. 34A-2-103 (7) (c) permits an employer contracting with a business entity to rely upon a valid coverage waiver issued by the Division as proof that the business entity is not required to have a workers' compensation insurance policy.~~

~~B. Verification of coverage waiver. An employer seeking to rely upon a business entity's coverage waiver shall retain the following documents:~~

~~1. A photocopy of the coverage waiver issued to the business entity by the Division; and~~

~~2. A printout of the Division's web page showing that the business entity's coverage waiver had not been revoked as of the date on which the employer contracted with the business entity.~~

~~C. Limitations to effect of coverage waiver. A coverage waiver does not excuse a business entity from obtaining and maintaining workers' compensation insurance coverage for employees who are entitled to such coverage under the Utah Workers' Compensation Act. If and when a business entity has such employees, any coverage waiver previously issued to that business entity becomes void and the business entity must immediately obtain workers' compensation coverage.~~

~~**KEY: workers' compensation, administrative procedures, reporting, settlements**~~

~~**Date of Enactment or Last Substantive Amendment: June 22, 2011**~~

~~**Authorizing, and Implemented or Interpreted Law: 34A-2-101 et seq.; 34A-3-101 et seq.; 34A-1-104; 78B-8-402; 78B-8-404**~~

Labor Commission, Industrial Accidents **R612-13** Proceedings to Impose Non-Reporting Penalties Against Employers

NOTICE OF PROPOSED RULE

(Repeal)

DAR FILE NO.: 37141

FILED: 12/28/2012

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The Labor Commission proposes to repeal this and other Industrial Accident Division rules in order to consolidate, reorganize, and reenact the substance of those rules in a format that is more logical and user friendly.

SUMMARY OF THE RULE OR CHANGE: The existing Rule R612-13 will be repealed in its entirety. The substance of the existing rule will be reenacted in new Rule R612-100. (DAR NOTE: The proposed new Rule R612-100 is under DAR No. 37124 in this issue, January 15, 2013, of the Bulletin.)

STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 34A-2-101 et seq. and Section 34A-3-101 et seq. and Section 78B-8-402 and Section 78B-8-404 and Subsection 34A-1-104(1) and Subsection 63G-4-202(1)

ANTICIPATED COST OR SAVINGS TO:

◆ **THE STATE BUDGET:** Because the substantive provisions of the existing rule will be reenacted as a new rule, repeal of the existing rule will not result in costs or savings to the state budget.

◆ **LOCAL GOVERNMENTS:** Because the substantive provisions of the existing rule will be reenacted as a new rule, repeal of the existing rule will not result in costs or savings to local government.

◆ **SMALL BUSINESSES:** Because the substantive provisions of the existing rule will be reenacted as a new rule, repeal of the existing rule will not result in costs or savings to small businesses.

◆ **PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES:** Because the substantive provisions of the existing rule will be reenacted as a new rule, repeal of the existing rule will not result in costs or savings to other affected persons.

COMPLIANCE COSTS FOR AFFECTED PERSONS: The repeal of existing Rule R612-13 and reenactment of its substantive provisions in Rule R612-100 will not change interested parties' rights or duties and will not impose any compliance costs on affected persons.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: The repeal of existing Rule R612-13, coupled with reenactment of the rule's substantive provisions in the new Rule R612-100, is intended to make the rule easier to find and use by businesses and all other stakeholders in the workers' compensation system. The Commission does not anticipate that the improved organization of these rules will result in any fiscal impact on businesses.

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:

◆ Ron Dressler by phone at 801-530-6841, by FAX at 801-530-6804, or by Internet E-mail at rdressler@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN AT 5:00 PM ON 02/14/2013

THIS RULE MAY BECOME EFFECTIVE ON: 02/21/2013

AUTHORIZED BY: Sherrie Hayashi, Commissioner

R612. Labor Commission, Industrial Accidents.

~~[R612-13. Proceedings to Impose Non-Reporting Penalties Against Employers.~~

R612-13-1. Authority.

~~_____ This rule is enacted under authority of U.C.A. Sections 34A-1-104(1) and 63G-4-202(1) and is applicable to proceedings under 34A-2-407 to assess a penalty against an employer who does not timely report an industrial accident.~~

R612-13-2. Designation as Informal Proceedings.

~~_____ Initial proceedings to assess such penalty are hereby designated as informal adjudicatory proceeding, while all subsequent proceedings with respect to assessment of such penalty are hereby designated as formal proceedings.~~

~~**KEY:** workers' compensation, administrative procedures, reporting, penalties~~

~~**Date of Enactment or Last Substantive Amendment:** January 12, 2010~~

~~**Authorizing, and Implemented or Interpreted Law:** 34A-1-104(1); 34A-2-101 et seq.; 34A-3-101 et seq.; 63G-4-202(1); 78B-8-402; 78B-8-404]~~

Labor Commission, Industrial Accidents**R612-100****Workers' Compensation Rules -
General Provisions****NOTICE OF PROPOSED RULE**

(New Rule)

DAR FILE NO.: 37124

FILED: 12/28/2012

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The substance of this rule is currently found in Rules R612-1, R612-2, R612-3, R612-4, R612-5, R612-7, R612-8, R612-9, R612-11, R612-12, and R612-13, which will be repealed. The Labor Commission is repealing all existing Industrial Accident Division rules to allow those rules to be consolidated, reorganized, and reenacted in a format that is more logical and user friendly.

SUMMARY OF THE RULE OR CHANGE: The proposed Rule R612-100 contains the authority, definitions, official forms, and the designation of proceedings as informal provisions of existing Rules R612-1, R612-2, R612-3, R612-4, R612-5, R612-7, R612-8, R612-9, R612-11, R612-12, and R612-13, which are being repealed. (DAR NOTE: The proposed repeal of Rule R612-1 is under DAR No. 37129, the proposed repeal of Rule R612-2 is under DAR No. 37130, the proposed repeal of Rule R612-3 is under DAR No. 37131, the proposed repeal of Rule R612-4 is under DAR No. 37132, the proposed repeal of Rule R612-5 is under DAR No. 37133, the proposed repeal of Rule R612-7 is under DAR No. 37135, the proposed repeal of Rule R612-8 is under DAR No. 37136, the proposed repeal of Rule R612-9 is under DAR No. 37137, the proposed repeal of Rule R612-11 is under DAR No. 37139, the proposed repeal of Rule R612-12 is under DAR No. 37140, and the proposed repeal of Rule R612-13 is under DAR No. 37141 in this issue, January 15, 2013, of the Bulletin.)

STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 34A-1-104 et seq. and Section 34A-2-101 et seq. and Section 34A-3-101 et seq. and Section 63G-4-102 et seq.

ANTICIPATED COST OR SAVINGS TO:

- ◆ **THE STATE BUDGET:** Because the substantive provisions of the new rule are the same as an existing rule that is being repealed, enactment of the new rule will not result in costs or savings to the state budget.
- ◆ **LOCAL GOVERNMENTS:** Because the substantive provisions of the new rule are the same as an existing rule that is being repealed, enactment of the new rule will not result in costs or savings to local government.
- ◆ **SMALL BUSINESSES:** Because the substantive provisions of the new rule are the same as an existing rule that is being repealed, enactment of the new rule will not result in costs or savings to small businesses.
- ◆ **PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES:** Because the substantive provisions of the new rule are the same as an existing rule that is being repealed, enactment of the new rule will not result in costs or savings to other affected persons.

COMPLIANCE COSTS FOR AFFECTED PERSONS: Reenactment of the authority, definitions, official forms, and the designation of proceedings as informal, substantive

provisions currently found in Rule R612-1, R612-2, R612-3, R612-4, R612-5, R612-7, R612-8, R612-9, R612-11, R612-12, and R612-13 will not change interested parties' rights or duties and will not impose any compliance costs on affected persons.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: The repeal of existing Rules R612-1, R612-2, R612-3, R612-4, R612-5, R612-7, R612-8, R612-9, R612-11, R612-12, and R612-13, coupled with reenactment of the rules' substantive provisions in a more logical format is intended to make the rules easier to find and use by businesses and all other stakeholders in the workers' compensation system. The Commission does not anticipate that the improved organization of these rules will result in any fiscal impact on businesses.

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:
 ◆ Ron Dressler by phone at 801-530-6841, by FAX at 801-530-6804, or by Internet E-mail at rdressler@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN AT 5:00 PM ON 02/14/2013

THIS RULE MAY BECOME EFFECTIVE ON: 02/21/2013

AUTHORIZED BY: Sherrie Hayashi, Commissioner

R612. Labor Commission, Industrial Accidents.
R612-100. Workers' Compensation Rules - General Provisions.
R612-100-1. Authority.
 _____ These rules are enacted pursuant to the following statutory authority:
 _____ A. Section 34A-1-104 of the Utah Labor Commission Act;
 _____ B. Section 34A-2-103, 34A-2-201.3, 34A-2-407 and 34A-2-412 of the Utah Workers' Compensation Act;
 _____ C. Section 34A-2-1001 et seq. of the Workers' Compensation Coverage Waiver Act;
 _____ D. Sections 34A-8a-202 and 34A-8a-203 of the Utah Injured Worker Reemployment Act;
 _____ E. Section 59-9-101 of the Taxation of Admitted Insurers Act;
 _____ F. Section 63G-4-202(1) of the Utah Administrative Procedures Act; and
 _____ G. Section 78B-8-404 of Chapter 8, Title 78B, Utah Code Annotated.

R612-100-2. Definitions.

A. "Administrative Law Judge" means a person duly designated by the Commission to hear and decide disputed cases.

B. "Aggregate Excess Insurance" is the amount of insurance required to cover the total accumulated workers' compensation benefits for all claims payable for a given period of time with the employer, retaining an obligation for a designated amount as a deductible and the insurance company paying all amounts due thereafter up to a maximum total obligation.

C. "Applicant/Plaintiff" means, for purposes of a workers' compensation proceeding, an injured employee or his/her dependent(s) or any person seeking relief or claiming benefits under the Workers' Compensation and/or Occupational Disease and Disability Laws.

D. "Award" means the finding or decision of the Commission, Appeals Board or Administrative Law Judge as the benefits due an injured employee or the dependent(s) of a deceased employee.

E. "Commission" means the Labor Commission.

F. "Contact" means the designated person(s) within an emergency medical services agency or the employer of an emergency medical services provider.

G. "Defendant" means, for purposes of workers' compensation proceedings, an employer, insurance carrier, self-insurer, the Employers' Reinsurance Fund, and/or the Uninsured Employers' Fund.

H. "Department" means the Utah Labor Commission.

I. "Division" means the Division of Industrial Accidents within the Labor Commission.

J. "Disabled Injured Worker" means an injured worker who:

1. because of the injury or disease that is the basis for the employee being an injured worker:

a. is or will be unable to return to work in the injured worker's usual and customary occupation; or

b. is unable to perform work for which the injured worker has previous training and experience; and

2. reasonably can be expected to attain gainful employment after an evaluation provided for in accordance with the Utah Injured Worker Reemployment Act, Title 34A, Chapter 8a.

K. "Emergency medical services provider" means Emergency Medical personnel as defined in Section 26-8a-102, a public safety officer, local fire department personnel, or personnel employed by the Department of Corrections or by a county jail, who provide prehospital Emergency medical care for an emergency medical services agency either as an employee or a volunteer.

L. "Emergency medical services (EMS) agency" means an agency, entity, or organization that employs or utilizes emergency medical services providers as defined in (4) as employees or volunteers.

M. "Employee leasing company" is as defined per Title 58, Chapter 59.

N. "Employer" includes self-insured employers and uninsured employers that are paying an injured workers' claim for benefits.

O. "Global Fee Cases" - are those flat fee cases where fees include pre-operative and follow-up or aftercare.

P. "Insurer" includes workers' compensation insurance carriers and self-insured employers unless otherwise specified.

Q. "Insurance Carrier" includes all insurance companies writing workers' compensation and occupational disease and disability insurance, the Workers' Compensation Fund, and self-insurers who are granted self-insuring privileges by the Commission. In all cases involving no insurance coverage by the employer, the term "Insurance Carrier" includes the employer.

R. "Medical Panel" means a panel appointed by an Administrative Law Judge pursuant to the standards set forth in Section 34A-2-601, which is responsible to make findings regarding disputed medical aspects of a compensation claim, and may make any additional findings, perform any tests, or make any inquiry as the Administrative Law Judge may require.

S. "Medical Practitioner" means any person trained in the healing arts and licensed by the State in which such person practices.

T. "Receiving facility" means a hospital, health care or other facility where the patient is delivered by the emergency medical services provider for care.

U. "Reserve" is defined as the amount necessary to satisfy all debts, past, present, and future, incurred by reason of industrial accidents or occupational diseases, the origins of which commenced prior to the date of reserve determination.

V. "Significant Exposure" and "Significantly Exposed" mean exposure of the body of one person to the blood or body fluids visibly contaminated by blood of another person by:

1. percutaneous injury, including a needle stick or cut with a sharp object or instrument; or

2. contact with an open wound, mucous membrane, or non-intact skin because of a cut, abrasion, dermatitis, or other damage; or

W. "Source Patient" means any individual cared for by a pre-hospital emergency medical services provider, including but not limited to victims of accidents or injury, deceased persons, and prisoners or persons in the custody of the Department of Corrections.

X. "Specific Excess Insurance" is defined as the amount of insurance required to cover the workers' compensation benefits arising out of a specific occurrence (accident) or occupational disease under the Workers' Compensation Law with the employer retaining an obligation for a designated amount as a deductible and the insurance company assuming the obligation for all amounts due thereafter up to a maximum total obligation.

Y. "Usual and Customary Rate (UCR)" is the rate of payment using Ingenix, or a similar service, for charges for services for a particular zip code.

R612-100-3. 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 time 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 - Forms 221(a) Spine, 221(b) Upper Extremity, and 221(c) Lower Extremity" - These forms are 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 the appropriate 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 benefits.

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.

R612-100-4. Designation as Informal Proceedings.

A. Pursuant to 63G-4-202, the following are designated as informal adjudicatory proceedings:

1. Assessment of penalty under 34A-2-211 against an employer conducting business without obtaining workers' compensation coverage;

2. Assessment of penalty under 34A-2-201.3 against an insured employer for direct payment of workers' compensation benefits; and

3. Assessment of penalty under 34A-2-407 against an employer who does not timely report an industrial accident.

B. All subsequent adjudicative proceedings in the above-identified matters are designated as formal proceedings.

KEY: workers' compensation, administrative procedures

Date of Enactment or Last Substantive Amendment: 2013

Authorizing, and Implemented or Interpreted Law: 34A-2-101 et seq.; 34A-3-101 et seq.; 34A-1-104 et seq.; 63G-4-102 et seq.

Labor Commission, Industrial Accidents **R612-200** Workers' Compensation Rules - Filing and Paying Claims

NOTICE OF PROPOSED RULE

(New Rule)

DAR FILE NO.: 37125

FILED: 12/28/2012

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The substance of this rule is currently found in Rule R612-1, which will be repealed. The Labor Commission is repealing all existing Industrial Accident Division rules to allow those rules to be consolidated, reorganized, and reenacted in a format that is more logical and user friendly.

SUMMARY OF THE RULE OR CHANGE: The proposed Rule R612-200 contains the substance of existing Rule R612-1, which is being repealed. (DAR NOTE: The proposed repeal of Rule R612-1 is under DAR No. 37129 in this issue, January 15, 2013, of the Bulletin.)

STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 34A-1-104 et seq. and Section 34A-2-101 et seq. and Section 34A-3-101 et seq. and Section 63G-4-102 et seq.

ANTICIPATED COST OR SAVINGS TO:

◆ **THE STATE BUDGET:** Because the substantive provisions of the new rule are the same as an existing rule that is being repealed, enactment of the new rule will not result in costs or savings to the state budget.

◆ **LOCAL GOVERNMENTS:** Because the substantive provisions of the new rule are the same as an existing rule that is being repealed, enactment of the new rule will not result in costs or savings to local government.

◆ **SMALL BUSINESSES:** Because the substantive provisions of the new rule are the same as an existing rule that is being repealed, enactment of the new rule will not result in costs or savings to small businesses.

◆ **PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES:** Because the substantive provisions of the new rule are the same as an existing rule that is being repealed, enactment of the new rule will not result in costs or savings to other affected persons.

COMPLIANCE COSTS FOR AFFECTED PERSONS: Reenactment of the substantive provisions currently found in Rule R612-1 will not change interested parties' rights or duties and will not impose any compliance costs on affected persons.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: The repeal of existing Rule R612-1, coupled with reenactment of the rule's substantive provisions in a more logical format is intended to make the rule easier to find and use by businesses and all other stakeholders in the workers' compensation system. The Commission does not anticipate that the improved organization of these rules will result in any fiscal impact on businesses.

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:

◆ Ron Dressler by phone at 801-530-6841, by FAX at 801-530-6804, or by Internet E-mail at rdressler@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN AT 5:00 PM ON 02/14/2013

THIS RULE MAY BECOME EFFECTIVE ON: 02/21/2013

AUTHORIZED BY: Sherrie Hayashi, Commissioner

**R612. Labor Commission, Industrial Accidents.
R612-200. Workers' Compensation Rules - Filing and Paying Claims.**

R612-200-1. Acceptance/Denial of a Claim.

A. Upon receiving a claim for workers' compensation benefits, the insurance carrier or self-insured employer shall promptly investigate the claim and begin payment of compensation within 21 days from the date of notification of a valid claim or the insurance carrier or self-insured employer shall send the claimant and the division written notice on a division form or letter containing similar information, within 21 days of notification, that further investigation is needed stating the reason(s) for further investigation. Each 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 division in writing that the claim is denied and the reason(s) why the claim is being denied.

B. The payment of compensation shall be considered overdue if not paid within 21 days of a valid claim or within the 45 days of investigation unless denied.

C. Failure to make payment or to deny a claim within the 45 day time period without good cause shall result in a referral of the insurance company to the Insurance Department for appropriate disciplinary action and may be cause for revocation of the self-insurance certification for a self-insured employer. Good cause is defined as:

1. Failure by an employee claiming benefits to sign requested medical releases;
2. Injury or occupational disease did not occur within the scope of employment;
3. Medical information does not support the claim;
4. Claim was not filed within the statute of limitations;
5. Claimant is not an employee of the employer he/she is making a claim against;
6. Claimant has failed to cooperate in the investigation of the claim;
7. A pre-existing condition is the sole cause of the medical problem and not the claimed work-related injury or occupational disease;
8. Tested positive for drugs or alcohol; or
9. Other - a very specific reason must be given.

D. If an insurance carrier or self-insured employer begins payment of benefits on an investigation basis so as to process the claim in a timely fashion, a later denial of benefits based on newly discovered information may be allowed.

R612-200-2. Issuance of Checks.

A. Any entity issuing compensation checks or drafts must make those checks/drafts payable directly to the injured worker and must mail them directly to the last known mailing address of the injured worker, with the following exceptions:

1. If the employer provides full salary to the injured worker in return for the worker's compensation benefits, the check may be mailed to the worker at the place of employment;

2. If the employer coordinates other benefits with the worker's compensation benefits, the check may be mailed to the worker at the place of employment.

B. In no case may the check be made out to the employer.

C. Where attorney fees are involved, a separate check should be issued to the worker's attorney in the amount approved or ordered by the Commission, unless otherwise directed by the Commission. Payment of the worker's attorney by issuing a check payable to the worker and his attorney jointly constitutes a violation of this rule.

R612-200-3. Interest.

A. Interest must be paid on each benefit payment which comprises the award from the date that payment would have been due and payable at the rate of 8% per annum.

B. For the purpose of interest calculation, benefits shall become "due and payable" as follows:

1. Temporary total compensation shall be due and payable within 21 days of the date of the accident.

2. Permanent partial compensation shall be due and payable on the next day following the termination of a temporary total disability. However, where the condition is not fixed for rating purposes, the interest shall commence from the date the permanent partial impairment can be medically determined.

3. Permanent partial or permanent total disability compensation payable by the Employers' Reinsurance Fund or the Uninsured Employers' Fund shall be due and payable as soon as reasonably practical after an order is issued.

R612-200-4. Discount.

Eight percent shall be used for any discounting or present value calculations. Lump sums ordered by the Commission or for any attorney fees paid in a single up-front amount, or of any other sum being paid earlier than normally paid under a weekly benefit method shall be subject to the 8% discounting. The Commission shall create and make available a precise discount or present value table based on a 365 day year. For those instances where discount calculations are not routinely utilized or where the Commission's precise table is not available, the following table, which is a shortened version of the precise table, may be utilized by interpolating between the stated weeks and the related discount.

TABLE

Unaccrued Weeks	X Weekly Benefit \$	X Cumulative Discount	= Discount \$
1			.001475
10			.008076
20			.015343
30			.022538
40			.029663
50			.036719
60			.043706
70			.050626
80			.057478
90			.064264
100			.070984
110			.077639
120			.084229
130			.090756
140			.097221
150			.103623
160			.109963
170			.116243
180			.122463
190			.128623
200			.134724
210			.140767
220			.146752
230			.152680
240			.158552
250			.164368
260			.170129
270			.175835
280			.181488
290			.187087
300			.192633
312			.199219

R612-200-5. Compensation Agreements.

A. An applicant, insurance company and/or employer may enter into a compensation agreement for the purpose of resolving a worker's compensation claim. Compensation agreements must be approved by the Commission. The compensation agreement must be that contained on Form 019 of the Commission forms and shall include the following information:

1. Signatures of the parties involved;
2. Form 122 - Employer's First Report of Injury;
3. Doctor's report of impairment rating;
4. Form 141 - Payment of Benefits Statement.

B. Failure to provide any of the above documentation and forms may result in the return of the compensation agreement to the carrier or self-insured employer without approval.

R612-200-6. Insurance Carrier/Employer Liability.

A. This rule governs responsibility for payment of workers' compensation benefits for industrial accidents when:

1. The worker's ultimate entitlement to benefits is not in dispute; but

2. There is a dispute between self-insured employers and/or insurers regarding their respective liability for the injured worker's benefits arising out of separate industrial accidents which are compensable under Utah law.

B. In cases meeting the criteria of subsection A, the self-insured employer or insurer providing workers' compensation coverage for the most recent compensable injury shall advance workers' compensation benefits to the injured worker. The benefits advanced shall be limited to medical benefits and temporary total disability compensation. The benefits advanced shall be paid according to the entitlement in effect on the date of the earliest related injury.

1. The self-insured employer or insurance carrier advancing benefits shall notify the non-advancing party(s) within the time periods as specified in rule R612-1-7, that benefits are to be advanced pursuant to this rule.

2. The self-insured employers or insurers not advancing benefits, upon notification from the advancing party, shall notify the advancing party within 10 working days of any potential defenses or limitations of the non-advancing party(s) liability.

C. The parties are encouraged to settle liabilities pursuant to this rule, however, any party may file a request for agency action with the Commission for determination of liability for the workers' compensation benefits at issue.

D. The medical utilization decisions of the self-insured employer or insurer advancing benefits pursuant to this rule shall be presumed reasonable with respect to the issue of reimbursement.

R612-200-7. Permanent Total Disability.

A. This rule applies to claims for permanent total disability compensation under the Utah Workers' Compensation Act.

1. Subsection B applies to permanent total disability claims arising from accident or disease prior to May 1, 1995.

2. Subsection C applies to permanent total disability claims arising from accident or disease on or after May 1, 1995.

B. For claims arising from accident or disease on or after July 1, 1988 and prior to May 1, 1995, the Commission is required under Section 34A-2-413, to make a finding of total disability as measured by the substance of the sequential decision-making process of the Social Security Administration under Title 20 of the Code of Federal Regulations, amended April 1, 1993. The use of the term "substance of the sequential decision-making process" is deemed to confer some latitude on the Commission in exercising a degree of discretion in making its findings relative to permanent total disability. The Commission does not interpret the code section to eliminate the requirement that a finding by the Commission in permanent and total disability shall in all cases be tentative and not final until rehabilitation training and/or evaluation has been accomplished.

1. In the event that the Social Security Administration or its designee has made, or is in the process of making, a determination of disability under the foregoing process, the Commission may use this information in lieu of instituting the process on its own behalf.

2. In evaluating industrial claims in which the injured worker has qualified for Social Security disability benefits, the Commission will determine if a significant cause of the disability is the claimant's industrial accident or some other unrelated cause or causes.

3. To make a tentative finding of permanent total disability the Commission incorporates the rules of disability determination in 20 CFR 404.1520, amended April 1, 1993. The sequential decision-making process referred to requires a series of questions and evaluations to be made in sequence. In short, these are:

a. Is the claimant engaged in a substantial gainful activity?

b. Does the claimant have a medically severe impairment?

c. Does the severe impairment meet or equal the duration requirement in 20 CFR 404.1509, amended April 1, 1993, and the listed impairments in 20 CFR Subpart P Appendix 1, amended April 1, 1993?

d. Does the impairment prevent the claimant from doing past relevant work?

e. Does the impairment prevent the claimant from doing any other work?

4. After the Commission has made a tentative finding of permanent total disability:

a. In those cases arising after July 1, 1994, the Commission shall order initiation of payment of permanent total disability compensation;

b. the Commission shall review a summary of reemployment activities undertaken pursuant to the Utah Injured Worker Reemployment Act, as well as any qualified reemployment plan submitted by the employer or its insurance carrier; and

c. unless otherwise stipulated, the Commission shall hold a hearing to consider the possibility of rehabilitation and reemployment of the claimant pending final adjudication of the claim.

5. After a hearing, or waiver of the hearing by the parties, the Commission shall issue an order finding or denying permanent total disability based upon the preponderance of the evidence and with due consideration of the vocational factors in combination with the residual functional capacity which the commission incorporates as published in 20 CFR 404 Subpart P Appendix 2, amended April 1, 1993.

C. For permanent total disability claims arising on or after May 1, 1995, Section 34A-2-413 requires a two-step adjudicative process. First, the Commission must make a preliminary determination whether the applicant is permanently and totally disabled. If so, the Commission will proceed to the second step, in which the Commission will determine whether the applicant can be reemployed or rehabilitated.

1. First Step - Preliminary Determination of Permanent Total Disability: On receipt of an application for permanent total disability compensation, the Adjudication Division will assign an Administrative Law Judge to conduct evidentiary proceedings to determine whether the applicant's circumstances meet each of the elements set forth in Subsections 34A-2-413(1)(b) and (c).

(a) If the ALJ finds the applicant meets each of the elements set forth in Subsections 34A-2-413(1)(b) and (c), the ALJ will issue a preliminary determination of permanent total disability and shall order the employer or insurance carrier to pay permanent total disability compensation to the applicant pending completion of the second step of the adjudication process. The payment of permanent total disability compensation pursuant to a preliminary determination shall commence as of the date established by the preliminary determination and shall continue until otherwise ordered.

(b) A party dissatisfied with the ALJ's preliminary determination may obtain additional agency review by either the Labor Commissioner or Appeals Board pursuant to Subsection 34A-2-801(3). If a timely motion for review of the ALJ's preliminary determination is filed with either the Labor Commissioner or Appeals Board, no further adjudicative or enforcement proceedings shall take place pending the decision of the Commissioner or Board.

(c) A preliminary determination of permanent total disability by the Labor Commissioner or Appeals Board is a final agency action for purposes of appellate judicial review.

(d) Unless otherwise stayed by the Labor Commissioner, the Appeals Board or an appellate court, an appeal of the Labor Commissioner or Appeals Board's preliminary determination of permanent total disability shall not delay the commencement of "second step" proceedings discussed below or payment of permanent total disability compensation as ordered by the preliminary determination.

(e) The Commissioner or Appeals Board shall grant a request for stay if the requesting party has filed a petition for judicial review and the Commissioner or Appeals Board determine that:

(i) the requesting party has a substantial possibility of prevailing on the merits;

(ii) the requesting party will suffer irreparable injury unless a stay is granted; and

(iii) the stay will not result in irreparable injury to other parties to the proceeding.

2. Second Step - Reemployment and Rehabilitation: Pursuant to Subsection 34A-2-413(6), if the first step of the adjudicatory process results in a preliminary finding of permanent total disability, an additional inquiry must be made into the applicant's ability to be reemployed or rehabilitated, unless the parties waive such additional proceedings.

(a) The ALJ will hold a hearing to consider whether the applicant can be reemployed or rehabilitated.

(i) As part of the hearing, the ALJ will review a summary of reemployment activities undertaken pursuant to the Utah Injured Worker Reemployment Act;

(ii) The employer or insurance carrier may submit a reemployment plan meeting the requirements set forth in Subsection 34A-2-413(6)(a)(ii) and Subsections 34A-2-413(6)(d)(i) through (iii).

(b) Pursuant to Subsection 34A-2-413(4)(b) the employer or insurance carrier may not be required to pay disability compensation for any combination of disabilities of any kind in excess of the amount of compensation payable over the initial 312 weeks at the applicable permanent total disability compensation rate.

(i) Any overpayment of disability compensation may be recouped by the employer or insurance carrier by reasonably offsetting the overpayment against future liability paid before or after the initial 312 weeks.

(ii) An advance of disability compensation to provide for the employee's subsistence during the rehabilitation process is subject to the provisions of Subsection 34A-2-413(4)(b), described in subsection 2.(b) above, but can be funded by reasonably offsetting the advance of disability compensation against future liability normally paid after the initial 312 weeks.

(iii) To fund an advance of disability compensation to provide for an employee's subsistence during the rehabilitation process, a portion of the stream of future weekly disability compensation payments may be discounted from the future to the present to accommodate payment. Should this be necessary, the employer or insurance carrier shall be allowed to reasonably offset the amounts paid against future liability payable after the initial 312 weeks. In this process, care should be exercised to reasonably minimize adverse financial impact on the employee.

(iv) In the event the parties cannot agree as to the reasonableness of any proposed offset, the matter may be submitted to an ALJ for determination.

(c) Subsections 34A-2-413(7) and (9) require the applicant to fully cooperate in any evaluation or reemployment plan. Failure to

do so shall result in dismissal of the applicant's claim or reduction or elimination of benefit payments including disability compensation and subsistence allowance amounts, consistent with the provisions of Section 34A-2-413(7) and (9).

(d) Subsection 34A-2-413(6) requires the employer or its insurance carrier to diligently pursue any proffered reemployment plan. Failure to do so shall result in a final award of permanent total disability compensation to the applicant.

(e) If, after the conclusion of the foregoing "second step" proceeding, the ALJ concludes that successful rehabilitation is not possible, the ALJ shall enter a final order for continuing payment of permanent total disability compensation. The period for payment of such compensation shall be commence on the date the employee became permanently and totally disabled, as determined by the ALJ.

(f) Alternatively, if after the conclusion of the "second step" proceeding, the ALJ concludes that successful rehabilitation and/or reemployment is possible, the ALJ shall enter a final order to that effect, which order shall contain such direction to the parties as the ALJ shall deem appropriate for successful implementation and continuation of rehabilitation and/or reemployment. As necessary under the particular circumstances of each case, the ALJ's final order shall provide for reasonable offset of payments of any disability compensation that constitute an overpayment under Subsection 34A-2-413(4)(b).

(g) The ALJ's decision is subject to all administrative and judicial review provided by law.

D. For purposes of this rule, the following standards and definitions apply:

1. Other work reasonably available: Subject to medical restrictions and other provisions of the Act and rules, other work is reasonably available to a claimant if such work meets the following criteria:

a. The work is either within the distance that a resident of the claimant's community would consider to be a typical or acceptable commuting distance, or is within the distance the claimant was traveling to work prior to his or her accident;

b. The work is regular, steady, and readily available; and

c. The work provides a gross income at least equivalent to:

(1) The current state average weekly wage, if at the time of the accident the claimant was earning more than the state average weekly wage then in effect; or

(2) The wage the claimant was earning at the time of the accident, if the employee was earning less than the state average weekly wage then in effect.

2. Cooperation: As determined by an administrative law judge, an employee is not entitled to permanent total disability compensation or subsistence benefits unless the employee fully cooperates with any evaluation or reemployment plan. The ALJ will evaluate the cooperation of the employee using, but not limited to, the following factors: attendance, active participation, effort, communication with the plan coordinator, and compliance with the requirements of the vocational plan. In determining if these factors were met, the ALJ shall consider relevant changes in the employee's documented medical condition.

3. Diligent Pursuit: The employer or its insurance carrier shall diligently pursue the reemployment plan. The ALJ will evaluate the employer or insurance carrier's diligent pursuit of the plan using, but not limited to, the following factors: timely payment of expenses and benefits outline in the vocational plan, and as required by the

educational institution providing the vocational training, communication with the employee, compliance with the requirements of the vocational plan, and timely modification of the plan as required by documented changes in the employee's medical condition.

4. Resolution of disputes regarding "cooperation" and "diligent pursuit": If a party believes another party is not cooperating with or diligently pursuing either the evaluations necessary to establish a plan, or the requirements of an approved reemployment or rehabilitation plan, the aggrieved party shall submit to the workers' compensation mediation unit an outline of the specific instances of non-cooperation or lack of diligence. Other parties may submit a reply. The Mediation Unit will promptly schedule mediation to reestablish cooperation among the parties necessary to evaluate or comply with the plan. If mediation is unsuccessful, a party may request the Adjudication Division resolve the dispute. The Adjudication Division will conduct a hearing on the matter within 30 days and shall issue a written decision within 10 days thereafter.

R612-200-8. Burial Expenses.

(1) Pursuant to Section 34A-2-418 if death results from an industrial injury or occupational disease, burial expenses in ordinary cases shall be paid by the employer or insurance carrier up to \$8,000. Unusual cases may result in additional payment, either voluntarily by the employer or insurance carrier or through commission order.

(2) Beginning in the year 2004 and every two years thereafter, the Commission shall review this rule and shall make such adjustments as are necessary so that the burial expense provided by this rule remains equitable when compared to the average cost of burial in this state.

KEY: workers' compensation, filing deadlines, time, administrative proceedings

Date of Enactment or Last Substantive Amendment: 2013

Authorizing, and Implemented or Interpreted Law: 34A-2-101 et seq.; 34A-3-101 et seq.; 34A-1-104

Labor Commission, Industrial Accidents

R612-300

Workers' Compensation Rules - Medical Care

NOTICE OF PROPOSED RULE

(New Rule)

DAR FILE NO.: 37126

FILED: 12/28/2012

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The substance of this rule is currently found in Rules R612-2 and R612-10, which will be repealed. The Labor Commission is repealing all existing Industrial Accident Division rules to allow those rules to be consolidated, reorganized, and reenacted in a format that is more logical and user friendly.

SUMMARY OF THE RULE OR CHANGE: The proposed Rule R612-300 contains the substance of existing Rules R612-2 and R612-10, which are being repealed. (DAR NOTE: The proposed repeal of Rule R612-2 is under DAR No. 37130, and the proposed repeal of Rule R612-10 is under DAR No. 37138 in this issue, January 15, 2013, of the Bulletin.)

STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 34A-1-104 et seq. and Section 34A-2-101 et seq. and Section 34A-3-101 et seq.

MATERIALS INCORPORATED BY REFERENCES:

- ◆ Adds Optum Essential RBRVS, published by Optum, 2012 1st Quarter
- ◆ Adds Current Procedural Terminology, published by American Medical Association, 2012
- ◆ Adds Medical Fee Guidelines, published by Utah Labor Commission, 12/01/2012

ANTICIPATED COST OR SAVINGS TO:

- ◆ THE STATE BUDGET: Because the substantive provisions of the new rule are the same as an existing rule that is being repealed, enactment of the new rule will not result in costs or savings to the state budget.
- ◆ LOCAL GOVERNMENTS: Because the substantive provisions of the new rule are the same as an existing rule that is being repealed, enactment of the new rule will not result in costs or savings to local government.
- ◆ SMALL BUSINESSES: Because the substantive provisions of the new rule are the same as an existing rule that is being repealed, enactment of the new rule will not result in costs or savings to small businesses.
- ◆ PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES: Because the substantive provisions of the new rule are the same as an existing rule that is being repealed, enactment of the new rule will not result in costs or savings to other affected persons.

COMPLIANCE COSTS FOR AFFECTED PERSONS: Reenactment of the substantive provisions currently found in Rules R612-2 and R612-10 will not change interested parties' rights or duties and will not impose any compliance costs on affected persons.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: The repeal of existing Rules R612-2 and R612-10, coupled with reenactment of the rule's substantive provisions in a more logical format, is intended to make the rule easier to find and use by businesses and all other stakeholders in the workers' compensation system. The Commission does not anticipate that the improved organization of these rules will result in any fiscal impact on businesses.

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:

♦ Ron Dressler by phone at 801-530-6841, by FAX at 801-530-6804, or by Internet E-mail at rdressler@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON
THIS RULE BY SUBMITTING WRITTEN COMMENTS NO
LATER THAN AT 5:00 PM ON 02/14/2013

THIS RULE MAY BECOME EFFECTIVE ON: 02/21/2013

AUTHORIZED BY: Sherrie Hayashi, Commissioner

R612. Labor Commission, Industrial Accidents.

R612-300. Workers' Compensation Rules - Medical Care.

R612-300-1. Whom May Attend Industrial Patients.

A. The employer has first choice of physicians; but if the employer fails or refuses to provide medical attention, the employee has the choice of physicians.

B. An employee of an employer with an approved medical program may procure the services of any qualified practitioner for emergency treatment if a physician employed in the program is not available for any reason.

R612-300-2. Injured Workers' Right to Privacy.

A. No agent of the employer or the employer's insurance carrier shall be present during an injured worker's visit with a medical provider, unless agreed upon by the claimant.

B. If an agent of the employer or the employer's insurance carrier is excluded from the medical visit, the medical provider and the injured worker shall meet with the agent at the conclusion of the visit so as to communicate regarding medical care and return to work issues.

R612-300-3. Changes of Doctors and Hospitals.

A. It shall be the responsibility of the insurance carrier or self-insured employer to notify each claimant of the change of doctor rules. Those rules are as follows:

1. If a company doctor, designated facility or PPO is named, the employee must first treat with that designated provider. The insurance carrier or self-insured employer shall be responsible for payment for the initial visit, less any health insurance copays and subject to any health insurance reimbursement, if the employee was directed to and treated by the employer's or insurance carrier's designated provider, and liability for the claim is denied and if the treating physician provided treatment in good faith and provided the insurance carrier or self-insured employer a report necessary to make a determination of liability. Diagnostic studies beyond plain x-rays would need prior approval unless the claimed industrial injury or occupational illness required emergency diagnosis and treatment.

2. The employee may make one change of doctor without requesting the permission of the carrier, so long as the carrier is promptly notified of the change by the employee.

(a) Physician referrals for treatment or consultation shall not be considered a change of doctor.

(b) Changes from emergency room facilities to private physicians, unless the emergency room is named as the "company doctor", shall not be considered a change of doctor. However, once private physician care has begun, emergency room visits are prohibited except in cases of:

(i) Private physician referral, or

(ii) Threat to life.

3. Regardless of prior changes, a change of doctor shall be automatically approved if the treating physician fails or refuses to rate permanent partial impairment.

B. Any changes beyond those listed above made without the permission of the carrier/self-insurer may be at the employee's own expense if:

1. The employee has received notification of rules, or

2. A denial of request is made.

C. An injured employee who knowingly continues care after denial of liability by the carrier may be individually responsible for payment. It shall be the burden of the carrier to prove that the patient was aware of the denial.

D. It shall be the responsibility of the employee to make the proper filings with the division when changing locale and doctor. Those forms can be obtained from the division.

E. Except in special cases where simultaneous attendance by two or more medical care practitioners has been approved by the carrier/employer or the division, or specialized services are being provided the employee by another physician under the supervision and/or by the direct referral of the treating physician, the injured employee may be attended by only one practitioner and fees will not be paid to two practitioners for similar care during the same period of time.

F. The Director of the Division of Industrial Accidents may authorize an injured worker to be examined by another physician for the purpose of obtaining a further medical examination or evaluation pertaining to the medical issues involved, and to obtain a report addressing these medical issues in all cases where:

1. The treating physician has failed or refused to give an impairment rating, and/or

2. A substantial injustice may occur without such further evaluation.

G. The Commission has jurisdiction to decide liability for medical care allegedly related to an industrial accident.

R612-300-4. Filings.

A. Within one week following the initial examination of an industrial patient, nurse practitioners, 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 practitioner 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.

R612-300-5. Regulation of Medical Practitioner Fees.

Pursuant to Section 34A-2-407(9):

A. The Labor Commission of Utah:

1. Establishes and regulates fees and other charges for medical provider services as required for the treatment of a work-related injury or illness.

2. Adopts and by this reference incorporates the Optum Essential RBRVS, 2012 1st Quarter Emergency Update, 1761/RBRCU/1766R/RBRC12?RBRC/U1766R ("RBRVS"), as the method for calculating reimbursement and the 2012 American Medical Association Current Procedural Terminology ("CPT").

a. 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.

b. The CPT and RBRVS, are subject to the Utah Labor Commission's Medical Fee Guidelines and the following Labor Commission conversion factors for medical care rendered for a work-related injury or illness, effective December 1, 2012: (Conversion Rates below EFFECTIVE December 1, 2012, to be used with the RBRVS procedural Unit value as per specialty.)

Anesthesiology \$41.00 (1 unit per 15 minutes of anesthesia);

Medicine, E and M \$46.00;

Evaluation and Management codes 99201 - 99204 and 99211 - 99214 \$46.00;

Pathology and Laboratory \$52.00;

Radiology \$53.00;

Restorative Services \$46.00;

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 2013 Medical Fee Guidelines, effective December 1, 2012. The Utah Medical Fee Guidelines 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.

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.

G. For procedures not covered by other provisions of this rule, medical providers have three options.

1. Medical providers may request preauthorization for a procedure from the insurance carrier.

2. Medical providers may present evidence to Medical Fee Committee for incorporating a procedure into the Commission's fee schedule. However, such incorporation will have prospective effect only.

3. Medical providers may apply for hearing before the Commission's Adjudication Division pursuant to Subsection 34A-2-801(1)(c) to establish a reasonable fee for the procedure.

R612-300-6. Method of Rating.

A. For rating all impairments, which are not expressly listed in Section 34A-2-412, the Commission incorporates by reference "Utah's 2006 Impairment Guides" as published by the Commission for all injuries rated on or after July 11, 2006. For those conditions not found in "Utah's 2006 Impairment Guides," the American Medical Association's "Guides to the Evaluation of Permanent Impairment, Fifth Edition" are to be used.

R612-300-7. Adjusting Resource-Based Relative Value Scale (RBRVS) Codes.

A. When adjusting any medical provider's bill who has billed per the Commission's adopted RBRVS the adjusting entity shall provide one or more of the following explanations as applies to the down coding when payment is made to the medical provider:

1. Code 99202, 99203, 99204 or 99205 - the submitted documentation for a new patient did not meet the three key components lacking in the level of history for the code billed.

2. Code 99202, 99203, 99204 or 99205 - the submitted documentation for a new patient did not meet the three key components lacking in the level of examination for the code billed.

3. Code 99202, 99203, 99204 or 99205 - the submitted documentation for a new patient did not meet the three key components lacking in the level of medical decision making for the code billed.

4. Code 99202, 99203, 99204, or 99205 - the submitted documentation for a new patient did not meet the three key components lacking in the level of history and exam for the code billed.

5. Code 99213, 99214 or 99215 - the submitted documentation for an established patient did not meet the two key components lacking in the level of history and exam that the code billed.

6. Code 99213, 99214 or 99215 - the submitted documentation for an established patient did not meet the two key components lacking in the level of history and medical decision making for the code billed.

7. Code 99213, 99214 or 99215 - the submitted documentation for the established patient did not meet the two key components lacking in the level of exam and medical decision making for the code billed.

B. The above explanations may be abbreviated, with a legend provided, to accommodate the space of computerized messages.

R612-300-8. Fees in Cases Requiring Unusual Treatment.

The RBRVS scheduled fees are maximum fees except that fees higher than RBRVS scheduled may be authorized by the Commission when extraordinary difficulties encountered by the physician justify increased charges and are documented by written reports.

R612-300-9. Hospital or Surgery Pre-Authorization.

Any ambulatory surgery or inpatient hospitalization other than a life or limb threatening admission, allegedly related to an industrial injury or occupational disease, shall require pre-authorization by the employer/insurance carrier. Within two working days of a telephone request for pre-authorization, the employer/carrier shall notify the physician and employee of approval or denial of the surgery or hospitalization, or that a medical examination or review is going to be obtained. The medical examination/review must be conducted without undue delay which in most circumstances would be considered less than thirty days. If the request for pre-authorization is made in writing, the employer/carrier shall have four days from receipt of the request to notify the physician and employee. If the employee chooses to be hospitalized and/or to have the surgery prior to such pre-authorization or medical examination/review, the employee may be personally responsible for the bills incurred and may not be reimbursed for the time lost unless a determination is made in his/her favor.

R612-300-10. One Fee Only to be Paid in global Fee Cases.

In a global fee case which is transferred from one doctor to another doctor, one fee only will be paid, apportioned at the discretion of the Commission. Adequate remuneration shall also be paid to the medical practitioner who renders first aid treatment where the circumstances of the case require such treatment.

R612-300-11. Surgical Assistants' Fees.

Fees, in accordance with the Commission's adopted Resource-Based Relative Value Scale (RBRVS), in addition to the global fee for surgical services, will be paid surgical assistants only, when specifically authorized by the employer or insurance carrier involved, or in hospitals where interns and residents are not available and the complexity of the surgery makes a surgical assistant necessary.

R612-300-12. Separate Bills.

Separate bills must be presented by each surgeon, assistant, anesthetist, consultant, hospital, special nurse, or other medical practitioner within 30 days of treatment on a HCFA 1500 billing form so that payment can be made to the medical practitioner who rendered the service. All bills must contain the federal ID number of the person submitting the bill.

R612-300-13. Hospital Fees Separate.

Fees covering hospital care shall be separate from those for professional services and shall not extend beyond the actual necessary hospital care. When it becomes evident that the patient needs no further hospital treatment, he/she must be discharged. All billings must be submitted on a UB92 form and be properly itemized and coded and shall include all appropriate documentation to support the billing. There shall not be a separate fee charged for the necessary documentation in billing for payment of hospital services. The documentation of hospital services shall include at a minimum the

discharge summary. The insurance carrier may request further documentation if needed in order to determine liability for the bill.

R612-300-14. Charges for Ordinary Supplies, Materials, or Drugs.

Fees covering ordinary dressing materials or drugs used in treatment shall not be charged separately but shall be included in the amount allowed for office dressings or treatment.

R612-300-15. Charges for Special or Unusual Supplies, Materials, or Drugs.

A. Charges for special or unusual supplies, materials, or drugs not included as a normal and usual part of the service or procedure shall, upon receipt of an itemized and coded billing, be paid at cost plus 15% restocking fees.

B. For purposes of part A above, the amount to be paid shall be calculated as follows:

1. Applicable shipping charges shall be added to the purchase price of the product;

2. The 15% restocking fee shall then be added to the amount determined in sub part 1;

3. The amount of taxes paid on the purchase of the supplies, materials, or drugs shall then be added to the amount determined in sub part 2, which sum shall constitute the total amount to be paid.

R612-300-16. Fees for Unscheduled Procedures.

Fees for medical or surgical procedures not appearing in the Commission's adopted RBRVS current fee schedule are subject to the Commission's approval and should be submitted to the Commission when the physician and employer or insurance carrier do not agree on the value of the service. Such fees shall be in proportion as nearly as practicable to fees for similar services appearing in the RBRVS.

R612-300-17. Ambulance Charges.

Ambulance charges must not exceed the rates adopted by the State Emergency Medical Service Commission for similar services.

R612-300-18. Dental Injuries.

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.

R612-300-19. HIV, Hepatitis B and C Testing and Reporting for Emergency Medical Service Providers.

A. Authority - The HIV, Hepatitis B and C Testing and Reporting for Emergency Medical Services Providers rule is established under the authority of U.C.A. Section 78B-8-404.

B. Purpose - To establish procedures pursuant to U.C.A. Section 78B-8-401 for source patient testing and reporting following a significant exposure of an emergency medical services provider.

C. Definitions

1. Department means the Utah Labor Commission.

2. Contact means designated person(s) within the emergency medical services agency or the employer of the emergency medical services provider.

3. Disease means Human Immunodeficiency Virus, acute or chronic Hepatitis B or Hepatitis C infections.

4. Emergency medical services provider means Emergency Medical personnel as defined in Section 26-8a-102, a public safety officer, local fire department personnel, or personnel employed by the

Department of Corrections or by a county jail, who provide prehospital Emergency medical care for an emergency medical services agency either as an employee or a volunteer.

5. Emergency medical services (EMS) agency means an agency, entity, or organization that employs or utilizes emergency medical services providers as defined in (4) as employees or volunteers.

6. Source Patient means any individual cared for by a prehospital emergency medical services provider, including but not limited to victims of accidents or injury, deceased persons, and prisoners or persons in the custody of the Department of Corrections.

7. Receiving facility means a hospital, health care or other facility where the patient is delivered by the emergency medical services provider for care.

8. "Significant Exposure" and "Significantly Exposed" mean:

a. exposure of the body of one person to the blood or body fluids visibly contaminated by blood of another person by:

1. percutaneous injury, including a needle stick or cut with a sharp object or instrument; or

2. contact with an open wound, mucous membrane, or nonintact skin because of a cut, abrasion, dermatitis, or other damage; or

b. exposure that occurs by any other method of transmission defined by the Department of Health as a significant exposure.

D. Emergency Medical Services Provider Responsibility.

1. The EMS provider shall document and report all significant exposures to the receiving facility and contact as defined in (C) (2).

2. The reporting process is as follows:

a. The exposed EMS provider shall complete the Exposure Report Form (ERF) at the time the patient is delivered to the receiving facility and provide a copy to the person at the receiving facility authorized by the facility to receive the form. In the event the exposed EMS provider does not accompany the source patient to the receiving facility, he/she may report the exposure incident, with information requested on the ERF, by telephone to a person authorized by the facility to receive the form. In this event, the exposed EMS provider shall nevertheless submit a written copy of the ERF within three days to an authorized person of the receiving facility.

b. The exposed EMS provider shall, within three days of the incident, submit a copy of the ERF to the contact as defined in (C) (2).

E. Receiving Facility Responsibility:

1. The receiving facility shall establish a system to receive ERFs as well as telephoned reports from exposed EMS providers on a 24-hour per day basis. The facility shall also have available or on call, trained pre-test counselors for the purpose of obtaining consent and counseling of source patients when HIV testing has been requested by EMS providers. The receiving facility shall contact the source patient prior to release from the facility to provide the individual with counseling or, if unable to provide counseling, provide the source patient with phone numbers for a trained counselor to provide the counseling within 24 hours.

2. Upon notification of exposure, the receiving facility shall request permission from the source patient to draw a blood sample for disease testing, as defined in (C) (3). In conjunction with this request, the source patient must be advised of his/her right to refuse testing and be advised that if he/she refuses to be tested that fact will be forwarded to the EMS agency or employer of EMS provider. The source patient

shall also be advised that if he/she refuses to be tested, the EMS agency or provider may seek a court order to compel the source patient to submit to a blood draw for the disease testing.

Testing is authorized only when the source patient, his/her next of kin or legal guardian consents to testing, with the exception that consent is not required from an individual who has been convicted of a crime and is in the custody or under the jurisdiction of the Department of Corrections, or if the source patient is dead. If consent is denied, the receiving facility shall complete the ERF and send it to the EMS agency or employer of the EMS provider. If consent is received, the receiving facility shall draw a sample of the source patient's blood and send it, along with the ERF, to a qualified laboratory for testing.

3. The laboratory that the receiving facility has sent source patient's blood draw to shall send the disease test results, by Case ID number, to the EMS agency or employer of the EMS provider.

F. EMS Agency/Employer Responsibility:

1. The EMS agency/employer, upon receipt of the disease tests, from the receiving facility laboratory, shall immediately report the result, by case number, not name, to the exposed EMS provider.

2. The EMS agency/employer, upon the receipt of refusal of testing by the source, shall report that refusal to the EMS provider.

3. The agency/employer or its insurance carrier shall pay for the EMS provider and the source patient testing for the covered diseases per the Labor Commission fee schedule.

4. The EMS agency/employer shall maintain the records of any disease exposures contained in this rule per the OSHA Blood Borne Pathogen standards.

R612-300-20. Travel Allowance and Per Diem.

A. An employee who, based upon his/her physician's advice, requires hospital, medical, surgical, or consultant services for injuries arising out of and in the course of employment and who is authorized by the self-insurer, the carrier, or the Commission to obtain such services from a physician and/or hospital shall be entitled to:

1. Subsistence expenses of \$6 per day for breakfast, \$9 per day for lunch, \$15 per day for dinner, and actual lodging expenses as per the state of Utah's in-state travel policy provided:

(a) The employee travels to a community other than his/her own place of residence and the distance from said community and the employee's home prohibits return by 10:00 p.m., and

(b) The absence from home is necessary at the normal hour for the meal billed.

2. Reasonable travel expenses regardless of distance that are consistent with the state of Utah's travel reimbursement rates, or actual reasonable costs of practical transportation modes above the state's travel reimbursement rates as may be required due to the nature of the disability.

B. This rule applies to all travel to and from medical care with the following restrictions:

1. The carrier is not required to reimburse the injured employee more often than every three months, unless:

(a) More than \$100 is involved, or

(b) The case is about to be closed.

2. All travel must be by the most direct route and to the nearest location where adequate treatment is reasonably available.

3. Travel may not be required between the hours of 10:00 p.m. and 6:00 a.m., unless approved by the Commission.

4. Requests for travel reimbursement must be submitted to the carrier for payment within one year of the authorized medical care.

5. Travel allowance shall not include picking up prescriptions unless documentation is provided substantiating a claim that prescriptions cannot be obtained locally within the injured worker's community.

6. The Commission has jurisdiction to resolve all disputes.

R612-300-21. Interest for Medical Services.

A. All hospital and medical bills must be paid promptly on an accepted liability claim. All bills which have been submitted properly on an accepted liability claim are due and payable within 45 days of being billed unless the bill or a portion of the bill is in dispute. Any portion of the bill not in dispute is payable within 45 days of the billing.

B. Per Section 34A-2-420, any award for medical treatment made by the Commission shall include interest at 8% per annum from the date of billing for the medical service.

R612-300-22. Medical Records.

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 extent 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, a designated person(s) within the Industrial Accidents Division or an administrative law judge if the claim is being adjudicated.

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 and 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.

R612-300-23. Insurance Carrier's Privilege to Examine.

The employer or the employer's insurance carrier or a self-insured employer shall have the privilege of medical examination of an injured employee at any reasonable time. A copy of the medical examination report shall be made available to the Commission at any time upon request of the Commission.

R612-300-24. Notice to Health Care Providers.

Any notice from a carrier denying further liability must be mailed to the Commission and the patient on the same day as it is mailed to the health care provider. Where it can be shown, in fact, that a medical care provider and the injured employee have received a denial of further care by the insurance carrier or self-insured employer, further treatment may be performed at the expense of the employee. Any future ratification of the denial by the Commission will not be considered a retroactive denial but will serve to uphold the force and effect of the previous denial notice.

R612-300-25. Review of Medical Payments.

A. Health care providers and payors are primarily responsible to resolve disputes over fees for medical services between themselves. However, in some cases it is necessary to submit such disputes to the Division for resolution. The Commission therefore establishes the following procedure for submission and review of fees for medical services.

1. The provider shall submit a bill for services rendered, with supporting documentation, to the payor within one year of the date of service;

2. The payor shall evaluate the bill according to the guidelines contained in the Commission's Medical Fee Guidelines and RBRVS and shall pay the provider the appropriate fee within 45 days as required by Rule R612-2-13.

3. If the provider believes that the payor has improperly computed the fee under the RBRVS, the provider or designee shall request the payor to re-evaluate the fee. The provider's request for re-evaluation shall be in writing, shall describe the specific areas of disagreement and shall include all appropriate documentation. The provider shall submit all requests for re-evaluation to the payor within one year of the date of the original payment.

4. Within 30 days of receipt of the written request for re-evaluation, the payor shall either pay the additional fee due the provider or respond with a specific written explanation of the basis for its denial of additional fees. The payor shall maintain proof of transmittal of its response.

B. If the provider continues to disagree with the payor's determination of the appropriate fee, the provider shall submit the matter to the Division by filing with the Division a written explanation of the disagreement. The provider's explanation shall include copies of:

1. The provider's original bill and supporting documentation;

2. The payor's initial payment of that bill;

3. The provider's request for re-evaluation and supporting documentation; and

4. The payor's written explanation or its denial of additional fees.

C. The Division will evaluate the dispute according to the requirements of the Medical Fee Guidelines and RBRVS and, if necessary, by consulting with the provider, payor, or medical specialists. Within 45 days from the date the Division receives the provider's request, the Division will mail its determination to both parties.

D. Any party aggrieved by the Division's determination may file an application for hearing with the Division of Adjudication to obtain formal adjudication of the dispute.

E. A payor seeking reimbursement from a provider for overpayment of a bill shall submit a written request to the provider detailing the circumstances of the payment requested within one year of submission of the bill.

1. Providers should make appropriate reimbursements, or respond in writing detailing the reasons why repayment will not be made, within 90 days of receipt of a written request from a payor.

2. If a dispute as to reimbursement occurs, an aggrieved party may request resolution of the dispute by the Labor Commission.

R612-300-26. Utilization Review Standards.

A. As used in this subsection:

1. "Payor" means a workers' compensation insurance carrier, a self-insured employer, third-party administrator, uninsured employer or the Uninsured Employers' Fund, which is responsible for payment of the workers' compensation claim.

2. "Health Care Provider" means a provider of medical services, including an individual provider, a health-service plan, a health-care organization, or a preferred-provider organization.

3. "Request for Authorization" means any request by a physician for assurance that appropriate payment will be made for a course of proposed medical treatment, including surgery or hospitalization, or any diagnostic studies beyond plain X-rays.

4. "Utilization Review," as authorized in Section 34A-2-111, is a process used to manage medical costs, improve patient care, and enhance decision-making. Utilization review includes, but is not limited to, the review of requests for authorization to treat, and the review of bills, for the purpose of determining whether the medical services provided were or would be necessary, to treat the effects of the injury/illness. Utilization review does not include bill review for the purpose of determining whether the medical services rendered were accurately billed. Nor does it include any system, program, or activity in connection with making decisions concerning whether a person has sustained an injury or illness which is compensable under Section 34A-2 or 34A-3.

5. "Reasonable Attempt" is defined as at least two phone calls and a fax, or three phone calls, within five business days from date of the payor's receipt of the physician's request for review.

B. Any utilization review system shall establish an appeals process which utilizes a physician(s) for a final decision by the insurer, should an initial review decision be contested. The payor may establish levels of review that meet the following criteria:

1. Level I--Initial Request and Review. A payor may use medical or non-medical personnel to initially apply medically-based criteria to a request for authorization for payment of a specific treatment. The treating physician must send all the necessary

documentation for the payor to make a decision regarding the treatment recommended. The payor must then notify the physician within five business days of the request for authorization of payment for the treatment, by a method which provides certification of transmission of the document, of either an acceptance or a denial of the request. A denial for authorization of payment for a recommended treatment utilizing the Commission's form, Form 223, must be sent to the provider with the criteria used in making the determination to deny payment for the treatment. A copy of the denial must also be mailed to the claimant. Level I--Request and Review does not include authorization requests for services billed from the Restorative section of the Resource-Based Relative Value Scale (RBRVS). Requests for authorization for restorative services are governed by rule R612-2-3(B).

2. Level II--Review. A physician, who has been denied authorization of payment for treatment, or has received no response within five business days from the request for authorization for payment at Level I review, may request a physician's review by sending the completed portion of the Commission form 223 to the payor. Such a request for review may be filed by any physician who has been denied authorization for payment for restorative services beyond the initial eight visits as authorized by Rule R612-2-3(B). The requesting physician must include the times and days that he/she is available to discuss the case with the reviewing physician, and must be reasonably available during normal business hours. The payor's physician representative must complete the review within five business days of the treating physician's request for review. Before the insurer's physician representative may issue a denial of an authorization for payment to treat, a reasonable effort must have made to contact the requesting treating physician to discuss the differing aspects of the case. Failure by the payor to respond within five business days, by a method which provides certification of transmission, to a denial for authorization for payment for treatment, shall constitute an authorization for payment of the treatment. The payor's denial to pay for the recommended treatment must be issued on Commission's form 223, and the denial must be accompanied by the criteria that was used in making the decision to deny authorization, along with the name and speciality of the reviewing physician. The denial to authorize payment for treatment must then be sent to the physician, the claimant, and the Commission. The payor shall notify the Commission if an additional five days is needed in order to contact the treating physician or to review the case. An additional extension of time may be requested from the Commission to accommodate highly unusual circumstances or particularly difficult cases.

C. Upon receipt of denial of authorization for payment for medical treatment at Level II, the Commission will facilitate, upon the request of the claimant, the final disposition of the case. If the parties agree, the medical dispute may be resolved by the Commission through binding mediation or medical review. If there is not agreement among the parties, the Commission will resolve the dispute through formal adjudication. The payor shall be responsible for sending the claimant the Commission appeals information when the denial for authorization for payment for medical treatment is sent to the claimant.

D. If the medical treatment requested is not an emergency, and treatment is rendered by the physician after receiving notice of the utilization standards encompassed in this rule, the following shall apply:

1. The Commission shall, if the disputed medical treatment is ultimately determined to be compensable as an expense necessary to treat the industrial injury or occupational disease, order that the physician be reimbursed at only 75% of the of the amount otherwise payable had appropriate authorization been timely obtained. The injured worker shall not be liable for any additional payment to the physician above the 75%.

2. Neither the worker's employer or its workers' compensation insurer shall be liable for any portion of the cost of disputed medical treatment, if that treatment is ultimately determined not to be compensable as an expense necessary to treat an industrial injury or occupational disease.

3. A worker may become liable for the cost of the disputed medical treatment, if that treatment is ultimately determined not to be compensable as an expense necessary to treat the industrial injury or occupational disease.

4. Except for any co-pays or deductibles under the worker's health insurance plan, the penalty provision in D(1) and D(3) shall not apply if the physician performs the medical treatment in question, having been preauthorized in writing to do the same by a health insurer or other non-worker's compensation insurance payor.

5. The penalty provisions in D(1) shall not apply to medical treatment rendered in emergency situations, which are defined as a threat to life or limb.

6. The Commission shall notify a physician, in writing, of reported violations of this rule. Repeated violations of this rule by a physician may result in a report from the Commission to the Department of Commerce, Division of Occupational/Professional Licensing.

R612-300-27. Commission Approval of Health Care Treatment Protocols.

A. Authority. Pursuant to authority granted by Section 34A-2-111(2)(c)(i)(B)(VII) of the Utah Workers' Compensation Act, the Utah Labor Commission establishes the following standards and procedures for Commission approval of medical treatment and quality care guidelines.

B. Standards:

1. Scientifically based: Section 34A-2-111(2)(c)(i)(B)(VII)(Aa) of the Act requires that guidelines be scientifically based. The Commission will consider a guideline to be "scientifically based" when it is supported by medical studies and/or research.

2. Peer reviewed: Section 34A-2-111(2)(c)(i)(B)(VII)(Bb) of the Act requires that guidelines be peer reviewed. The Commission will consider a guideline to be "peer reviewed" when the medical study's content, methodology, and results have been reviewed and approved prior to publication by an editorial board of qualified experts".

3. Other standards: Pursuant to its rulemaking authority under Section 34A-2-111(2)(c)(i)(B)(VII), the Utah Labor Commission establishes the following additional standards for medical treatment and quality care guidelines.

a. The guidelines must be periodically updated and, subject to Commission discretion, may not be approved for use unless updated in whole or in part at least biannually;

b. Guideline sources must be identified;

c. The guidelines must be reasonably priced;

d. The guidelines must be easily accessible in print and electronic versions.

C. Procedure: Pursuant to Section 34A-2-111(2)(c)(i)(B)(VII) of the Utah Workers' Compensation Act, a party seeking Commission action to approve or disapprove a guideline shall file a petition for such action with the Labor Commission.

KEY: workers' compensation, fees, medical practitioners

Date of Enactment or Last Substantive Amendment: 2013

Authorizing, and Implemented or Interpreted Law: 34A-1-104; 34A-2-201

Labor Commission, Industrial Accidents **R612-400** Workers' Compensation Insurance, Self-Insurance and Waivers

NOTICE OF PROPOSED RULE

(New Rule)

DAR FILE NO.: 37127

FILED: 12/28/2012

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The substance of this rule is currently found in Rules R612-3, R612-5, R612-6, R612-12, and R612-4, which will be repealed. The Labor Commission is repealing all existing Industrial Accident Division rules to allow those rules to be consolidated, reorganized, and reenacted in a format that is more logical and user friendly.

SUMMARY OF THE RULE OR CHANGE: The proposed Rule R612-400 contains the substance of existing Rules R612-3, R612-5, R612-6, R612-12, and R612-4, which are being repealed. (DAR NOTE: The proposed repeal of Rule R612-3 is under DAR No. 37131, the proposed repeal of Rule R612-4 is under DAR No. 37132, the proposed repeal of Rule R612-5 is under DAR No. 37133, the proposed repeal of Rule R612-6 is under DAR No. 37134, and the proposed repeal of Rule R612-12 is under DAR No. 37140 in this issue, January 15, 2013, of the Bulletin.)

STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 34A-1-104 et seq. and Section 34A-2-101 et seq. and Section 34A-3-101 et seq. and Section 78B-8-402 and Section 78B-8-404 and Subsection 59-9-101(2)

ANTICIPATED COST OR SAVINGS TO:

♦ **THE STATE BUDGET:** Because the substantive provisions of the new rule are the same as an existing rule that is being repealed, enactment of the new rule will not result in costs or savings to the state budget.

♦ **LOCAL GOVERNMENTS:** Because the substantive provisions of the new rule are the same as an existing rule that is being repealed, enactment of the new rule will not result in costs or savings to local government.

♦ **SMALL BUSINESSES:** Because the substantive provisions of the new rule are the same as an existing rule that is being repealed, enactment of the new rule will not result in costs or savings to small businesses.

♦ **PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES:** Because the substantive provisions of the new rule are the same as an existing rule that is being repealed, enactment of the new rule will not result in costs or savings to other affected persons.

COMPLIANCE COSTS FOR AFFECTED PERSONS: Reenactment of the substantive provisions currently found in Rules R612-3, R612-5, R612-6, R612-12, and R612-4, will not change interested parties' rights or duties and will not impose any compliance costs on affected persons.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: The repeal of existing Rules R612-3, R612-5, R612-6, R612-12, and R612-4, coupled with reenactment of the rule's substantive provisions in a more logical format, is intended to make the rule easier to find and use by businesses and all other stakeholders in the workers' compensation system. The Commission does not anticipate that the improved organization of these rules will result in any fiscal impact on businesses.

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:

♦ Ron Dressler by phone at 801-530-6841, by FAX at 801-530-6804, or by Internet E-mail at rdressler@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN AT 5:00 PM ON 02/14/2013

THIS RULE MAY BECOME EFFECTIVE ON: 02/21/2013

AUTHORIZED BY: Sherrie Hayashi, Commissioner

R612. Labor Commission, Industrial Accidents.

R612-400. Workers' Compensation Insurance, Self-Insurance and Waivers.

R612-400-1. Notification of Workers' Compensation Insurance Coverage.

Any insurance carrier subject to the policy reporting requirements of Section 34A-2-205 may satisfy such reporting requirements by either of the following methods:

1. The insurance carrier may directly file the required information electronically with the Industrial Accidents Division in accordance with the International Association of Industrial Accidents Boards and Commissions (IAIABC) standards and format.

2. Alternatively, the insurance carrier may use an agent to file the required information electronically with the Industrial Accidents Division in accordance with IAIABC standards and format, provided that the agent has been authorized by the Labor Commission as meeting its electronic filing standards.

R612-400-2. Employee Leasing Company Workers' Compensation Policy Endorsements.

2.1. Workers' Compensation Coverage for Client Companies Under an Endorsement Arrangement.

An insurance company licensed to write workers' compensation coverage in the state of Utah underwriting an employee leasing company as the named insured shall insure all of the primary insured's client companies under an umbrella policy and shall provide a separate endorsement for each client company unless the client company provides workers' compensation coverage under a separate policy.

2.2. Notification of a New Policy and Endorsements.

A. Any insurance carrier underwriting a new policy naming an employee leasing company as the primary insured shall notify the division in writing or by electronic means within ten working days of the new policy including all client companies covered under the policy. The notification shall include all the information as specified in this rule.

B. The insurance carrier shall subsequently notify the division in writing or by electronic means within ten working days of any new client company endorsements covered under a leasing company's umbrella policy after the initial policy is written giving all information as specified in this rule.

2.3. Required Information.

The following information is required on any notice sent to the division on a policy underwritten by the insurance carrier naming an employee leasing company as the primary insured.

A. Name and both mailing and physical address of the employee leasing company.

B. The policy number and effective dates of coverage for the employee leasing company.

C. Each client company's DBA's (doing business as) names(s) and mailing and physical location(s).

D. The Standard Industrial Classification (SIC) for each client company.

E. The effective dates of coverage on the endorsement for each client company.

2.4. Reporting Injuries.

The reporting of injuries as required in Section 34A-2-407 shall be in the name of the client company.

2.5. Cancellations.

Any insurance carrier underwriting an employee leasing company as the primary insured shall:

A. Give the division a 30 day advance notice in writing or by electronic means of a proposed cancellation of an employee leasing company or any client company written as an endorsement under an employee leasing company's policy.

B. Give the division notice in writing or through electronic means within ten working days after cancellation of a policy underwritten naming the employee leasing company as the primary insured and any cancellation of an endorsement of a client company covered under the primary insured.

C. Failure by an insurance carrier to notify the division of the cancellation of either the primary insured employee leasing company or a client company will result in the continuation of coverage by the insurance carrier until the division receives notification as specified in this rule.

R612-400-3. Workers' Compensation Rules-Self Insurance.

3.1. Application.

A. An employer seeking authorization to become self-insured under the provision of Section 34A-2-201 of the Utah Workers' Compensation Act must apply to the division through the use of a form entitled "Application for Self Insurance."

B. The division will require annual renewals for continuing self-insurance. Renewal, through the use of a form entitled "Renewal Application for Self-Insurance", will require an update of the initial information. Renewal information must be submitted at least 60 days before the self-insurance anniversary date. Failure to file a renewal application on time may result in an interruption or cancellation of self-insurance privileges.

C. The initial and all renewal applications must be completed and signed by the employer's duly authorized representative.

3.2. Qualifying Requirements.

A. To qualify, an employer must be in business for a period of not less than five years and shall demonstrate sufficient financial strength and liquidity of the business to assure that all obligations will be promptly met. An employer in business less than five years will be considered only if a pre-existing parent corporation (in business more than five years) guarantees the liability. In cases of merger or name identification change, the history of the pre-existing entity will be considered for the five year requirement. Upon applying for self-insurance privileges, the applicant must forward a current, certified financial statement or other proof of financial ability to pay direct compensation and other expenses as provided by Section 34A-2-201. Mergers occurring after an entity is self-insured will require a new application by the merged entity. However, entities whose financial information can be obtained from Dunn and Bradstreet will not be required to file financial statements unless clarification or supplemental statements are deemed appropriate or necessary.

B. Specific or aggregate excess insurance with policy limits and retention amounts acceptable are required as a condition of approval and continuation of self-insurance privileges.

C. Excess Insurance policies shall include a bankruptcy and insolvency endorsement (Form 303) for each self-insured entity. The endorsement adds the Uninsured Employer's Fund to the excess insurance policy and specifies the conditions of the Utah bankruptcy and insolvency endorsement for individual self-insureds.

D. A minimum \$100,000 surety bond.

E. No corporate surety shall be eligible to write self-insurers' surety bonds or excess insurance unless authorized to transact such business in this state.

F. Surety bonds must be issued on a prescribed form entitled "Self-Insurance Aggregate Surety Bond" and shall be exchanged or

replaced with another surety bond only if a 60 day notice of termination of liability is given by the bonding company. The replacement bond must be issued on a form as prescribed by the Commission. No replacements will be authorized by the Commission unless the new surety accepts the liability of the previous surety(ies) or a guarantee is filed by both (all) sureties acknowledging their respective liabilities and periods of time covering such liabilities.

G. All subsidiary companies must have the parent company guarantee liability for payment of benefits (unless such requirement is waived by the division). The form and substance of such guarantees are to be approved by the division.

H. The division may utilize services such as Dunn and Bradstreet credit ratings for the purpose of evaluating a company's financial ability to pay.

I. Entities that fall within the top two composite credit appraisal ratings by Dunn and Bradstreet (or information from an equivalent service) and their top two ratings on estimated financial strength may qualify for self-insurance in Utah with the minimum requirements as set forth in Rule R612-3-4C. Companies with a 5A or 4A estimated financial strength rating and falling within the fair composite credit appraisal of Dunn and Bradstreet may qualify for self-insurance with higher security requirements as determined by the division. The provisions herein are to be construed as optional, with the division having the option.

J. Self-insured entities, or their parent company if such is a guarantor, that fall below either the 5A or 4A estimated financial strength rating or the top three composite credit appraisal ratings of Dunn and Bradstreet will not be allowed to self-insure. A company already self-insured that falls in the aforementioned disqualifying categories will not be allowed to continue self-insurance privileges. However, at the discretion of the division continuation of self-insurance will be considered if the following steps are taken:

1. An independent actuarial study satisfactory to the division and the employer is made of the reserve requirements of the self-insured entity, said study to be at the employer's expense. Selection of the actuary will be mutually agreed upon by the division and the employer. However, should the parties fail to agree, the division will make the final selection.

2. Satisfactory security is obtained for the reserves plus the aggregate excess retention amount.

3. Any company whose self-insurance privileges are revoked under the provisions of these rules will be required to obtain security for their reserve requirements under the foregoing two step process regardless of whether or not self-insurance privileges are continued.

4. Companies whose privileges are to be revoked will be allowed 60 days from notice to comply with steps 1 through 3 above.

5. Quarterly financial reviews will be taken of entities which retain their self-insurance privileges by following 1, 2, and 3 above.

K. Security requirements for all entities requiring security will be determined by a review of past incurred losses and application of exposure, loss, and contingency factors. The minimum acceptable bond amount is \$100,000.

L. Public and eleemosynary entities are classified as special categories requiring separate consideration for self-insurance privileges and security requirements.

3.3. Administration of the Self-Insurance Program.

A. A self-insurer must procure the services of an insurance carrier or adjusting company to administer the self-insurance program with regard to claims, setting up of reserves, and safety programs; or

B. The self-insurer must show proof of sufficient and competent staff to administer the self-insurance program and provide safety engineering. The division reserves the right to train and test adjusters and administrators of self-insurance programs.

C. Whether a self-insurer hires their own adjuster or contracts with an insurance carrier or service organization, the following conditions must be met:

1. A knowledgeable contact concerning claims will be located in the state of Utah.

2. The self-insurer will maintain a toll free number or accept during office hours a reasonable number of collect calls from injured employees if either employees of the company or the division offices are in a different city than that of the adjuster.

D. The self-insurer will comply with all rules of the Commission and with the Workers' Compensation Act.

3.4. Notice of Certification for Self-Insurance or Denial and Renewal.

Upon meeting the requirements set forth in these rules, an employer shall receive a formal certificate approving self-insured status. The privilege may be renewed from year to year with renewal procedure as required by these rules. An employer whose original or renewal application for self-insurance has been denied or revoked, or who takes exception to insurance or reserve requirements, may request a review or reconsideration by the Commission. The request must be made within 20 days of the notice of Commission action issued to the employer. A request for review will not automatically extend the authorization to self-insure. However, the Commission may extend the privilege pending review. Without such an extension, the privilege is revoked on the anniversary date.

3.5. Revocation of Right to Self-Insure.

The right to self-insure may be revoked by the division for failure to comply with the rules contained herein.

R612-400-4. Waivers.

4.1. Authority and Purpose.

This rule is enacted under authority of 34A-1-104 of the Utah Labor Commission Act and Title 34A, Chapter Two, Part One, the Workers' Compensation Coverage Waivers Act ("the Act"). The purpose of this rule is to establish procedures for workers' compensation coverage waivers ("coverage waivers"). The rule also addresses the effect of coverage waivers and the adjudicative procedures to be followed by the Division in granting, denying, or revoking coverage waivers.

4.2. Administration by Industrial Accidents Division.

Except as otherwise provided, the Utah Labor Commission's Division of Industrial Accidents ("Division") shall administer the provisions of the Act and this rule.

4.3. Procedure for Application and Issuance of Certificate.

A. A business entity may apply for a coverage waiver by completing a form provided by the Commission, submitting required supporting documents, and paying a fee of \$50. The Division's determination of whether to grant or deny a request for coverage waiver shall be conducted as informal proceedings under the Utah Administrative Procedures Act.

B. Supporting documents. 34A-2-1004 of the Workers' Compensation Coverage Waivers Act requires a business entity to

submit the following documentation to support its request for a coverage waiver:

(1) a copy of two or more of the following:

(a) the business entity's federal or state income tax return that shows business income for the complete taxable year that immediately precedes the day on which the business entity submits the information;

(b) a valid business license;

(c) a license to engage in an occupation or profession, including a license under Title 58, Occupations and Professions; or

(d) documentation of an active liability insurance policy that covers the business entity's activities; or

(2) a copy of one item listed in Subsection (1) and a copy of two or more of the following:

(a) proof of a bank account for the business entity;

(b) proof that for the business entity there is:

(i) a telephone number; and

(ii) a physical location; or

(c) an advertisement of services in a newspaper of general circulation or telephone directory showing the business entity's:

(i) name; and

(ii) contact information.

C. Fee. A business entity applying for a workers' compensation coverage waiver certificate shall submit payment of a fee of \$50.00. Such fees are used to defray the costs of processing and evaluating the application and are nonrefundable. If payment of the fee is made by check, the Division may delay issuance of a coverage waiver until it has verified that the check will be honored.

D. Issuance or Denial of Certificate. If the Division determines that a business entity has satisfied each requirement for a coverage waiver, the Division will issue the coverage waiver. If the Division determines that a business entity has not satisfied each requirement for a workers' compensation insurance waiver, the Division will issue a written denial to the business entity, stating the basis for denial and setting forth the business entity's appeal rights.

4.4. Duration, Renewal and Revocation.

A. Duration. Subject to revocation of a coverage waiver as provided by subparagraph C. of this section, a coverage waiver remains in effect for the following time periods:

1. A coverage waiver issued by a licensed workers' compensation insurance company prior to July 1, 2011, the effective date of the Workers' Compensation Coverage Waivers Act, shall remain effective for the period shown on the coverage waiver.

2. A coverage waiver issued by the Division after July 1, 2011, shall be effective for one year from the date the coverage waiver is issued.

B. Renewal. The Division will renew a business entity's coverage waiver if:

1. The business entity requests renewal; and

2. The business entity satisfies all requirements in effect at the time of the renewal request.

C. Revocation. If the Division has reason to believe that a business entity no longer qualifies for a coverage waiver, the Division shall institute proceedings to determine whether the business entity's coverage waiver should be revoked. Such proceedings shall be conducted as informal proceedings under the Utah Administrative Procedures Act. If the Division concludes that the business entity does not satisfy each requirement for a workers' compensation insurance waiver, the Division will issue a written order revoking the waiver.

certificate, stating the basis for revocation, and setting forth the business entity's appeal rights. The Division may also initiate other proceedings authorized by the Utah Workers' Compensation Act to compel the business entity to obtain workers' compensation coverage for its employees.

4.5. Review of Division Decisions to Deny or Revoke Waiver Certificate.

A business entity may challenge a Division decision to deny or revoke the business entity's coverage waiver by filing an appeal of the decision with the Commission's Adjudication Division. Such appeal proceedings shall be assigned to an administrative law judge and conducted as de novo formal adjudicatory proceedings pursuant to the Utah Administrative Procedures Act.

4.6. Effect, Verification and Limitation of Coverage Waiver.

A. Effect of coverage waiver. 34A-2-103 (7) (c) permits an employer contracting with a business entity to rely upon a valid coverage waiver issued by the Division as proof that the business entity is not required to have a workers' compensation insurance policy.

B. Verification of coverage waiver. An employer seeking to rely upon a business entity's coverage waiver shall retain the following documents:

1. A photocopy of the coverage waiver issued to the business entity by the Division; and

2. A printout of the Division's web page showing that the business entity's coverage waiver had not been revoked as of the date on which the employer contracted with the business entity.

C. Limitations to effect of coverage waiver. A coverage waiver does not excuse a business entity from obtaining and maintaining workers' compensation insurance coverage for employees who are entitled to such coverage under the Utah Workers' Compensation Act. If and when a business entity has such employees, any coverage waiver previously issued to that business entity becomes void and the business entity must immediately obtain workers' compensation coverage.

R612-400-5. Premium Rates for the Uninsured Employer' Fund and the Employers' Reinsurance Fund.

A. Pursuant to Section 59-9-101(2), Section 59-9-101.3 and 34A-2-202 the workers' compensation premium rates effective January 1, 2013, as established by the Labor Commission, shall be:

1. 0.15% for the Uninsured Employers' Fund;

2. 2.9% for the Employers' Reinsurance Fund;

B. The premium rates are a percentage of the total workers' compensation insurance premium income as detailed in Section 59-9-101(2)(a).

KEY: workers' compensation, insurance, rates, waivers

Date of Enactment or Last Substantive Amendment: 2013

Authorizing, and Implemented or Interpreted Law: 59-9-101(2)

Labor Commission, Industrial Accidents
R612-500
Procedural Guidelines for the
Reemployment Act

NOTICE OF PROPOSED RULE

(New Rule)

DAR FILE NO.: 37128

FILED: 12/28/2012

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The substance of this rule is currently found in Rule R612-8, which will be repealed. The Labor Commission is repealing all existing Industrial Accident Division rules to allow those rules to be consolidated, reorganized, and reenacted in a format that is more logical and user friendly.

SUMMARY OF THE RULE OR CHANGE: The proposed Rule R612-500 contains the substance of existing Rule R612-8, which is being repealed. (DAR NOTE: The proposed repeal of Rule R612-8 is under DAR No. 37136 in this issue, January 15, 2013, of the Bulletin.)

STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 34A-1-104 and Section 34A-8-109

ANTICIPATED COST OR SAVINGS TO:

◆ **THE STATE BUDGET:** Because the substantive provisions of the new rule are the same as an existing rule that is being repealed, enactment of the new rule will not result in costs or savings to the state budget.

◆ **LOCAL GOVERNMENTS:** Because the substantive provisions of the new rule are the same as an existing rule that is being repealed, enactment of the new rule will not result in costs or savings to local government.

◆ **SMALL BUSINESSES:** Because the substantive provisions of the new rule are the same as an existing rule that is being repealed, enactment of the new rule will not result in costs or savings to small businesses.

◆ **PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES:** Because the substantive provisions of the new rule are the same as an existing rule that is being repealed, enactment of the new rule will not result in costs or savings to other affected persons.

COMPLIANCE COSTS FOR AFFECTED PERSONS: Reenactment of the substantive provisions currently found in Rule R612-8 will not change interested parties' rights or duties and will not impose any compliance costs on affected persons.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: The repeal of existing Rule R612-8, coupled with reenactment of the rule's substantive provisions in a more logical format, is intended to make the rule easier to find and use by businesses and all other stakeholders in the workers' compensation system. The Commission does not anticipate that the improved organization of these rules will result in any fiscal impact on businesses.

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:

♦ Ron Dressler by phone at 801-530-6841, by FAX at 801-530-6804, or by Internet E-mail at rdressler@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN AT 5:00 PM ON 02/14/2013

THIS RULE MAY BECOME EFFECTIVE ON: 02/21/2013

AUTHORIZED BY: Sherrie Hayashi, Commissioner

**R612. Labor Commission, Industrial Accidents.
R612-500. Procedural Guidelines for the Reemployment Act.
R612-500-1. Purpose, Authority and Definitions.**

A. These rules guide insurance carriers and employers in complying with reporting and other requirements of the Utah Injured Workers Reemployment Act, Title 34A, Chapter 8a, Utah Code Annotated.

B. The Utah Labor Commission enacts these rules under the authority of section 34A-8a-202 and section 34A-8a-203.

C. Definitions established by section 34A-8a-102, section 34A-8a-203(1) and rule R612-1 apply to this rule. The following definitions also apply to this rule:

1. "Insurance Carrier" includes insurance carriers providing workers' compensation coverage and the Uninsured Employers Fund;

2. "Employer" includes self-insured employers and uninsured employers that are paying an injured workers' claim for benefits.

3. "disabled Injured Worker" means an injured worker who:
a. because of the injury or disease that is the basis for the employee being an injured worker:

i. is or will be unable to return to work in the injured worker's usual and customary occupation; or

ii. is unable to perform work for which the injured worker has previous training and experience; and

b. reasonably can be expected to attain gainful employment after an evaluation provided for in accordance with the Utah Injured Worker Reemployment Act, Title 34A, Chapter 8a.

R612-500-2. Form 206-Insurer/Employer Initial Reemployment Report for Injured workers.

A. Pursuant to section 34A-8a-301, a worker who has suffered a work-related injury or disease must be provided an initial written report (Form 206) that assesses the injured worker's need for vocational reemployment assistance. Form 206 is only required in those instances in which:

1. it appears the injured worker is or will be a "disabled injured worker"; or

2. the duration of the injured workers' temporary total disability compensation exceeds 90 days.

B. If the injured worker was covered by workers' compensation insurance at the time of injury or disease or the claim is being paid by the Uninsured employers' Fund (UEF), the insurance carrier or UEF must prepare and submit Form 206. If the injured worker's claim is being paid by a self-insured employer or an uninsured employer, the employer must prepare and submit Form 206.

C. Form 206 must be mailed or otherwise delivered to the injured worker and to the Division within 30 days after the insurance carrier or employer knows or should know that the injured worker's circumstances satisfy either of the conditions described in subsection A. (1) of A. (2).

R612-500-3. Referral of Disabled Injured Worker for Evaluation; Permission to Waive or Postpone Referral.

A. If Form 206 determinates that an injured worker satisfies the definition of a "disabled injured worker", the insurance carrier or employer shall refer the injured worker to the Utah State Office of Rehabilitation or to a private rehabilitation or reemployment service for evaluation and development of a reemployment plan. This referral must be made within 10 days after the insurance carrier or employer submits Form 206 to the Division unless the Division grants a waiver or postponement as provided in the following submstion B of this rule.

B. Section 34A-8a-302(3) authorizes the Labor Commission through the Division of Industrial Accidents to waive or postpone an insurance carrier or employer's referral obligation. An insurance carrier or employer shall make its request by completing and submitting "Form 215 - Insurer/Employer Request to Waive/Postpone Reemployment Referral" to the Division and mailing a copy of the completed form to the injured worker. The Division will consider such requests on a case-by-case basis. The Division will generally grant requests for waiver or postponement for the following reasons, or for other reasons similarly establishing good cause:

1. the injured worker was not medically stable;
2. the injured worker's physical capacity has not been determined; or

3. liability for the injured worker's claim is under review provided, however, that the Division may require the insurance carrier or employer to refer the injured worker for the free services offered by the Utah State Office of Rehabilitation.

R612-500-4. Form 239-Insurer/Employer Quarterly Report on Reemployment Efforts to the Division; Penalties.

A. Beginning with the calendar quarter commencing on July 1, 2009, and continuing for each quarter thereafter, section 34A-8a-203(2) requires insurance carriers and employers (referred to as "reporting entities") to file quarterly reports enumerating their efforts to return injured workers to gainful employment.

B. Reporting entities shall submit their quarterly reports by completing Form 239 - Insurer/Employer Quarterly Report on Reemployment Efforts," and filing the form with the Division no later than 45 days after the end of each calendar quarter.

C. Section 34A-8a-203(4) requires the Commission to impose a civil penalty of up to \$500 against a reporting entity that fails to file Form 206. Initial proceedings to assess such penalty are hereby designated as informal adjudicatory proceedings, while all subsequent proceedings with respect to assessment of such penalty are hereby designated as formal proceedings.

R612-500-5. Administrative Review.

An injured worker, insurance carrier or employer may submit any dispute arising from the provisions of the Utah Injured Worker Reemployment Act or these rules to the Labor Commission's Adjudication Division for resolution according to the procedures established by the Utah Administrative Procedures Act, Title 63G, Chapter 4, Utah Code Annotated.

KEY: workers' compensation, reemployment guidelines
Date of Enactment or Last Substantive Amendment: 2013
Authorizing, and Implemented or Interpreted Law: 34A-2-103

Natural Resources, Water Rights
R655-7
Administrative Procedures for Notifying
the State Engineer of Sewage Effluent
Use or Change in the Point of
Discharge for Sewage Effluent

NOTICE OF PROPOSED RULE

(Repeal)
 DAR FILE NO.: 37119
 FILED: 12/27/2012

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The rule is being repealed because it no longer applies in statute.

SUMMARY OF THE RULE OR CHANGE: This rule is repealed in its entirety.

STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Title 73, Chapter 3c

ANTICIPATED COST OR SAVINGS TO:

- ◆ **THE STATE BUDGET:** No cost involved, clarification of processing does not require a dollar figure.
- ◆ **LOCAL GOVERNMENTS:** No cost involved, clarification of processing does not require a dollar figure.
- ◆ **SMALL BUSINESSES:** No cost involved, clarification of processing does not require a dollar figure.
- ◆ **PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES:** No cost involved, clarification of processing does not require a dollar figure.

COMPLIANCE COSTS FOR AFFECTED PERSONS: None--No individual costs involved.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: No fiscal impact, clarification of process procedures does not require a dollar figure.

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

NATURAL RESOURCES
 WATER RIGHTS
 ROOM 220
 1594 W NORTH TEMPLE
 SALT LAKE CITY, UT 84116-3154
 or at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:

◆ Marianne Burbidge by phone at 801-538-7370, by FAX at 801-538-7467, or by Internet E-mail at marianneburbidge@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN AT 5:00 PM ON 02/14/2013

THIS RULE MAY BECOME EFFECTIVE ON: 02/21/2013

AUTHORIZED BY: Michael Styler, Executive Director

R655. Natural Resources, Water Rights.

~~[R655-7. Administrative Procedures for Notifying the State Engineer of Sewage Effluent Use or Change in the Point of Discharge for Sewage Effluent.~~

~~**R655-7-1. Authority and Effective Date.**~~

~~1.1. These rules establish and govern procedures for notifying the state engineer of sewage effluent use or change in the point of discharge for sewage effluent as required under Section 73-3e-8(1).~~

~~1.2. These rules govern all notifications for use of sewage effluent or change in point of discharge of sewage effluent commenced on or after May 5, 1998.~~

~~**R655-7-2. Definitions.**~~

~~"Application to Appropriate" means an official request for authorization to develop a source and quantity of water for beneficial uses as covered in Section 73-3-2.~~

~~"Beneficial Use" means the basis, the measure and the limit of a water right and includes the amount of water use allowed by the water right expressed in terms of the purposes to which the water may be applied. For example, in the case of irrigation, the beneficial use is expressed as the number of acres which may be irrigated by the water right (e.g. 40 acres).~~

~~"Change Application" means an application filed to obtain authorization from the state engineer to allow water right to be changed with respect to point of diversion, period of use, place of use, or nature of use. As allowed by Section 73-3-3, any person entitled to the use of water may make permanent or temporary changes listed by making application upon forms furnished by the state engineer.~~

~~"Depletion" means water consumed and no longer available as a source of supply; that part of a withdrawal that has been evaporated, transpired, incorporated into crops or products, consumed by man or livestock, or otherwise removed.~~

~~"Diversion" means the maximum total volume of water in acre-feet or the flow in second-feet which may be diverted as allowed~~

by a water right to meet the needs of the beneficial uses authorized under the right.

"Effluent" means discharged wastewater or similar products, such as a stream flowing out of a body of water and includes products that result from the treatment of sewage and other pollutants pursuant to discharge limitations set under the Clean Water Act.

"Hydrologic System" means the complete area or basin where waters, both surface and underground, are interconnected by a common drainage basin.

"Notification" means an application filed with the state engineer requesting authorization to use or to change the point of discharge for sewage effluent.

R655-7-3. Contents of the Notification.

3.1. The notification shall include adequate information for the state engineer to determine if the use of sewage effluent is consistent with and without enlargement of the underlying water rights or if a change in point of discharge is required. This information shall be supplied on forms provided by the state engineer or an acceptable reproduction and shall include the information described below as well as any other information deemed necessary by the state engineer to evaluate the notification.

3.2. Information Required on a Notification for Use of Sewage Effluent.

A. The name and post office address of the applicant.

B. The Water Right Numbers of the water proposed for reuse.

C. An evaluation of the diversion and depletion limits of the underlying water rights. This would include evaluating the diversion and depletion limits allowed for the underlying right at the time it was originally approved and certificated by the state engineer.

D. The nature of use of the underlying water rights. This would include the present approved use of the water and the original approved use if different from the present.

E. The quantity of water in acre-feet or the flow in second-feet to be reused.

F. The point of diversion, the nature of use, and the place of use for the proposed sewage effluent use.

G. The point of discharge of the sewage effluent where the sewage would be released if it were not put to beneficial use.

H. An evaluation of the amount of water depleted from the hydrologic system from the use of the sewage effluent.

I. An evaluation of the cumulative total depletion of water from the hydrologic system from the initial use of water and the proposed use of the sewage effluent.

J. An indication whether or not a change application needs to be filed to cover the proposed uses. A change application is required if the proposed nature or place of use for the water reused was not authorized by the underlying water right upon which the reuse is based.

K. An indication whether or not an application to appropriate water needs to be filed to cover the proposed uses of any of the water. An application to appropriate is required if the reuse project proposes to use any unappropriated water of the state.

3.3. Information Required on a Notification for a Change in Point of Discharge

A. The name and post office address of the applicant.

B. The Water Right Numbers of the water proposed to change the point of discharge.

C. The quantity of water in acre-feet or second-feet to have the point of discharged changed.

D. The current point of discharge for the sewage effluent.

E. The proposed point of discharge for the sewage effluent.

F. In addition to the above information required, if the sewage effluent is to be put to a beneficial use in conjunction with the change in point of discharge, the information required in Subsection 3.2. "Notification for Use of Sewage Effluent" must be provided.

R655-7-4. Processing the Notification.

4.1. Upon receipt of the notification, the state engineer shall determine if the information submitted is acceptable and complete.

A. If the information is acceptable and complete, the state engineer shall deem the notification filed.

B. If the information is not acceptable and complete, the state engineer shall return the notification to the applicant and indicate the deficiencies.

C. Once the notification is filed, the state engineer shall publish information from the notification to inform the public of its contents in accordance with Section 73-3e-8(2).

D. Any interested person may file comments with the state engineer within 20 days after the notice is published.

E. A meeting regarding the notification and public comment may be held at the discretion of the state engineer.

4.2. The state engineer shall determine if water use is consistent with, and without enlargement of, the underlying water right or whether an application is required to use the sewage effluent water.

A. If the proposed sewage effluent use is consistent with the and without enlargement of the applicant's water rights, the state engineer shall issue a letter indicating that there is a water right for the proposed use.

B. If the proposed sewage effluent use is not consistent with the existing beneficial uses or enlarges the right, the state engineer shall issue a letter indicating that there is not a water right for the proposed use.

B.1. If a change application or an application to appropriate is required in conjunction with the proposed use of sewage effluent, it shall be the responsibility of the applicant to file the required application with the state engineer. The state engineer shall process the change application or the application to appropriate according to Section 73-3 of the Utah Code.

B.2. The state engineer shall review the change application and the application to appropriate according to Sections 73-3-3 and 73-3-8, respectively, of the Utah Code.

KEY: sewage effluent use

Date of Enactment or Last Substantive Amendment: February 1, 2003

Notice of Continuation: February 1, 2008

Authorizing, and Implemented or Interpreted Law: 73-3C]

Public Safety, Homeland Security R704-2 Statewide Mutual Aid Act Activation

NOTICE OF PROPOSED RULE

(New Rule)

DAR FILE NO.: 37117

FILED: 12/20/2012

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The purpose of this rule is to outline a process for jurisdictions that are acting as agents of the state to use in mobilizing or demobilizing available assets in response to an intrastate or interstate disaster as provided in Title 53, Chapter 2, Part 2, Emergency Management Assistance Compact.

SUMMARY OF THE RULE OR CHANGE: This rule outlines procedures to be followed in the event that the Statewide Mutual Aid Act is activated. Specifically, this rule outlines procedures related to requests for disaster assistance in a state of emergency, agent of the state deployment, providing mutual aid, pre-mobilization of resources, mobilization of resources, demobilization of resources, mutual aid reimbursement, waiver of reimbursement, and reimbursable expenses.

STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Subsection 53-2-506(1)(b)

ANTICIPATED COST OR SAVINGS TO:

- ◆ **THE STATE BUDGET:** This is a procedural rule that outlines processes to follow in the event that the Statewide Mutual Aid Act is activated. As such, there is no anticipated costs or savings to the state budget.
- ◆ **LOCAL GOVERNMENTS:** This is a procedural rule that outlines processes to follow in the event that the Statewide Mutual Aid Act is activated. As such, there is no anticipated costs or savings to local government.
- ◆ **SMALL BUSINESSES:** This is a procedural rule that outlines processes to follow in the event that the Statewide Mutual Aid Act is activated. As such, there is no anticipated costs or savings to small businesses.
- ◆ **PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES:** This is a procedural rule that outlines processes to follow in the event that the Statewide Mutual Aid Act is activated. As such, there is no anticipated costs or savings to persons other than small businesses, businesses or local government entities.

COMPLIANCE COSTS FOR AFFECTED PERSONS: There are no compliance costs for affected persons. This rule strictly outlines procedures to be followed in the event that the Statewide Mutual Aid Act is activated.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: There is no anticipated fiscal impact on businesses associated with this rule. This is a procedural rule that outlines processes associated with Statewide Mutual Aid Act activation.

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

PUBLIC SAFETY
HOMELAND SECURITY
ROOM 1110 STATE OFFICE BUILDING
450 N STATE ST
SALT LAKE CITY, UT 84114-1201
or at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:

◆ Jerriane Kolby by phone at 801-209-7513, or by Internet E-mail at jkolby@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN AT 5:00 PM ON 02/14/2013

THIS RULE MAY BECOME EFFECTIVE ON: 02/21/2013

AUTHORIZED BY: Keith Squires, Deputy Commissioner

R704. Public Safety, Homeland Security.**R704-2. Statewide Mutual Aid Act Activation.****R704-2-1. Purpose.**

The purpose of this rule is to outline a process for jurisdictions that are acting as agents of the state to use in mobilizing or demobilizing available assets in response to an intrastate or interstate disaster as provided in Title 53, Chapter 2, Part 2, Emergency Management Assistance Compact.

R704-2-2. Authority.

This rule is authorized by Section 53-2-506(1)(b).

R704-2-3. Definitions.

(1) Terms used in this rule are defined in Section 53-2-502.

(2) "Jurisdiction" means political subdivision as defined in Section 53-2-502 (5); (9); and (10).

(3) In addition to the terms defined in Section 53-2-502:

(a) "agent of the state" means any person designated to represent the state;

(b) "authorized representative" means an officer or employee from a participating jurisdiction empowered to request, offer, or provide assistance on behalf of the chief executive officer;

(c) "division" means the Utah Division of Emergency Management;

(d) "EMAC" means Emergency Management Assistance Compact, Utah Code Ann. 53-2-201 to 202;

(e) "EMAC coordinator" means a designated division representative functioning as the coordinator of all Emergency Management Assistance Compact activities and actions between the states;

(f) "emergency manager" means a person designated by a jurisdiction to oversee preparedness, emergency response, mitigation, and recover for its community;

(g) "Form 100," SMAA Checklist for Requesting and Checklist for Responding, is a checklist provided to assist the jurisdictions in procedures to follow when enacting statewide mutual aid under the Act;

(h) "Form 101," SMAA Mission Request Form, is a form used to request resources;

(i) "Form 102A," Agent of the State of Utah - EMAC Agreement, is a document that outlines liability, benefits, and financial responsibilities in deployment to another state;

(j) "Form 102B," Agent of the State of Utah - SMAA Agreement, is a document that outlines liability, benefits, and financial responsibilities within the state;

(k) "Form 103," SMAA Pre-deployment Checklist for Personnel, is a document to list steps in preparation for deployment;

(l) "Form 104," SMAA Mobilization Sheet, is a document that outlines the steps and processes needed at the time of deployment;

(m) "Form 105," SMAA Personnel Location, is a tracking tool used to locate deployed personnel who are serving an SMAA mission assignment;

(n) "Form 106," SMAA Resource Availability Log, is a log that identifies available resources offered by supporting agencies in response to an event;

(o) "Form 107," SMAA Resource Tracking Form, is a tracking tool used to identify and locate resources being utilized under an SMAA mission;

(p) "Form 109," SMAA Demobilization/Return of Assets Guidelines, provides guidelines for the responding jurisdictions to use in tracking assets used in an incident or event;

(q) "Form 110," SMAA Intergovernmental Reimbursement Form, is a form that a jurisdiction uses to request reimbursement from the requesting jurisdiction;

(r) "Form 111," SMAA After Action/Corrective Action Report Survey, is a form that summarizes and analyzes performance in both exercise and actual events, and may also evaluate achievement of the selected exercise objectives and demonstration of the overall capabilities being exercised ;

(s) "Form 112," SMAA Demobilization Checklist, is a document that outlines the steps to follow in preparing to leave the mission;

(t) "Form 113," SMAA Activation Agreement, is a document that shows the intent to activate the SMAA;

(u) "ICS Form 221," Demobilization Checklist, is a FEMA form for tracking resources as they are released from deployment and return to their responding jurisdiction;

(v) "local to local" means assistance between county/city jurisdictions to another county/city jurisdiction that may not utilize coordination from the state;

(w) "mission number" means a number assigned that identifies a mission;

(x) "SMAA" means Statewide Mutual Aid Act, Utah Code Ann. 53-2-501 to 510;

(y) "SMAA coordinator" means a designated Division representative functioning as the coordinator of all Statewide Mutual Aid Act activities and actions between the participating jurisdictions;

(z) "state EOC" means the State of Utah Emergency Operations Center facility operated by the division which assists state agencies and jurisdictions in coordinating information and resources when local emergency response and recovery resources require supplementation; and

(aa) "state EOC manager" means a person designated to manage the State Emergency Operation Center.

R704-2-4. Requests for Disaster Assistance in a State of Emergency.

(1) When seeking to utilize the statewide mutual aid system for an emergency or disaster event, the chief executive officer or emergency manager of the requesting jurisdiction shall contact the division director or deputy director after they have made a written or oral declaration of emergency. If an oral declaration is provided, it should be followed up with a written declaration within 24 hours.

(a) The chief executive officer or designee of the requesting jurisdiction shall submit Form 100 to the division director within 24 hours of seeking assistance from the system for state resources or to receive assistance coordinating local to local assistance.

(2) Upon request by the requesting jurisdiction, the SMAA coordinator or state EOC manager shall coordinate services and resources for the emergency or disaster event and shall:

(a) assign a mission number;

(b) post information on WebEOC; and

(c) seek needed equipment and personnel from a participating jurisdiction.

(3) Once a responding jurisdiction that is available to render aid has been identified, the participating jurisdictions shall sign Form 113.

(a) If urgency dictates, the requesting jurisdiction and the responding jurisdiction may enter into a verbal agreement, but the agreement must be put in writing and signed by both jurisdictions no later than 48 hours after the verbal agreement.

(b) If unanticipated circumstances arise during the emergency or disaster event, the requesting and responding jurisdictions may amend or supplement Form 101.

(c) Any amendments or supplements to Form 101 shall be acknowledged by the participating jurisdictions with authorizing signatures.

R704-2-5. Agent of the State.

(1) At the request of the division, a jurisdiction may agree to provide the skills and expertise of their personnel to be deployed as an agent of the state for the purpose of rendering aid to a requesting jurisdiction whether it is in state or out of the state. The division will only provide logistics support to the agent of the state.

(a) The governing authority of the employee serving as an agent of the state shall sign Form 102A or Form 102B with the division in response to an intrastate/interstate disaster.

(b) The responding jurisdiction employee shall be entitled to the same salary and benefits to which they would otherwise be

entitled to and shall remain an employee of the responding jurisdiction for all other purposes except that the supervision of their duties during the period of assignment may be governed by agreement between the responding jurisdiction and the requesting jurisdiction.

(c) The division assumes no responsibility for the responding jurisdiction's employee other than the coordination of their travel arrangements, lodging, and per diem expenses.

(d) Upon completion of the mission, the agent of the state will turn Form 110 in to the division. The division will then reimburse the responding jurisdiction from the receipt of reimbursement from the requesting jurisdiction for the eligible expenses incurred by the agent of the state.

R704-2-6. Procedures for Providing Mutual Aid.

(1) When providing assistance pursuant to the SMAA, the requesting jurisdiction shall control and supervise the personnel, equipment, and resources of any responding jurisdiction.

(a) The requesting jurisdiction shall advise supervisory personnel of the responding jurisdiction concerning assignments or mission tasks.

(b) While providing mutual aid, the incident commander of the requesting jurisdiction shall:

(i) maintain daily personnel time records, material records, and a log of equipment hours;

(ii) oversee the operation, control, and maintenance of the equipment and other resources furnished by the responding jurisdiction;

(iii) report work progress to the responding jurisdiction.

(c) The responding jurisdiction will notify the requesting jurisdiction if the requested resources are donated or loaned.

(d) The responding jurisdiction may recall its personnel subject to providing a minimum of 24 hours advance notice of intent to withdraw personnel or resources from the requesting jurisdiction, unless circumstances make 24 hours advance notice unreasonable.

(2) The responding jurisdiction may release personnel or resources for SMAA assistance after it has determined that its remaining resources are adequate to support its own normal operations:

(a) The requesting jurisdiction shall be responsible for providing food and housing for the personnel from the responding jurisdiction, beginning with the time of arrival at the designated location and until departure, unless otherwise indicated in Form 101.

(b) The requesting jurisdiction may request personnel who are self-sustaining, but must specify what resources it is able to provide to the responding jurisdiction.

(3) The requesting jurisdiction is responsible for coordinating communication between its own personnel and the personnel of the responding jurisdiction.

(a) The responding jurisdiction shall furnish equipment to communicate among its respective operating units.

(4) Each participating jurisdiction shall maintain its own equipment in safe and operational condition.

(5) The division shall receive and maintain an inventory of the state and local services, equipment, supplies, personnel, and other

resources related to participation in Title 53, Chapter 2 Part 5, Statewide Mutual Aid Act.

R704-2-7. Pre-Mobilization of Resources.

(1) The requesting jurisdiction shall submit Form 101 to the division. The required information includes:

(a) type of resources requested; and

(b) quantity of resources requested.

(2) The responding jurisdiction will confirm the following incident information:

(a) name of incident;

(b) location of incident;

(c) date and time the incident was declared; and

(d) current time of deployment of resources requested.

(3) A situational briefing and Form 103 shall be given to responding personnel by the SMAA coordinator or state EOC manager if the request came through the SMAA or EOC channel.

(a) Travel information shall be provided by the SMAA coordinator or state EOC manager.

(4) A requesting jurisdiction shall first use local agency resources prior to requesting resources through SMAA.

(5) The requesting jurisdiction shall specify a location for a staging area and assign a person to ensure the resources are ready to be released.

(a) If the requested resources are for equipment, the responding jurisdiction shall confirm its readiness to be deployed.

(6) The responding jurisdiction shall perform a communications check with all assigned communications equipment, prior to departure, to ensure compatibility with the requesting jurisdiction.

R704-2-8. Mobilization of Resources.

(1) Deployed personnel and resources from a responding jurisdiction will notify the local point of contact for both the requesting jurisdiction, and the responding jurisdiction, of their arrival. The notification will occur at the point of assignment or staging area, and the deployed personnel will then obtain a mission briefing. The division shall use Form 104 for each deployment of resources.

(2) The requesting jurisdiction will notify the responding jurisdiction if there is a change in assignments or locations for the requested resources.

(3) The division will track deployed personnel by using Form 105.

(a) The division will track deployed resources and available resources for the SMAA through Form 106 and Form 107.

R704-2-9. Demobilization of Resources.

(1) The requesting jurisdiction will be responsible for demobilization.

(a) After termination of the mission time, the requesting jurisdiction will release resources and return those resources to the responding jurisdiction according to the terms of Form 104, unless the circumstances of the incident make compliance with the terms impracticable or impossible.

(b) The requesting jurisdiction will debrief all personnel assigned to the incident prior to departure. The debriefing will include:

(i) confirmation of personnel's travel arrangements;

(ii) review of personnel's responsibilities for demobilization; and

(iii) use of ICS Form 221.

(2) Equipment issued to personnel from a responding jurisdiction shall be returned, and all documentation will be completed and submitted as required in Form 109.

(3) Personnel and the responding jurisdiction will notify the requesting jurisdiction of the safe arrival of the deployed resources upon returning to their home station.

(4) The responding jurisdiction's returning employee will complete and submit Form 111 to the division for all SMAA deployments.

R704-2-10. Reimbursement Procedures for Rendering Mutual Aid.

(1) A responding jurisdiction that seeks reimbursement shall provide notice to the requesting jurisdiction within 30 days of the termination of statewide mutual aid assistance.

(a) The notice of intent should include the following:

(i) Form 110;

(ii) a brief summary of the services provided by the responding jurisdiction; and

(iii) contact information for the designated person or financial representative responsible for the request.

(b) The responding jurisdiction must use the assigned mission number when seeking reimbursement from a requesting jurisdiction.

(c) In addition to the notice of intent to seek reimbursement, the responding jurisdiction shall provide the requesting jurisdiction and the SMAA coordinator if the state was involved, with a copy of all documents related to deployment and reimbursement including:

(i) Form 101 and any amendments or supplements;

(ii) the requesting jurisdiction's acknowledgement of the responding jurisdiction's notice of intent to seek reimbursement;

(iii) any notices of dispute; and

(iv) any payments made by the requesting jurisdiction in response to the responding jurisdiction's request.

(2) The requesting jurisdiction shall acknowledge receipt, in writing, of the notice of intent to seek reimbursement from the responding jurisdiction.

(3) The SMAA coordinator shall record all documents related to deployment and reimbursement from the requesting jurisdiction.

(a) The SMAA coordinator shall coordinate with both jurisdictions to encourage and facilitate proper reimbursement, if needed.

(b) The SMAA coordinator may provide reminder notices in anticipation of due dates including the notifications required under Subsections (3) and (4).

(c) The division may designate a financial representative to monitor and provide guidance to participating jurisdictions concerning reimbursement.

(4) When the notification requirements of Subsection (3) have been met, the responding jurisdiction may submit a request for reimbursement to the requesting jurisdiction within 60 days of the termination of statewide mutual aid assistance.

(a) The request for reimbursement shall include a cover letter that summarizes the assistance provided under Form 101.

(b) The request for reimbursement shall also include the following:

(i) a copy of Form 112 with authorizing signatures;

(ii) a comprehensive invoice listing resources provided with the total cost; and

(iii) supporting documentation including copies of individual invoices, travel claims, vouchers, and other similar items.

(c) The request for reimbursement shall also include a copy of any amendments or supplements to the original Form 101 and accompanied by the itemized costs and respective supporting documents.

(5) The requesting jurisdiction shall reimburse the responding jurisdiction no later than 30 days from the date of receiving the notice under Subsection (1) unless:

(a) either jurisdiction provides written notice to the other jurisdiction that disputes the reimbursement costs, or alleges noncompliance with the applicable procedures and criteria; or

(b) the jurisdictions agree to an extension for reimbursement.

(6) Disputes regarding reimbursement shall first be addressed between the responding jurisdictions and requesting jurisdiction within 30 days after either party provides notice of the dispute.

(a) The jurisdiction shall make a reasonable effort to resolve the dispute during the 30 day period.

(7) If a dispute cannot be resolved by the jurisdiction within 90 days after the notice of dispute, either party may submit the dispute to the Statewide Mutual Aid Act Committee.

(a) Requests to the committee must be made no later than 30 days after the end of 90-day period described in Subsection (7).

(b) The requesting jurisdiction shall submit Form 110, a concise narrative explaining the dispute, and the documents listed in Subsections (4)(a) through (c).

(c) The requesting and responding jurisdictions may submit other supporting evidence that is relevant to the dispute.

(d) The committee has 30 days to schedule the matter for a hearing.

(e) The committee chairperson shall select a quorum of seven committee members to participate in the hearing.

(f) Hearings are designated as informal adjudications pursuant to Utah Code Ann. §63G-4-202.

(g) The committee, by majority vote, shall issue a final written decision within 30 days of the hearing that includes findings of fact and its reasons for its decision.

R704-2-11. Waiver of Reimbursement.

(1) A responding jurisdiction may waive, in writing, any rights to reimbursement under Sections 53-2-507 and 53-2-508.

(2) Waiver of any reimbursable right shall specify each item waived in order to provide notice to the requesting jurisdiction and the SMAA coordinator, if applicable.

(3) Waiver of any reimbursable right shall be delivered to the requesting jurisdiction with a copy delivered to the SMAA coordinator, if applicable, no later than 90 days after the termination of statewide mutual aid assistance.

R704-2-12. Reimbursable Expenses.

(1) The requesting jurisdiction shall reimburse the responding jurisdiction for costs related to deployment pursuant to Form 101.

(a) In order to be eligible for reimbursement, all costs must be documented and sufficiently detailed in Form 101.

(b) A jurisdiction that fails to submit all required reimbursement forms by due dates listed in this rule forfeits its right to reimbursement.

(2) Unless otherwise specified in Form 101, the responding jurisdiction shall continue to pay its employees according to ordinances, rules, and regulations at the time of the event.

(a) The requesting jurisdiction shall reimburse the responding jurisdiction for agreed upon costs and expenses incurred during the event.

(3) The requesting jurisdiction shall reimburse the responding jurisdiction for use, damage, or loss of any equipment that the responding jurisdiction provided during the event, exercise, or drill.

(a) If practicable and at the request of the responding jurisdiction, the requesting jurisdiction may provide fuels, miscellaneous supplies, and minor repairs.

(4) Unless damage is caused by gross negligence, bad faith, or willful misconduct by the responding jurisdiction, the requesting jurisdiction shall reimburse the responding jurisdiction for all materials and supplies exhausted or damaged during the event.

(a) The parties may agree that the requesting jurisdiction may replace equipment, materials, and supplies with like, kind, and quality as determined by the responding jurisdiction.

KEY: Statewide Mutual Aid Act, agent of the state
Date of Enactment or Last Substantive Amendment: 2013
Authorizing, and Implemented or Interpreted Law: 53-2-506(1)
(b)

**Public Service Commission,
 Administration
 R746-313
 Electric Service Reliability**

**NOTICE OF PROPOSED RULE
 (Amendment)**

DAR FILE NO.: 37116
 FILED: 12/20/2012

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The purpose of this rule amendment, as recommended by Rocky Mountain Power, is to replace the requirement for an electric corporation to report Momentary Average Interruption Frequency Index (MAIFI) data with the requirement to report Momentary Average Interruption Frequency Index Event (MAIFle) data, to clarify reporting requirements for MAIFle data, and to make other minor changes. As proposed by Rocky Mountain Power, the impact of a momentary electric service interruption experienced by a

customer is related to the entire momentary event (as represented by MAIFle) rather than the electric system's attempts to automatically restore power after a fault event (as represented by MAIFI). Therefore the electric service reliability rules addressing momentary outages should reference MAIFle, not MAIFI.

SUMMARY OF THE RULE OR CHANGE: The term MAIFI is replaced with MAIFle in Sections R746-313-2, R746-313-4, R746-313-7. The requirements to report MAIFle data are clarified in Section R746-313-7 and removed from Section R746-313-8. In addition, the word "reliability" is added in Section R746-313-7 to clarify the requirements to provide specific information for reliability reporting areas.

STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 54-3-1 and Section 54-4-2 and Section 54-4-7

ANTICIPATED COST OR SAVINGS TO:

- ◆ **THE STATE BUDGET:** This rule amendment will have no cost effect on the state budget because it only pertains to the reporting of electrical system momentary interruption data by electric corporations.
- ◆ **LOCAL GOVERNMENTS:** This rule amendment will have no cost effect on local governments in general or local governments who operate their own municipal electric utility systems because it only pertains to the reporting of electrical system momentary interruption data by electric corporations.
- ◆ **SMALL BUSINESSES:** This rule amendment will have no direct cost effect on small businesses because it only pertains to the reporting of electrical system momentary interruption data by electric corporations.
- ◆ **PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES:** This rule amendment will have no cost effect on persons other than small businesses, businesses, or local government entities because it only pertains to the reporting of electrical system momentary interruption data by electric corporations.

COMPLIANCE COSTS FOR AFFECTED PERSONS: This rule amendment reduces reporting requirements for electrical corporations but does not materially effect compliance costs of the entire rule.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: This rule amendment will have no fiscal impact on businesses as the amendment provides only for minor changes and clarifications for reporting of electric system outage data applicable only to electric corporations

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

PUBLIC SERVICE COMMISSION
 ADMINISTRATION
 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:

♦ David Clark by phone at 801-530-6708, by FAX at 801-530-6796, or by Internet E-mail at drexclark@utah.gov
♦ Sheri Bintz by phone at 801-530-6714, by FAX at 801-530-6796, or by Internet E-mail at sbintz@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN AT 5:00 PM ON 02/14/2013

THIS RULE MAY BECOME EFFECTIVE ON: 02/21/2013

AUTHORIZED BY: David Clark, Legal Counsel

R746. Public Service Commission, Administration.

R746-313. Electrical Service Reliability.

R746-313-1. Authority.

(1) This rule establishes electric service reliability and continuity requirements as provided for in Utah Code Sections 54-3-1, 54-4-2 and 54-4-7.

R746-313-2. Definitions.

(1) "Customer average interruption duration index" ("CAIDI") has the same meaning as in IEEE 1366 or RUS 1730A-119, as applicable.

(2) "Electric company" means an electrical corporation or a distribution electrical cooperative that is also a public utility, as defined in Utah Code 54-2-1(16).

(3) "Form 7 - Information on Service Interruptions" means:

(a) Part G of the United States Department of Agriculture Rural Utilities Service Form 7 Financial and Statistical Report,

(b) Part H of the National Rural Utilities Cooperative Finance Corporation Form 7 Financial and Statistical Report, or

(c) their equivalents.

(4) "Governing Authority" means:

(a) for a distribution electrical cooperative as defined in Utah Code 54-2-1(6), its board of directors; and

(b) for an electrical corporation as defined in Utah Code 54-2-1(7), the Public Service Commission of Utah, otherwise referred to as the commission.

(5) "The Institute of Electrical and Electronics Engineers Standard 1366" ("IEEE 1366") means the 2012 edition of the IEEE Guide for Electric Power Distribution Reliability Indices.

(6) "Loss of power supply"

(a) "Loss of power supply - Distribution Substation" means the loss of the electrical power supply system due to an outage/failure of a distribution substation component.

(b) "Loss of power supply - Generation/Transmission" means the loss of the electrical power supply from the electric company's own electric generator or transmission system, including transmission lines and transmission substations, or from another electric company or electric corporation.

(7) "Momentary average interruption event frequency index" ("MAIFI_e") has the same meaning as in IEEE 1366 or RUS 1730A-119, as applicable.

(8) "Major event day identification threshold value" ("T_{MED}") has the same meaning as in IEEE 1366 or RUS 1730A-119.

(9) "Operating area" means a geographic subdivision of an electric company's Utah service territory that functions under the direction of an electric company office and as a separate entity used for reliability reporting within the electric company. An operating area may also be referred to as regions, divisions, or districts and may also be a reliability reporting area.

(10) "Reliability" means the degree to which electric service is supplied without interruptions to customers.

(11) "Reliability indices" means the electric service interruption indices identified in IEEE 1366 or RUS 1730A-119, as applicable.

(12) "Reliability reporting area" means a grouping of one or more operating areas, for which the electric company calculates major event thresholds.

(13) "Reporting Period" means the 12-month period, based on the previous 365 days, or 366 days for leap years, for which an electric company is tracking and reporting reliability performance.

(14) "Rules" means the Electric Service Reliability rules R746-313-1 through 8.

(15) "RUS 1730A-119" means the United States Department of Agriculture Rural Utilities Service Bulletin 1730A-119 entitled "Interruption Reporting and Service Continuity Objectives for Electric Distribution Systems," dated March 24, 2009.

(16) "System average interruption duration index" ("SAIDI") has the same meaning as in IEEE 1366 or RUS 1730A-119, as applicable.

(17) "System average interruption frequency index" ("SAIFI") has the same meaning as in IEEE 1366 or RUS 1730A-119, as applicable.

(18) "System-wide" means pertaining to and limited to the electric company's customers in Utah.

R746-313-3. Purpose, Scope, Applicability and Exceptions.

(1) This rule establishes requirements for each electric company to monitor and report on electric service reliability.

(2) Unless otherwise approved, an electric company whose governing authority is the commission shall:

(a) follow the provisions of IEEE 1366 in the collection and analysis of interruption data and in the calculation and reporting of reliability indices as required by these rules. If there is a conflict between any provision in IEEE 1366 and the rules, the rules govern; and

(b) include both "distribution system" interruptions and "interruptions caused by events outside of the distribution system," as defined in IEEE 1366, in the electric company's record keeping, calculations, reporting, and filing as required by R746-313-4 through R746-313-8.

(3) Unless otherwise approved, an electric company whose governing authority is not the commission shall:

(a) follow the provisions of either IEEE 1366 or the RUS Bulletin 1730A-119 in the collection and analysis of interruption data and in the calculation and reporting of reliability indices as required by these rules. If a conflict exists between any provision in IEEE 1366 or RUS 1730A-119 and the rules, the rules govern; and

(b) include both "distribution system" interruptions and interruptions caused by events outside of the distribution system in the electric company's record keeping, calculations, reporting, and filing as

required by the Electric Service Reliability Rules R746-313-4 through R746-313-8.

(4) The commission may, upon written request and for good cause shown, waive or modify any provision of these rules in accordance with R746-100-15, Deviation from Rules.

R746-313-4. Electric Service Reliability.

(1) An electric company must have a written reliability program.

(2) Within 3 months after the effective date of these rules an electric company whose governing authority is the commission must file for commission approval of reliability performance baselines for SAIDI and SAIFI reliability indices.

(3) The filing required by 746-313-4(2) must include, but is not limited to:

(a) the basis for the proposed SAIDI and SAIFI values; and
(b) identification of systems and description of internal processes to collect, monitor and analyze interruption data and events including:

(i) definitions of all parameters used to calculate the proposed standards and major event days, and the time-period upon which the proposed standards are based (e.g., 12-month rolling average, 365-day rolling average, annual average);

(ii) identification of all proposed deviations from IEEE 1366 used in the calculation of reliability indices and determination of major event days; and

(iii) a description of all data estimation methods used for the collection and calculation of SAIDI, SAIFI, CAIDI, and MAIF_I.

R746-313-5. Electric Service Interruption Records.

(1) Except as provided in subsection (4) of this Section:

(a) An electric company using predominantly non-automated methods for identifying outages and tracking reliability shall keep an accurate record of each sustained interruption of service that affects one or more customers.

(b) An electric company using an electronic outage management system for identifying electric service interruptions and/or tracking outages shall keep an accurate record of each interruption of service that affects one or more customers.

(2) Each record shall contain at least the following information:

(a) the operating area where the interruption occurred;
(b) the reference identification of the substation involved;
(c) the reference identification of the circuit involved;
(d) the date and time the interruption started or was reported. If the exact time is unknown, the beginning of an interruption is recorded as the earlier of an automatic alarm or the reported initiation time;

(e) the date and time service was restored;

(f) the duration of the interruption;

(g) the number of metering points affected by the interruption;

(h) the cause of the interruption;

(i) whether the interruption was planned or unplanned;

(j) the interrupting device that made the interruption, if known; and

(k) the component involved (e.g., transmission line, substation, overhead primary main, underground primary main, transformer, etc.).

(3) For interruptions where customers are not simultaneously restored, an electric company shall keep records that document the step-restoration operations.

(4) For major events where an electric company is unable to obtain accurate data, the electric company shall make reasonable estimates and explain these estimates in any report filed with its governing authority.

(5) An electric company shall retain the records associated with this rule in accordance with R746-310-10 Preservation of Records.

R746-313-6. Inquiries about Electric Service Reliability.

(1) A customer may request a report from its electric company about the reliability of the electric service provided to the customer's own meter which the electric company must provide at no cost within 20 business days of the request. If a customer requests one or more additional reliability reports for the same meter within one year of the date of the first request, the electric company may charge the customer the cost of preparing the report(s).

(2) For an electric company whose governing authority is the commission, the report to the customer must include:

(a) The name of the customer;

(b) The date of the request;

(c) The address where the meter is installed;

(d) The meter identification number;

(e) The general identification of the equipment serving the customer; and

(f) A chronological listing of interruptions to the customer including all associated interruption data required by R746-313-5(2) covering at least the 36 months preceding the date of the request, if available. If 36 months of data are not available, the chronological listing must include all available data.

(3) For an electric company whose governing authority is not the commission, the report to the customer must include:

(a) The name of the customer;

(b) The date of the request;

(c) The address where the meter is installed;

(d) The meter identification number;

(e) The general identification of the equipment serving the customer; and

(f) A chronological listing of interruptions on the feeder serving the customer's meter including all interruption data required by R746-313-5(2) covering at least the 12 months preceding the date of the request. If 12 months of data are not available, the chronological listing must include all available data.

(4) Other than those inquiries specified in R746-313-6(1), each electric company must have a written policy for consistent treatment of all other inquiries pertaining to electric reliability. At a minimum, the electric company must provide to the inquiring party, by electronic means, the electric company's most-recently filed report on electric service reliability required by R746-313-7.

R746-313-7. Reporting on Electric Service Reliability.

(1) An electric company must report deviations from the reliability performance baselines established in accordance with R746-313-4 within 60 days after the end of the month when the deviation(s) occurred.

(2) Beginning May 1, 2013, and by May 1 of each succeeding year, an electric company shall file with the commission a

report on electric service reliability for the previous calendar year. The electric company must make electronic copies of the report available to the public upon request and may charge a reasonable cost for requested paper copies.

(3) For an electric company whose governing authority is the commission, the report on electric service reliability must contain at a minimum:

(a) the calculated SAIDI, SAIFI, CAIDI, and MAIFLe reliability indices for the reporting period. At a minimum, the electric company must report this information on a system-wide basis compared with the previous four years' performance and, for SAIDI, SAIFI, and CAIDI on an operating area compared with the previous four years' performance;

(b) an analysis of the system-wide and reliability reporting area sustained interruption causes compared to the previous four-year performance. Outages may be categorized using the following cause categories:

- (i) Loss of Supply - Generation/Transmission;
- (ii) Loss of Supply - Distribution Substation;
- (iii) Distribution - Environment (e.g., unpreventable contamination, corrosion, airborne deposits, flooding, fire/smoke not related to faults or lightning);
- (iv) Distribution - Equipment Failure;
- (v) Distribution - Lightning;
- (vi) Distribution - Operational;
- (vii) Distribution - Planned Outages;
- (viii) Distribution - Public;
- (ix) Distribution - Vegetation;
- (x) Distribution - Weather (other than lightning);
- (xi) Distribution - Wildlife;
- (xii) Distribution - Unknown; and
- (xiii) Distribution - Other.

(c) a listing of the major events experienced during the reporting period and a listing of significant events as defined by the electric company, their cause, and their effect on reliability performance during the reporting period;

(d) comparisons of budgeted and actual maintenance spending, maintenance activities, capital spending, vegetation management spending and vegetation management activities;

(e) identification of areas whose reliability performance warrants additional improvement efforts.

(f) a listing of the T_{MED} values that will be used for each reliability reporting area for the forthcoming annual reporting period.

(g) a summary of the changes the electric company has made or will make pertaining to the collection, calculation, estimation, and reporting of electric service reliability information and changes in reliability reporting areas and/or operating areas; and

(h) a map showing the reliability reporting areas and/or operating areas.

(4) For an electric company whose governing authority is not the commission, the report on electric service reliability must contain, at a minimum:

(a) The reliability indices listed in Form 7 - Information on Service Interruptions based upon the cause codes listed in RUS1730A-119 ; and

(b) A summary of any estimation methods and/or an explanation of any factors used in calculating reliability indices presented in the electric company's report on electric service reliability.

R746-313-8. Major Event Reporting by Electric Utilities.

(1) Major event reporting for an electric company whose governing authority is the commission. Within 30 business days after the conclusion of each event which an electric company determines satisfies the criteria for major event classification in accordance with IEEE 1366, the electric company shall file a major event report with the commission for its consideration. The major event report must include, at a minimum:

(a) a description of the major event, the interruption causes, and a summary of restoration efforts and factors that affected restoration of service;

(b) identification of reliability reporting area and geographic area affected;

(c) the total number of customers affected, and the number of customers without service at periodic intervals;

(d) the calculated SAIDI, SAIFI, [~~MAIFI~~]and CAIDI impacts (i.e., Event SAIDI, SAIFI, [~~MAIFI~~]and CAIDI) associated with the major event to customers for each reliability reporting area and system-wide; and

(e) restoration of service information including resources used and cost.

(2) Major event reporting for electric company whose governing authority is not the commission. Within a timely period after each event which an electric company determines satisfies the criteria for major event classification in accordance with IEEE 1366 or RUS 1730A-119, as applicable, the electric company shall provide a major event analysis to its governing authority.

KEY: reliability, IEEE 1366, SAIDI/SAIFI, major event

Date of Enactment or Last Substantive Amendment: [September 24, 2012]2013

Authorizing, and Implemented or Interpreted Law: 54-3-1; 54-4-2; 54-4-7

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.

While the law does not designate a comment period for a **CHANGE IN PROPOSED RULE**, it does provide for a 30-day waiting period. An agency may accept additional comments during this period, and, at its option, may designate a comment period or may hold a public hearing. The 30-day waiting period for **CHANGES IN PROPOSED RULES** published in this issue of the *Utah State Bulletin* ends February 14, 2013.

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 between paragraphs (.) indicates that unaffected text, either whole sections or subsections, 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.

From the end of the 30-day waiting period through May 15, 2013, an 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 the **CHANGE IN PROPOSED RULE**. If the agency designates a public comment period, the effective date may be no fewer than seven calendar days after the close of the public comment period nor more than 120 days after the publication date. 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** by the end of the 120-day period after publication, 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 Section 63G-3-303; 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

Environmental Quality, Administration
R305-9
Recusal of a Board Member for Conflict of Interest

NOTICE OF CHANGE IN PROPOSED RULE

DAR FILE NO.: 36776
 FILED: 12/18/2012

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The change addresses an error in the proposed rule; board members must bring matters that may pose a conflict to the board for its consideration, not just matters that have been determined to be conflicts.

SUMMARY OF THE RULE OR CHANGE: Board members are required under the change to bring to the board any matter that may be prohibited under the Utah Public Officers' and Employees' Ethics Act. As proposed, the rule required board members to bring only matters that were prohibited under the act. (DAR NOTE: This change in proposed rule has been filed to make additional changes to a proposed new rule that was published in the October 1, 2012, issue of the Utah State Bulletin, on page 28. 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 change in proposed rule and the proposed new rule together to understand all of the changes that will be enforceable should the agency make this rule effective.)

STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Subsection 19-1-201(1)(d)(i)(B)

ANTICIPATED COST OR SAVINGS TO:

- ◆ **THE STATE BUDGET:** There will be no impact on the state's budget; the only impact will be on the ability of individual board members to participate in the board's decision-making process.
- ◆ **LOCAL GOVERNMENTS:** There will be no impact on local government budgets; the only impact will be on the ability of individual board members to participate in the board's decision-making process.
- ◆ **SMALL BUSINESSES:** There will be no fiscal impact on small businesses; the only impact will be on the ability of individual board members to participate in the board's decision-making process.
- ◆ **PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES:** There will be no fiscal impact on other persons; the only impact will be on the ability of individual board members to participate in the board's decision-making process.

COMPLIANCE COSTS FOR AFFECTED PERSONS: The only persons impacted will be individual board members. There will be no compliance costs associated with determinations about their ability to participate in the board's decision-making process.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: There will be no fiscal impact on businesses; the only impact will be on the ability of individual board members to participate in the board's decision-making process.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
 ENVIRONMENTAL QUALITY
 ADMINISTRATION
 195 N 1950 W
 SALT LAKE CITY, UT 84116-3085
 or at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:

◆ Debbie Oberndorfer by phone at 801-536-4402, by FAX at 801-536-0061, or by Internet E-mail at doberndorfer@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN AT 5:00 PM ON

THIS RULE MAY BECOME EFFECTIVE ON: 02/15/2013

AUTHORIZED BY: Amanda Smith, Executive Director

R305. Environmental Quality, Administration.

R305-9. Recusal of a Board Member for Conflict of Interest.

R305-9-101. Purpose and Authority.

The purpose of this rule is to establish standards and procedures for addressing potential conflicts of interest. This rule is authorized by Section 19-1-201(1)(d)(i)(B).

R305-9-102. Disclosure of Interest Statements.

Each board member shall provide disclosure of interest statements on forms provided by the Department.

R305-9-103. Recusal.

(1) A board member shall be recused from voting during any board proceeding involving a matter in which the member has a conflict of interest.

(2) A board member may also be recused from participating in the board's discussion of a matter in which the member has a conflict of interest.

R305-9-104. Potential Conflicts of Interest.

A board member has a potential conflict of interest with respect to a matter to be considered by the board if:

(1) the board member's participation ~~[is]~~may be prohibited under Title 67, Chapter 16, the Utah Public Officers' and Employees' Ethics Act; or

(2) the board member's participation may constitute a violation of constitutional due process under the Utah or United States constitutions.

R305-9-105. Procedures.

A board member who has a potential conflict of interest with respect to a matter before the board, as described in R305-9-104, may:

(1) recuse himself or herself from participation in the board's discussion of the matter and from voting with the board on the matter; or

(2) disclose the potential conflict of interest and seek a determination by the board about how to proceed in the matter.

R305-9-106. Decision of the Board.

(1) In making a decision under this rule R305-9, the board shall consider:

- (a) the nature of the matter before the board;
- (b) the nature of the potential conflict; and
- (c) the Legislative intent that the board reflect balanced viewpoints.

(2) The board shall determine:

(a) whether the circumstances constitute a conflict of interest such that the board member shall be recused from voting with the board on the matter; and

(b) if the board member has a conflict of interest, whether the board member shall also be recused from participation in the board's discussion of the matter.

KEY: conflict of interest, board member recusal, recusal

Date of Enactment or Last Substantive Amendments:
~~[2012]~~2013

Authorizing, and Implemented or Interpreted Law: 19-1-201(1)
(d)(i)(B)

End of the Notices of Changes in Proposed Rules Section

**NOTICES OF
120-DAY (EMERGENCY) RULES**

An agency may file a **120-DAY (EMERGENCY) RULE** when it finds that the regular rulemaking procedures would:

- (a) cause an imminent peril to the public health, safety, or welfare;
- (b) cause an imminent budget reduction because of budget restraints or federal requirements; or
- (c) place the agency in violation of federal or state law (Subsection 63G-3-304(1)).

As with a **PROPOSED RULE**, a **120-DAY RULE** is preceded by a **RULE ANALYSIS**. This analysis provides summary information about the **120-DAY RULE** including the name of a contact person, justification for filing a **120-DAY RULE**, anticipated cost impact of the rule, and legal cross-references. A row of dots in the text (.) indicates that unaffected text was removed to conserve space.

A **120-DAY RULE** is effective at the moment the Division of Administrative Rules receives the filing, or on a later date designated by the agency. A **120-DAY RULE** is effective for 120 days or until it is superseded by a permanent rule.

Because **120-DAY RULES** are effective immediately, the law does not require a public comment period. However, when an agency files a **120-DAY RULE**, it usually files a **PROPOSED RULE** at the same time, to make the requirements permanent. Comments may be made on the **PROPOSED RULE**. Emergency or **120-DAY RULES** are governed by Section 63G-3-304; and Section R15-4-8.

**Alcoholic Beverage Control,
Administration
R81-1-31
Duties of Commission Subcommittees**

NOTICE OF 120-DAY (EMERGENCY) RULE

DAR FILE NO.: 37114
FILED: 12/18/2012

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The purpose of this rule is to implement S.B. 66 passed by the Legislature in the 2012 General Session. S.B. 66 created commission subcommittees with duties to be defined by Subsection 32B-2-201.5(4). Emergency rulemaking is necessary to comply with statutory requirement of having rules in place within six months of enactment.

SUMMARY OF THE RULE OR CHANGE: The proposed Section R81-1-31 defines the duties of the two commission subcommittees -- the Compliance, Licensing and Enforcement Subcommittee, and the Operations and Procurement Subcommittee.

STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 32B-1-607 and Section 32B-2-201.5

EMERGENCY RULE REASON AND JUSTIFICATION:
REGULAR RULEMAKING PROCEDURES WOULD place the agency in violation of federal or state law.
JUSTIFICATION: Emergency rulemaking is necessary for the

agency to comply with state statute that administrative rules be in place within six months of enactment.

ANTICIPATED COST OR SAVINGS TO:

- ◆ **THE STATE BUDGET:** None--This rule filing simply makes the Department of Alcoholic Beverage Control (DABC) rules consistent with the new statute.
- ◆ **LOCAL GOVERNMENTS:** None--This rule filing simply makes the DABC rules consistent with the new statute.
- ◆ **SMALL BUSINESSES:** None--This rule filing simply makes the DABC rules consistent with the new statute.
- ◆ **PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES:** None--Any cost or savings result directly from S.B 66 (2012), not from this rule filing simply makes the DABC rules consistent with the new statute.

COMPLIANCE COSTS FOR AFFECTED PERSONS: None--Any cost or savings result directly from S.B 66 (2012), not from this rule filing simply makes the DABC rules consistent with the new statute.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: None--This rule filing simply makes the DABC rules consistent with the new statute.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
ALCOHOLIC BEVERAGE CONTROL
ADMINISTRATION
1625 S 900 W
SALT LAKE CITY, UT 84104-1630
or at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:

◆ Nina McDermott by phone at 801-977-6805, by FAX at 801-977-6888, or by Internet E-mail at nmcdermott@utah.gov

EFFECTIVE: 12/18/2012

AUTHORIZED BY: Sal Petilos, Executive Director

R81. Alcoholic Beverage Control, Administration.**R81-1. Scope, Definitions, and General Provisions.****R81-1-31. Duties of Commission Subcommittees.**

(1) This rule is promulgated pursuant to Section 32B-2-201.5 and shall govern the duties of the two commission subcommittees, Compliance Licensing and Enforcement Subcommittee and the Operations and Procurement Subcommittee.

(2) Duties reserved for the full commission: All major decisions, included but not limited to - Granting of licenses and special use permits, establishing state stores and adoption of formal rule making and policy.

(3) The Compliance Licensing and Enforcement Subcommittee will review and discuss items related to compliance, licensing and enforcement and make recommendations to the full commission on those items.

(4) The full commission may defer decision making to the subcommittee on all items related to licensing, compliance and enforcement not reserved to the full commission.

(5) The Operations and Procurement Subcommittee will review and discuss items related to operations and procurement and make recommendations to the full commission on those items.

(6) The full commission may defer decision making to the subcommittee on all items related to Operations and Procurement not reserved to the commission in section.

(7) A subcommittee quorum is the majority of standing members. Decision by subcommittee requires at least a majority vote of the quorum.

KEY: alcoholic beverages, commission subcommittees

Date of Enactment or Last Substantive Amendment: December 18, 2012

Notice of Continuation: May 10, 2011

Authorizing, and Implemented or Interpreted Law: 32B-2-201(10); 32B-2-202; 32B-3-203(3)(c); 32B-1-305; 32B-1-306; 32B-1-307; 32B-1-607; 32B-1-304(1)(a); 32B-6-702; 32B-6-805(3); 32B-9-204(4); 32B-4-414(1)(b) and (c)

Alcoholic Beverage Control,
Administration
R81-2-12
Store Site Selection

NOTICE OF 120-DAY (EMERGENCY) RULE
DAR FILE NO.: 37115
FILED: 12/18/2012

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: This new section establishes criteria and procedures for determining the location of a state store.

SUMMARY OF THE RULE OR CHANGE: It is necessary for the commission to write emergency rules to comply with Subsection 32B-2-202(i)(c)(ii), which requires a rule for state store selection.

STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 32B-1-607 and Subsection 32B-2-202(1)(c)(ii)

EMERGENCY RULE REASON AND JUSTIFICATION:

REGULAR RULEMAKING PROCEDURES WOULD place the agency in violation of federal or state law.

JUSTIFICATION: An emergency rule is necessary for the agency to comply with state statute that administrative rules be in place within six months of enactment. Here it has been six months since enactment and no rule has been put in place regarding store site selection as required by Subsection 32B-2-202(1)(c)(ii).

ANTICIPATED COST OR SAVINGS TO:

◆ **THE STATE BUDGET:** None--This rule simply makes the Department of Alcoholic Beverage Control (DABC) rules consistent with statute.

◆ **LOCAL GOVERNMENTS:** None--This rule simply makes the DABC rules consistent with statute.

◆ **SMALL BUSINESSES:** None--This rule simply makes the DABC rules consistent with statute.

◆ **PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES:** None--This rule simply makes the DABC rules consistent with statute.

COMPLIANCE COSTS FOR AFFECTED PERSONS: None--This rule simply makes the DABC rules consistent with statute.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: None--This rule simply makes the DABC rules consistent with statute.

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

ALCOHOLIC BEVERAGE CONTROL
ADMINISTRATION
1625 S 900 W
SALT LAKE CITY, UT 84104-1630
or at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:

◆ Nina McDermott by phone at 801-977-6805, by FAX at 801-977-6888, or by Internet E-mail at nmcdermott@utah.gov

EFFECTIVE: 12/18/2012

AUTHORIZED BY: Sal Petilos, Executive Director

R81. Alcoholic Beverage Control, Administration.

R81-2. State Stores.

R81-2-12. Store Site Selection.

This rule is promulgated pursuant to Subsection 32B-2-202(1)(c)(ii) which requires that criteria and procedures be established for determining the location of a state store: Prior to the commission establishing a new state store, the Operations and Procurement Subcommittee will determine the feasibility of a new site, weigh options and consider the investigation and recommendation of the department as outlined in Section 32B-2-502 then make its recommendation to the commission.

KEY: alcoholic beverages, store site selection

Date of Enactment or Last Substantive Amendment: December 18, 2012

Notice of Continuation: May 10, 2011

Authorizing, and Implemented or Interpreted Law: 32B-2-202

**Health, Health Care Financing,
Coverage and Reimbursement Policy
R414-303
Coverage Groups**

NOTICE OF 120-DAY (EMERGENCY) RULE

DAR FILE NO.: 37120
FILED: 12/28/2012

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The purpose of this change is to end coverage for the Qualifying Individuals (QI) program and for the 12-month Transitional Medicaid program.

SUMMARY OF THE RULE OR CHANGE: This change removes coverage for the QI program and for the 12-month Transitional Medicaid program, both of which are due to sunset under federal statute after 12/31/2012. (DAR NOTE: With the passage of Sections 621 and 622 of H.R. 8, American Taxpayer Relief Act of 2012, signed on 01/02/2013, another emergency rule was filed under DAR No. 37173 that restores these programs as of 01/07/2013, and supersedes this emergency rule. The emergency rule under DAR No. 37173 will be published in the February 1, 2013, issue of the Bulletin.)

STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 26-1-5 and Section 26-18-3

EMERGENCY RULE REASON AND JUSTIFICATION:

REGULAR RULEMAKING PROCEDURES WOULD cause an imminent budget reduction because of budget restraints or federal requirements; and place the agency in violation of federal or state law.

JUSTIFICATION: Federal authority to provide medical assistance under both of these coverage groups ends after 12/31/2012. There will be no federal funds to provide medical assistance to anyone under these two coverage groups. The Qualifying Individuals program is 100% federal match dollars, while the 12-month Transitional Medicaid program is at the regular federal match rate of about 70% federal funds, and 30% state funds. (See DAR NOTE under the summary above.)

MATERIALS INCORPORATED BY REFERENCES:

- ◆ Updates Section 1931(c)(1) and Section 1931(c)(2) of Title XIX of the Social Security Act, published by Social Security Administration, 11/19/2012
- ◆ Updates 42 CFR 435.112 and 435.115(f), (g) and (h), published by Government Printing Office, 10/01/2011
- ◆ Updates Sections 1634(b), (c) and (d), 1902(a)(10)(A)(i)(II), 1902(a)(10)(A)(ii)(X), 1902(a)(10)(E)(i) through (iii) of Title XIX of the Social Security Act, published by Social Security Administration, 11/19/2012

ANTICIPATED COST OR SAVINGS TO:

- ◆ **THE STATE BUDGET:** The state cost for the number of enrolled persons in these two programs would be about \$1,286,013 per month if the Department were to continue coverage after the federal sunset date.
- ◆ **LOCAL GOVERNMENTS:** This change does not create costs for local governments because they do not provide Medicaid services.
- ◆ **SMALL BUSINESSES:** This change could create a cost for some medical providers who could lose some revenue because they would not be able to provide services to individuals who previously had Medicaid coverage.
- ◆ **PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES:** This change creates a cost of about \$1,286,013 for individuals who will lose their medical benefits as a result of this change.

COMPLIANCE COSTS FOR AFFECTED PERSONS: An individual who loses eligibility for the Qualifying Individuals program will incur a cost of \$104.90 a month to pay the Medicare Part B premium. An individual losing eligibility for the 12-month Transitional Medicaid program could incur medical costs of any amount because the individual will not have Medicaid coverage. Some individuals losing coverage under the 12-month Transitional Medicaid program may qualify for a different Medicaid program, such as Child Medicaid or the Children's Health Insurance Program, and still have medical assistance.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: Lack of federal funding as of 01/01/2013 necessitates termination of this Medicaid eligibility group. Fiscal impact on businesses that serve Medicaid clients that qualify through this program is unavoidable.

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 by phone at 801-538-6641, by FAX at 801-538-6099, or by Internet E-mail at cdevashrayee@utah.gov

EFFECTIVE: 01/01/2013

AUTHORIZED BY: David Patton, PhD, Executive Director

R414. Health, Health Care Financing, Coverage and Reimbursement Policy.

R414-303. Coverage Groups.

R414-303-3. Medicaid for Individuals Who Are Aged, Blind or Disabled for Community and Institutional Coverage Groups.

(1) The Department provides Medicaid coverage to individuals as described in 42 CFR 435.120, 435.122, 435.130 through 435.135, 435.137, 435.138, 435.139, 435.211, 435.232, 435.236, 435.301, 435.320, 435.322, 435.324, 435.340, and 435.350, 2011 ed., which are incorporated by reference. The Department provides coverage to individuals as required by 1634(b), (c) and (d), 1902(a)(10)(A)(i)(II), 1902(a)(10)(A)(ii)(X), and 1902(a)(10)(E)(i) through (i)(iii) of Title XIX of the Social Security Act in effect [April 2]November 19, 2012, which are incorporated by reference. The Department provides coverage to individuals described in Section 1902(a)(10)(A)(ii)(XIII) of Title XIX of the Social Security Act in effect April 2, 2012, which is incorporated by reference. Coverage under Section 1902(a)(10)(A)(ii)(XIII) is known as the Medicaid Work Incentive Program.

(2) Proof of disability includes a certification of disability from the State Medicaid Disability Office, Supplemental Security Income (SSI) status, or proof that a disabled client is recognized as disabled by the Social Security Administration (SSA).

(3) An individual can request a disability determination from the State Medicaid Disability Office. The Department adopts the disability determination requirements described in 42 CFR 435.541, 2011 ed., and Social Security's disability requirements for the Supplemental Security Income program as described in 20 CFR 416.901 through 416.998, 2011 ed., which are incorporated by reference, to decide if an individual is disabled. The Department notifies the eligibility agency of its disability decision, who then sends a disability decision notice to the client.

(a) If an individual has earned income, the State Medicaid Disability Office shall review medical information to determine if the client is disabled without regard to whether the earned income exceeds the Substantial Gainful Activity level defined by the Social Security Administration.

(b) If, within the prior 12 months, SSA has determined that the individual is not disabled, the eligibility agency must follow SSA's decision. If the individual is appealing SSA's denial of disability, the State Medicaid Disability Office must follow SSA's decision throughout the appeal process, including the final SSA decision.

(c) If, within the prior 12 months, SSA has determined an individual is not disabled but the individual claims to have become disabled since the SSA decision, the State Medicaid Disability Office shall review current medical information to determine if the client is disabled.

(d) Clients must provide the required medical evidence and cooperate in obtaining any necessary evaluations to establish disability.

(e) Recipients must cooperate in completing continuing disability reviews as required by the State Medicaid Disability Office unless they have a current approval of disability from SSA. Medicaid eligibility as a disabled individual will end if the individual fails to cooperate in a continuing disability review.

(4) If an individual denied disability status by the Medicaid Disability Review Office requests a fair hearing, the Disability Review Office may reconsider its determination as part of fair hearing process. The individual must request the hearing within the time limit defined in Section R414-301-6.

(a) The individual may provide the eligibility agency additional medical evidence for the reconsideration.

(b) The reconsideration may take place before the date the fair hearing is scheduled to take place.

(c) The eligibility agency notifies the individual of the reconsideration decision. Thereafter, the individual may choose to pursue or abandon the fair hearing.

(5) If the eligibility agency denies an individual's Medicaid application because the Medicaid Disability Review Office or SSA has determined that the individual is not disabled and that determination is later reversed on appeal, the eligibility agency determines the individual's eligibility back to the application that gave rise to the appeal. The individual must meet all other eligibility criteria for such past months.

(a) Eligibility cannot begin any earlier than the month of disability onset or three months before the month of application subject to the requirements defined in Section R414-306-4, whichever is later.

(b) If the individual is not receiving medical assistance at the time a successful appeal decision is made, the individual must contact the eligibility agency to request the Disability Medicaid coverage.

(c) The individual must provide any verifications the eligibility agency needs to determine eligibility for past and current months for which the individual is requesting medical assistance.

(d) If an individual is determined eligible for past or current months, but must pay a spenddown or Medicaid Work Incentive (MWI) premium for one or more months to receive coverage, the spenddown or MWI premium must be met before Medicaid coverage may be provided for those months.

(e) The age requirement for Aged Medicaid is 65 years of age.

(7) For children described in Section 1902(a)(10)(A)(i)(II) of the Social Security Act in effect April 4, 2012, the [Department]agency shall conduct periodic redeterminations to assure that the child continues to meet the SSI eligibility criteria as required by such section.

~~[(8) Coverage for qualifying individuals described in Section 1902(a)(10)(E)(iv) of Title XIX of the Social Security Act in effect April 4, 2012, is limited to the amount of funds allocated under Section 1933 of Title XIX of the Social Security Act in effect April 4, 2012, for a given year, or as subsequently authorized by Congress. The eligibility agency will deny coverage to applicants when the uncommitted allocated funds are insufficient to provide such coverage.]~~

(9) To determine eligibility under Section 1902(a)(10)(A)(ii)(XIII), if the countable income of the individual and the individual's family does not exceed 250% of the federal poverty guideline for the applicable family size, the [Department]agency shall disregard an amount of earned and unearned income of the individual, the individual's spouse, and a minor individual's parents that equals the difference between the total income and the Supplemental Security Income maximum benefit rate payable.

(10) The [Department]agency shall require individuals eligible under Section 1902(a)(10)(A)(ii)(XIII) to apply for cost-effective health insurance that is available to them.

R414-303-5. [12-Month Transitional Family Medicaid.]Reserved.
~~[The Department covers households that lose eligibility for 1931 Family Medicaid, in accordance with the provisions of Title XIX of the Social Security Act, Sections 1925 and 1931 (e)(2).]~~

R414-303-6. Four Month Transitional Family Medicaid.
 (1) The Department adopts 42 CFR 435.112 and 435.115(f), (g) and (h), [2001]2011 ed., and Title XIX of the Social Security Act, Section 1931(c)(1) and Section 1931(c)(2) in effect [January 1, 2001]November 19, 2012 which are incorporated by reference.

(2) Changes in household composition do not affect eligibility for the four month extension period. New household members may be added to the case only if they meet the AFDC or AFDC two-parent criteria for being included in the household if they were applying in the current month. Newborn babies are considered household members even if they were unborn the month the household became ineligible for Family Medicaid under Section 1931 of the Social Security Act. New members added to the case will lose eligibility when the household loses eligibility. Assistance shall be terminated for household members who leave the household.

KEY: income, coverage groups, independent foster care adolescent
Date of Enactment or Last Substantive Amendment: January 1, 2013
Notice of Continuation: January 25, 2008
Authorizing, and Implemented or Interpreted Law: 26-18-3; 26-1-5

Health, Health Care Financing, Coverage and Reimbursement Policy **R414-306** Program Benefits and Date of Eligibility

NOTICE OF 120-DAY (EMERGENCY) RULE
 DAR FILE NO.: 37121
 FILED: 12/28/2012

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The purpose of this emergency rule is to make technical changes to the rule to end medical assistance coverage for the Qualifying Individuals program.

SUMMARY OF THE RULE OR CHANGE: This change removes language about the benefits and coverage period for individuals eligible for the Qualifying Individuals program, which is due to sunset under federal statute after 12/31/2012. (DAR NOTE: With the passage of Section 621 of H.R. 8, American Taxpayer Relief Act of 2012, signed on 01/02/2013, another emergency rule was filed under DAR No. 37174 that restores this program as of 01/07/2013, and supersedes this emergency rule. The emergency rule under DAR No. 37174 will be published in the February 1, 2013, issue of the Bulletin.)

STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 26-1-5 and Section 26-18-3

EMERGENCY RULE REASON AND JUSTIFICATION:
REGULAR RULEMAKING PROCEDURES WOULD cause an imminent budget reduction because of budget restraints or federal requirements; and place the agency in violation of federal or state law.

JUSTIFICATION: Federal authority to provide medical assistance for Qualifying Individuals ends after 12/31/2012. There will be no federal funds to provide medical assistance to anyone under this coverage group. The Qualifying Individuals program is 100% federal match dollars. (See DAR NOTE under the summary above.)

ANTICIPATED COST OR SAVINGS TO:
 ♦ **THE STATE BUDGET:** The state cost for the number of enrolled persons in the Qualifying Individuals group is about \$201,513 per month if the Department were to continue coverage after the federal sunset date. This cost, however, is considered in the companion filing for Rule R414-303, which actually removes coverage for this group.
 ♦ **LOCAL GOVERNMENTS:** This change does not create costs for local governments because they do not determine Medicaid eligibility.

♦ **SMALL BUSINESSES:** This change will not cost small businesses anything because the Qualifying Individuals program only pays the Medicare Part B premium. It does not provide any other benefits.

♦ **PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES:** This change creates a cost of about \$201,513 for individuals who will lose medical benefits as a result of this change.

COMPLIANCE COSTS FOR AFFECTED PERSONS: An individual who loses eligibility for the Qualifying Individuals program will incur a cost of \$104.90 a month to pay the Medicare Part B premium.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: Lack of federal funding as of 01/01/2013 necessitates termination of this Medicaid eligibility group. Fiscal impact on businesses that serve Medicaid clients that qualify through this program is unavoidable.

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 by phone at 801-538-6641, by FAX at 801-538-6099, or by Internet E-mail at cdevashrayee@utah.gov

EFFECTIVE: 01/01/2013

AUTHORIZED BY: David Patton, PhD, Executive Director

R414. Health, Health Care Financing, Coverage and Reimbursement Policy.

R414-306. Program Benefits and Date of Eligibility.

R414-306-2. QMB[;] and SLMB[; and QI] Benefits.

(1) The Department must provide the services outlined under 42 U.S.C. 1396d(p) and 42 U.S.C. 1396u-3 for Qualified Medicare Beneficiaries.

(2) The Department provides the benefits outlined under 42 U.S.C. 1396d(p)(3)(ii) for Specified Low-Income Medicare Beneficiaries[~~and Qualifying Individuals. Benefits for Qualifying Individuals are subject to the provisions of 42 U.S.C. 1396u-3.~~]

(3) The Department does not cover premiums for enrollment with any health insurance plans except for Medicare.

R414-306-4. Effective Date of Eligibility.

(1) Subject to the exceptions in Subsection R414-306-4(3), eligibility for any Medicaid program, and for the Specified Low-income Medicare Beneficiary (SLMB)[~~or Qualified Individual (QI)]~~

programs begins the first day of the application month if the individual is determined to meet the eligibility criteria for that month.

(2) An applicant for Medicaid[;] or SLMB [~~or QI~~] benefits may request medical coverage for the retroactive period. The retroactive period is the three months immediately preceding the month of application.

(a) An applicant may request coverage for one or more months of the retroactive period.

(b) Subject to the exceptions in Subsection R414-306-4(3), eligibility for retroactive medical coverage begins no earlier than the first day of the month that is three months before the application month.

(c) The applicant must receive medical services during the retroactive period and be determined eligible for the month he receives services.

(3) To determine the date eligibility for medical assistance may begin for any month, the following requirements apply:

(a) Eligibility of an individual cannot begin any earlier than the date the individual meets the state residency requirement defined in Section R414-302-2;

(b) Eligibility of a qualified alien subject to the five-year bar on receiving regular Medicaid services cannot begin earlier than the date that is five years after the date the person became a qualified alien, or the date the five-year bar ends due to other events defined in statute;

(c) Eligibility of a qualified alien not subject to the five-year bar on receiving regular Medicaid services can begin no earlier than the date the individual meets qualified alien status.

(d) An individual who is ineligible for Medicaid while residing in a public institution or an Institution for Mental Disease (IMD) may become eligible on the date the individual is no longer a resident of either one of these institutions. If an individual is under the age of 22 and is a resident of an IMD, the individual remains a resident of the IMD until he is unconditionally released.

(4) If an applicant is not eligible for the application month, but requests retroactive coverage, the agency will determine eligibility for the retroactive period based on the date of that application.

(5) The agency may use the same application to determine eligibility for the month following the month of application if the applicant is determined ineligible for both the retroactive period and the application month. In this case, the application date changes to the date eligibility begins. The retroactive period associated with the application changes to the three months preceding the new application date.

(6) Medicaid eligibility for certain services begins when the individual meets the following criteria:

(a) Eligibility for coverage of institutional services cannot begin before the date that the individual has been admitted to a medical institution and meets the level of care criteria for admission. The medical institution must provide the required admission verification to the Department within the time limits set by the Department in Rule R414-501. Medicaid eligibility for institutional services does not begin earlier than the first day of the month that is three months before the month of application for Medicaid coverage of institutional services.

(b) Eligibility for coverage of home and community-based services under a Medicaid waiver cannot begin before the first day of the month the client is determined by the case management agency to meet the level of care criteria and home and community-based services are scheduled to begin within the month. The case management

agency must verify that the individual meets the level of care criteria for waiver services. Medicaid eligibility for waiver services does not begin earlier than the first day of the month that is three months before the month of application for Medicaid coverage of waiver services.

~~[(7) An individual determined eligible for QI benefits in a calendar year is eligible to receive those benefits throughout the remainder of the calendar year, if the individual continues to meet the eligibility criteria and the program still exists. Receipt of QI benefits in one calendar year does not entitle the individual to QI benefits in any succeeding year.]~~

[(8)Z] After being approved for Medicaid, a client may later request coverage for the retroactive period associated with the approved application if the following criteria are met:

(a) The client did not request retroactive coverage at the time of application; and

(b) The agency did not make a decision about eligibility for medical assistance for that retroactive period; and

(c) The client states that he received medical services and provides verification of his eligibility for the retroactive period.

[(9)8] A client cannot request coverage for the retroactive period associated with a denied application. The client, however, may reapply and a new retroactive coverage period is considered based on the new application date.

KEY: effective date, program benefits, medical transportation
Date of Enactment or Last Substantive Amendment: January 1, 2013

Notice of Continuation: January 25, 2008

Authorizing, and Implemented or Interpreted Law: 26-18

End of the Notices of 120-Day (Emergency) 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 agency is required to review the rule. This review is intended 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 upon filing.

NOTICES are governed by Section 63G-3-305.

Education, Administration **R277-484** Data Standards

FIVE-YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION

DAR FILE NO.: 37142
FILED: 12/31/2012

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-1-401(3) permits the Utah State Board of Education to adopt rules in accordance with its responsibilities.

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 comment has been received.

REASONED JUSTIFICATION FOR THE CONTINUATION OF THE RULE, INCLUDING REASONS WHY THE AGENCY DISAGREES WITH COMMENTS IN OPPOSITION TO THE RULE, IF ANY: This rule is continued because it provides procedures necessary for certain data collection essential to the operation of statewide educational accountability and financial systems.

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 by phone at 801-538-7835, by FAX at 801-538-7768, or by Internet E-mail at carol.lear@schools.utah.gov

AUTHORIZED BY: Carol Lear, Director, School Law and Legislation

EFFECTIVE: 12/31/2012

Education, Administration **R277-487** Public School Student Confidentiality

FIVE-YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION

DAR FILE NO.: 37143
FILED: 12/31/2012

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-13-301(3) requires the Utah State Board of Education (Board) to make rules to establish standards for public education employees, student aides, and volunteers in public schools regarding the confidentiality of student information and student records, and Subsection 53A-1-401(3) allows the Board to make rules in accordance with its responsibilities.

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 comment has been received.

REASONED JUSTIFICATION FOR THE CONTINUATION OF THE RULE, INCLUDING REASONS WHY THE AGENCY DISAGREES WITH COMMENTS IN OPPOSITION TO THE RULE, IF ANY: This rule is continued because it provides necessary standards and procedures related to public school student information and confidentiality.

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 by phone at 801-538-7835, by FAX at 801-538-7768, or by Internet E-mail at carol.lear@schools.utah.gov

AUTHORIZED BY: Carol Lear, Director, School Law and Legislation

EFFECTIVE: 12/31/2012

**Public Service Commission,
Administration
R746-346
Operator-Assisted Services**

**FIVE-YEAR NOTICE OF REVIEW AND STATEMENT
OF CONTINUATION**
DAR FILE NO.: 37112
FILED: 12/17/2012

**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: This rule is authorized pursuant to Section 54-8b-13 which requires the commission to make

rules to implement requirements for operator-assisted services.

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 comments have been received in the last five years.

REASONED JUSTIFICATION FOR THE CONTINUATION OF THE RULE, INCLUDING REASONS WHY THE AGENCY DISAGREES WITH COMMENTS IN OPPOSITION TO THE RULE, IF ANY: Section 54-8b-13 continues to require this rule. This rule ensures that customers of operator-assisted services are informed of rates, surcharges, terms, or conditions of using operator-assisted services. The rule contains requirements for information: to be provided at the telephone set; to inform customers as to which provider is providing the service, or that a call is being transferred to another provider; and requirements for providers of operator-assisted services before a call is completed and when a call is "uncompleted". Requirements for 911 calls, "0" calls, and end-user choice are also provided in this rule. Availability of customer complaint toll-free number requirements are contained in this rule, along with caller access when a call aggregator is involved. This rule also contains enforcement provisions. Therefore, the rule should be continued.

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

PUBLIC SERVICE COMMISSION
ADMINISTRATION
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:
♦ David Clark by phone at 801-530-6708, by FAX at 801-530-6796, or by Internet E-mail at drexclark@utah.gov
♦ Sheri Bintz by phone at 801-530-6714, by FAX at 801-530-6796, or by Internet E-mail at sbintz@utah.gov

AUTHORIZED BY: David Clark, Legal Counsel

EFFECTIVE: 12/17/2012

End of the Five-Year Notices of Review and Statements of Continuation Section

**NOTICES OF
FIVE-YEAR REVIEW EXTENSIONS**

Rulewriting agencies are required by law to review each of their administrative rules within five years of the date of the rule's original enactment or the date of last review (Section 63G-3-305). If the agency finds that it will not meet the deadline for review of the rule (the five-year anniversary date), it may file an extension with the Division of Administrative Rules. The extension permits the agency to file the review up to 120 days beyond the anniversary date.

Agencies have filed extensions for the rules listed below. The "Extended Due Date" is 120 days after the anniversary date.

The five-year review extension is governed by Subsections 63G-3-305(4) and (5).

**Education, Administration
R277-469
Instructional Materials Commission
Operating Procedures**

FIVE-YEAR REVIEW EXTENSION
DAR FILE NO.: 37156
FILED: 12/31/2012

EXTENSION REASON AND NEW DEADLINE: The agency overlooked one of the pages that had all of the rules due in March 2013 making it impossible for them to get the necessary rules to the Board for review in time. New deadline is 07/01/2013.

DIRECT QUESTIONS REGARDING THIS RULE TO:
♦ Carol Lear by phone at 801-538-7835, by FAX at 801-538-7768, or by Internet E-mail at carol.lear@schools.utah.gov

AUTHORIZED BY: Carol Lear, Director, School Law and Legislation

EFFECTIVE: 12/31/2012

**Education, Administration
R277-483
Persistently Dangerous Schools**

FIVE-YEAR REVIEW EXTENSION
DAR FILE NO.: 37157
FILED: 12/31/2012

EXTENSION REASON AND NEW DEADLINE: The agency overlooked one of the pages that had all of the rules due in March 2013 making it impossible for them to get the necessary rules to the Board for review in time. New deadline is 07/01/2013.

DIRECT QUESTIONS REGARDING THIS RULE TO:
♦ Carol Lear by phone at 801-538-7835, by FAX at 801-538-7768, or by Internet E-mail at carol.lear@schools.utah.gov

AUTHORIZED BY: Carol Lear, Director, School Law and Legislation

EFFECTIVE: 12/31/2012

**Education, Administration
R277-485
Loss of Enrollment**

FIVE-YEAR REVIEW EXTENSION
DAR FILE NO.: 37158
FILED: 12/31/2012

EXTENSION REASON AND NEW DEADLINE: The agency overlooked one of the pages that had all of the rules due in March 2013 making it impossible for them to get the necessary rules to the Board for review in time. New deadline is 07/01/2013.

DIRECT QUESTIONS REGARDING THIS RULE TO:
♦ Carol Lear by phone at 801-538-7835, by FAX at 801-538-7768, or by Internet E-mail at carol.lear@schools.utah.gov

AUTHORIZED BY: Carol Lear, Director, School Law and Legislation

EFFECTIVE: 12/31/2012

**Education, Administration
R277-508
Employment of Substitute Teachers**

FIVE-YEAR REVIEW EXTENSION

DAR FILE NO.: 37159
FILED: 12/31/2012

EXTENSION REASON AND NEW DEADLINE: The agency overlooked one of the pages that had all of the rules due in March 2013 making it impossible for them to get the necessary rules to the Board for review in time. New deadline is 07/01/2013.

DIRECT QUESTIONS REGARDING THIS RULE TO:
♦ Carol Lear by phone at 801-538-7835, by FAX at 801-538-7768, or by Internet E-mail at carol.lear@schools.utah.gov

AUTHORIZED BY: Carol Lear, Director, School Law and Legislation

EFFECTIVE: 12/31/2012

Education, Administration
R277-518
Career and Technical Education
Licenses

FIVE-YEAR REVIEW EXTENSION

DAR FILE NO.: 37148
FILED: 12/31/2012

EXTENSION REASON AND NEW DEADLINE: The agency overlooked one of the pages that had all of the rules due in January 2013 making it impossible for them to get the necessary rules to the Board for review in time. New deadline is 05/08/2013.

DIRECT QUESTIONS REGARDING THIS RULE TO:
♦ Carol Lear by phone at 801-538-7835, by FAX at 801-538-7768, or by Internet E-mail at carol.lear@schools.utah.gov

AUTHORIZED BY: Carol Lear, Director, School Law and Legislation

EFFECTIVE: 12/31/2012

Education, Administration
R277-600
Student Transportation Standards and
Procedures

FIVE-YEAR REVIEW EXTENSION

DAR FILE NO.: 37149
FILED: 12/31/2012

EXTENSION REASON AND NEW DEADLINE: The agency overlooked one of the pages that had all of the rules due in January 2013 making it impossible for them to get the necessary rules to the Board for review in time. New deadline is 05/08/2013.

DIRECT QUESTIONS REGARDING THIS RULE TO:
♦ Carol Lear by phone at 801-538-7835, by FAX at 801-538-7768, or by Internet E-mail at carol.lear@schools.utah.gov

AUTHORIZED BY: Carol Lear, Director, School Law and Legislation

EFFECTIVE: 12/31/2012

Education, Administration
R277-605
Coaching Standards and Athletic
Clinics

FIVE-YEAR REVIEW EXTENSION

DAR FILE NO.: 37150
FILED: 12/31/2012

EXTENSION REASON AND NEW DEADLINE: The agency overlooked one of the pages that had all of the rules due in January 2013 making it impossible for them to get the necessary rules to the Board for review in time. New deadline is 05/08/2013.

DIRECT QUESTIONS REGARDING THIS RULE TO:
♦ Carol Lear by phone at 801-538-7835, by FAX at 801-538-7768, or by Internet E-mail at carol.lear@schools.utah.gov

AUTHORIZED BY: Carol Lear, Director, School Law and Legislation

EFFECTIVE: 12/31/2012

Education, Administration
R277-610
Released-Time Classes

FIVE-YEAR REVIEW EXTENSION

DAR FILE NO.: 37151
FILED: 12/31/2012

EXTENSION REASON AND NEW DEADLINE: The agency overlooked one of the pages that had all of the rules due in January 2013 making it impossible for them to get the necessary rules to the Board for review in time. New deadline is 05/08/2013.

DIRECT QUESTIONS REGARDING THIS RULE TO:
♦ Carol Lear by phone at 801-538-7835, by FAX at 801-538-7768, or by Internet E-mail at carol.lear@schools.utah.gov

AUTHORIZED BY: Carol Lear, Director, School Law and Legislation

EFFECTIVE: 12/31/2012

Education, Administration
R277-700

The Elementary and Secondary School
Core Curriculum

FIVE-YEAR REVIEW EXTENSION
DAR FILE NO.: 37152
FILED: 12/31/2012

EXTENSION REASON AND NEW DEADLINE: The agency overlooked one of the pages that had all of the rules due in January 2013 making it impossible for them to get the necessary rules to the Board for review in time. New deadline is 05/08/2013.

DIRECT QUESTIONS REGARDING THIS RULE TO:
♦ Carol Lear by phone at 801-538-7835, by FAX at 801-538-7768, or by Internet E-mail at carol.lear@schools.utah.gov

AUTHORIZED BY: Carol Lear, Director, School Law and Legislation

EFFECTIVE: 12/31/2012

Education, Administration
R277-702

Procedures for the Utah High School
Completion Diploma (Effective on July
1, 2009)

FIVE-YEAR REVIEW EXTENSION
DAR FILE NO.: 37153
FILED: 12/31/2012

EXTENSION REASON AND NEW DEADLINE: The agency overlooked one of the pages that had all of the rules due in January 2013 making it impossible for them to get the necessary rules to the Board for review in time. New deadline is 05/08/2013.

DIRECT QUESTIONS REGARDING THIS RULE TO:
♦ Carol Lear by phone at 801-538-7835, by FAX at 801-538-7768, or by Internet E-mail at carol.lear@schools.utah.gov

AUTHORIZED BY: Carol Lear, Director, School Law and Legislation

EFFECTIVE: 12/31/2012

Education, Administration
R277-709

Education Programs Serving Youth in
Custody

FIVE-YEAR REVIEW EXTENSION
DAR FILE NO.: 37154
FILED: 12/31/2012

EXTENSION REASON AND NEW DEADLINE: The agency overlooked one of the pages that had all of the rules due in January 2013 making it impossible for them to get the necessary rules to the Board for review in time. New deadline is 05/08/2013.

DIRECT QUESTIONS REGARDING THIS RULE TO:
♦ Carol Lear by phone at 801-538-7835, by FAX at 801-538-7768, or by Internet E-mail at carol.lear@schools.utah.gov

AUTHORIZED BY: Carol Lear, Director, School Law and Legislation

EFFECTIVE: 12/31/2012

Education, Administration
R277-719

Standards for Selling Foods Outside of
the Reimbursable Meal in Schools

FIVE-YEAR REVIEW EXTENSION
DAR FILE NO.: 37155
FILED: 12/31/2012

EXTENSION REASON AND NEW DEADLINE: The agency overlooked one of the pages that had the rule due in February 2013 making it impossible for them to get the necessary rule to the Board for review in time. New deadline is 06/07/2013.

DIRECT QUESTIONS REGARDING THIS RULE TO:
♦ Carol Lear by phone at 801-538-7835, by FAX at 801-538-7768, or by Internet E-mail at carol.lear@schools.utah.gov

AUTHORIZED BY: Carol Lear, Director, School Law and Legislation

EFFECTIVE: 12/31/2012

Education, Administration
R277-746
 Driver Education Programs for Utah
 Schools

FIVE-YEAR REVIEW EXTENSION
 DAR FILE NO.: 37160
 FILED: 12/31/2012

EXTENSION REASON AND NEW DEADLINE: The agency overlooked one of the pages that had all of the rules due in March 2013 making it impossible for them to get the necessary rules to the Board for review in time. New deadline is 07/01/2013.

DIRECT QUESTIONS REGARDING THIS RULE TO:
 ♦ Carol Lear by phone at 801-538-7835, by FAX at 801-538-7768, or by Internet E-mail at carol.lear@schools.utah.gov

AUTHORIZED BY: Carol Lear, Director, School Law and Legislation

EFFECTIVE: 12/31/2012

Education, Administration
R277-751
 Special Education Extended School
 Year (ESY)

FIVE-YEAR REVIEW EXTENSION
 DAR FILE NO.: 37161
 FILED: 12/31/2012

EXTENSION REASON AND NEW DEADLINE: The agency overlooked one of the pages that had all of the rules due in March 2013 making it impossible for them to get the necessary rules to the Board for review in time. New deadline is 07/01/2013.

DIRECT QUESTIONS REGARDING THIS RULE TO:
 ♦ Carol Lear by phone at 801-538-7835, by FAX at 801-538-7768, or by Internet E-mail at carol.lear@schools.utah.gov

AUTHORIZED BY: Carol Lear, Director, School Law and Legislation

EFFECTIVE: 12/31/2012

Education, Rehabilitation
R280-200
 Rehabilitation

FIVE-YEAR REVIEW EXTENSION
 DAR FILE NO.: 37162
 FILED: 12/31/2012

EXTENSION REASON AND NEW DEADLINE: The agency overlooked one of the pages that had all of the rules due in March 2013 making it impossible for them to get the necessary rules to the Board for review in time. New deadline is 07/01/2013.

DIRECT QUESTIONS REGARDING THIS RULE TO:
 ♦ Carol Lear by phone at 801-538-7835, by FAX at 801-538-7768, or by Internet E-mail at carol.lear@schools.utah.gov

AUTHORIZED BY: Carol Lear, Director, School Law and Legislation

EFFECTIVE: 12/31/2012

Natural Resources, Water Rights
R655-7

Administrative Procedures for Notifying
 the State Engineer of Sewage Effluent
 Use or Change in the Point of
 Discharge for Sewage Effluent

FIVE-YEAR REVIEW EXTENSION
 DAR FILE NO.: 37123
 FILED: 12/28/2012

EXTENSION REASON AND NEW DEADLINE: The agency requested an extension because they are in the process of repealing this rule but the process will not be complete before the deadline for the five-year review. The new deadline is 06/01/2013.

DIRECT QUESTIONS REGARDING THIS RULE TO:
 ♦ Marianne Burbidge by phone at 801-538-7370, by FAX at 801-538-7467, or by Internet E-mail at marianneburbidge@utah.gov

AUTHORIZED BY: Michael Styler, Executive Director

EFFECTIVE: 12/28/2012

NOTICES OF RULE EFFECTIVE DATES

State law provides for agencies to make their rules effective and enforceable after publication in the Utah State Bulletin. In the case of Proposed Rules or Changes in Proposed Rules with a designated comment period, the law permits an agency to file a notice of effective date any time after the close of comment plus seven days. In the case of Changes in Proposed Rules with no designated comment period, the law permits an agency to file a notice of effective date on any date including or after the thirtieth day after the rule's publication date. If an agency fails to file a Notice of Effective Date within 120 days from the publication of a Proposed Rule or a related Change in Proposed Rule the rule lapses and the agency must start the rulemaking process over.

Notices of Effective Date are governed by Subsection 63G-3-301(12), 63G-3-303, and Sections R15-4-5a and 5b.

Abbreviations

AMD = Amendment

CPR = Change in Proposed Rule

NEW = New Rule

R&R = Repeal & Reenact

REP = Repeal

Administrative Services

Facilities Construction and Management

No. 37026 (AMD): R23-14. Management of Roofs on State Buildings

Published: 11/15/2012

Effective: 12/24/2012

Education

Administration

No. 36946 (AMD): R277-108-5. Assurances

Published: 11/01/2012

Effective: 12/17/2012

No. 36947 (AMD): R277-422. State Supported Voted Local Levy, Board Local Levy and Reading Improvement Program

Published: 11/01/2012

Effective: 12/17/2012

Environmental Quality

Administration

No. 36775 (NEW): R305-8. Board Member Attendance

Requirements

Published: 10/01/2012

Effective: 12/19/2012

Air Quality

No. 36611 (AMD): R307-302. Davis, Salt Lake, Utah, Weber

Counties: Residential Fireplaces and Stoves

Published: 08/15/2012

Effective: 01/01/2013

No. 36611 (CPR): R307-302. Solid Fuel Burning Devices in Box Elder, Cache, Davis, Salt Lake, Tooele, Utah, and Weber

Counties

Published: 12/01/2012

Effective: 01/01/2013

No. 36483 (AMD): R307-309. Nonattainment and Maintenance Areas for PM10: Fugitive Emissions and Fugitive Dust

Published: 08/01/2012

Effective: 01/01/2013

No. 36483 (CPR): R307-309. Nonattainment and Maintenance Areas for PM10 and PM2.5: Fugitive Emissions and Fugitive Dust

Published: 12/01/2012

Effective: 01/01/2013

No. 36482 (AMD): R307-335. Ozone Nonattainment and Maintenance Areas: Degreasing and Solvent Cleaning Operations

Published: 08/01/2012

Effective: 01/01/2013

No. 36482 (CPR): R307-335. Degreasing and Solvent Cleaning Operations

Published: 12/01/2012

Effective: 01/01/2013

No. 36604 (NEW): R307-356. Appliance Pilot Light

Published: 08/15/2012

Effective: 01/01/2013

No. 36604 (CPR): R307-356. Appliance Pilot Light

Published: 12/01/2012

Effective: 01/01/2013

Financial Institutions

Administration

No. 37020 (AMD): R331-23. Lending Limits for Banks, Industrial Loan Corporations

Published: 11/15/2012

Effective: 12/24/2012

Governor

Planning and Budget, Inspector General of Medicaid Services (Office of)

No. 36993 (AMD): R367-1. Office of Inspector General of

Medicaid Services

Published: 11/15/2012

Effective: 12/27/2012

NOTICES OF RULE EFFECTIVE DATES

Health

Family Health and Preparedness, WIC Services
No. 37008 (AMD): R406-100-1. Incorporation of Federal
Regulations
Published: 11/15/2012
Effective: 12/27/2012

Human Services

Aging and Adult Services
No. 36920 (AMD): R510-302. Adult Protective Services
Published: 11/01/2012
Effective: 12/21/2012

Substance Abuse and Mental Health

No. 37009 (NEW): R523-2. Adult Peer Support Specialist
Training and Certification
Published: 11/15/2012
Effective: 12/27/2012

No. 37010 (NEW): R523-3. Child/Family Peer Support

Specialist Training and Certification
Published: 11/15/2012
Effective: 12/27/2012

Labor Commission

Adjudication
No. 36989 (AMD): R602-2-4. Attorney Fees
Published: 11/15/2012
Effective: 12/24/2012

Industrial Accidents

No. 36990 (AMD): R612-4-2. Premium Rates for the
Uninsured Employers' Fund and the Employers' Reinsurance
Fund
Published: 11/15/2012
Effective: 12/24/2012

Public Safety

Driver License
No. 36950 (AMD): R708-47. Emergency Contact Database
Published: 11/15/2012
Effective: 12/26/2012

End of the Notices of Rule Effective Dates Section

**2012 COMPLETE RULES INDEX
BY AGENCY (CODE NUMBER)
AND
BY KEYWORD (SUBJECT)**

This Rules Index is a complete index that reflects all effective changes to Utah's administrative rules for 2012. The Index lists changes made effective from January 2, 2012 through January 1, 2013. The Rules Index is published in the Utah State Bulletin and in the annual Utah Administrative Rules 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).

FIRST DAR NOTE: Because of space constraints, the Keyword Index is not included in this Bulletin.

SECOND DAR NOTE: The index may contain inaccurate page number references. 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 (5110 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	NSC = Nonsubstantive rule change
CPR = Change in proposed rule	REP = Repeal
EMR = Emergency rule (120 day)	R&R = Repeal and reenact
NEW = New rule	5YR = Five-Year Review
EXD = Expired	

CODE REFERENCE	TITLE	FILE NUMBER	ACTION	EFFECTIVE DATE	BULLETIN ISSUE/PAGE
ADMINISTRATIVE SERVICES					
<u>Administration</u>					
R13-2-4	Requests for Access	36285	AMD	08/07/2012	2012-12/8
R13-3	Americans with Disabilities Act Grievance Procedures	37089	5YR	12/04/2012	2013-1/87
<u>Archives</u>					
R17-9	Electronic Participation at Meetings	35304	NEW	01/30/2012	2011-20/6
<u>Child Welfare Parental Defense (Office of)</u>					
R19-1-6	Child Welfare Parental Defense Oversight Committee	35205	AMD	01/12/2012	2011-18/6
R19-1-7	Electronic Meetings	35206	AMD	01/12/2012	2011-18/7
<u>Debt Collection</u>					
R21-1	Transfer of Collection Responsibility of State Agencies	36420	5YR	06/28/2012	2012-14/59
R21-1	Transfer of Collection Responsibility of State Agencies	36495	AMD	09/07/2012	2012-15/6
R21-2	Office of State Debt Collection Administrative Procedures	36421	5YR	06/28/2012	2012-14/60
R21-3	Debt Collection Through Administrative Offset	36422	5YR	06/28/2012	2012-14/60
<u>Facilities Construction and Management</u>					
R23-1	Procurement of Construction	36145	5YR	05/03/2012	2012-11/177
R23-1-40	Procurement of Construction	36020	AMD	08/07/2012	2012-8/4
R23-1-40	Acceptable Bid Security; Performance and Payment Bonds	36020	CPR	08/07/2012	2012-13/88
R23-1-40	Acceptable Bid Security; Performance and Payment Bonds	36632	NSC	08/23/2012	Not Printed
R23-4	Suspension/Debarment	37049	5YR	11/14/2012	2012-23/79
R23-5	Contingency Funds	37050	5YR	11/14/2012	2012-23/79
R23-6	Value Engineering and Life Cycle Costing of State Owned Facilities Rules and Regulations	37051	5YR	11/14/2012	2012-23/80
R23-9	Cooperation with Local Government Planning	37052	5YR	11/14/2012	2012-23/81
R23-10	Naming of State Buildings	37053	5YR	11/14/2012	2012-23/81
R23-12	Building Code Appeals Process	36806	5YR	09/19/2012	2012-20/119
R23-14	Management of Roofs on State Buildings	37056	5YR	11/14/2012	2012-23/82
R23-14	Management of Roofs on State Buildings	37026	AMD	12/24/2012	2012-22/10
R23-19	Facility Use Rules	36146	5YR	05/03/2012	2012-11/177
R23-20	Free Speech Activities	36148	5YR	05/03/2012	2012-11/178
R23-21	Division of Facilities Construction and Management Lease Procedures	37054	5YR	11/14/2012	2012-23/82
R23-24	Capital Projects Utilizing Non-appropriated Funds	37055	5YR	11/14/2012	2012-23/83

Finance

R25-7	Travel-Related Reimbursements for State Employees	36112	AMD	07/01/2012	2012-10/4
R25-7-6	Reimbursements for Meals	36636	NSC	08/30/2012	Not Printed
R25-14	Payment of Attorneys Fees in Death Penalty Cases	35663	5YR	01/12/2012	2012-3/105
R25-20	Indigent Defense Funds Board, Procedures for Electronic Meetings	35975	NEW	05/22/2012	2012-8/5

Fleet Operations

R27-4	Vehicle Replacement and Expansion of State Fleet	35622	5YR	01/05/2012	2012-3/105
R27-5	Fleet Tracking	35617	5YR	01/05/2012	2012-3/106
R27-5	Fleet Tracking	35623	NSC	01/31/2012	Not Printed
R27-6	Fuel Dispensing Program	35620	5YR	01/05/2012	2012-3/106
R27-7	Safety and Loss Prevention of State Vehicles	36024	AMD	06/28/2012	2012-9/4
R27-8	State Vehicle Maintenance Program	35621	5YR	01/05/2012	2012-3/107
R27-9	Dispensing Compressed Natural Gas to the Public	35727	NEW	03/26/2012	2012-4/6

Purchasing and General Services

R33-1	Utah State Procurement Rules Definitions	35664	AMD	03/30/2012	2012-3/4
R33-1	Utah State Procurement Rules Definitions	36423	5YR	07/02/2012	2012-14/61
R33-2	Procurement Organization	36424	5YR	07/02/2012	2012-14/61
R33-3	Source Selection and Contract Formation	35613	AMD	03/30/2012	2012-2/6
R33-3	Source Selection and Contract Formation	36425	5YR	07/02/2012	2012-14/62
R33-3-7	Types of Contracts	35667	AMD	03/30/2012	2012-3/6
R33-4	Specifications	35665	AMD	03/30/2012	2012-3/10
R33-4	Specifications	36426	5YR	07/02/2012	2012-14/62
R33-5	Construction and Architect-Engineer Selection	36428	5YR	07/02/2012	2012-14/63
R33-6-101	Revisions to Contract Clauses	35666	AMD	03/30/2012	2012-3/12
R33-8	Property Management	36430	5YR	07/02/2012	2012-14/63
R33-12	Rules of Procedure for Procurement Policy Board and Procurement Appeals Panel	36657	NEW	10/08/2012	2012-17/4

Risk Management

R37-1	Risk Management General Rules	36286	5YR	05/30/2012	2012-12/81
R37-2	Risk Management State Workers' Compensation Insurance Administration	36287	5YR	05/30/2012	2012-12/81
R37-3	Risk Management Adjudicative Proceedings	36288	5YR	05/30/2012	2012-12/82
R37-4	Adjusted Utah Governmental Immunity Act Limitations on Judgments	36289	5YR	05/30/2012	2012-12/83
R37-4	Adjusted Utah Governmental Immunity Act Limitations on Judgments	35844	AMD	05/31/2012	2012-5/4

AGRICULTURE AND FOOD

Administration

R51-2	Administrative Procedures for Informal Proceedings Before the Utah Department of Agriculture and Food	35614	5YR	01/04/2012	2012-3/107
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Animal Industry

R58-1	Admission and Inspection of Livestock, Poultry, and Other Animals	35691	5YR	01/18/2012	2012-4/59
R58-3	Brucellosis Vaccination Requirements	36143	EMR	05/08/2012	2012-11/167
R58-3	Brucellosis Vaccination Requirements	36683	NEW	10/29/2012	2012-18/4
R58-6	Poultry	35692	5YR	01/18/2012	2012-4/59
R58-10	Meat and Poultry Inspection	36249	REP	07/26/2012	2012-12/9
R58-11	Slaughter of Livestock	35866	AMD	05/15/2012	2012-5/5
R58-11	Slaughter of Livestock and Poultry	36144	NSC	05/30/2012	Not Printed
R58-16	Swine Garbage Feeding	36248	REP	07/26/2012	2012-12/10
R58-18	Elk Farming	35695	5YR	01/18/2012	2012-4/60
R58-19	Compliance Procedures	35696	5YR	01/18/2012	2012-4/60
R58-21	Trichomoniasis	36164	AMD	07/10/2012	2012-11/4
R58-22	Equine Infectious Anemia (EIA)	35694	5YR	01/18/2012	2012-4/61
R58-23	Equine Viral Arteritis (EVA)	35693	5YR	01/18/2012	2012-4/61

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R65-5	Utah Red Tart and Sour Cherry Marketing Order	36488	5YR	07/12/2012	2012-15/73
R65-11	Utah Sheep Marketing Order	36490	5YR	07/12/2012	2012-15/74

Plant Industry

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R68-19	Compliance Procedures	35697	5YR	01/18/2012	2012-4/62
R68-21	Standard of Identity for Honey	35566	REP	03/07/2012	2012-2/16

Regulatory Services

R70-201	Compliance Procedures	35660	5YR	01/12/2012	2012-3/108
R70-320	Minimum Standards for Milk for Manufacturing Purposes, its Production and Processing	35661	5YR	01/12/2012	2012-3/109
R70-330	Raw Milk for Retail	36465	EMR	07/11/2012	2012-15/65
R70-350	Ice Cream and Frozen Dairy Food Standards	35658	5YR	01/12/2012	2012-3/109
R70-360	Procedure for Obtaining a License to Test Milk for Payment	35657	5YR	01/12/2012	2012-3/110
R70-520	Standard of Identity and Labeling Requirements for Honey	36147	NEW	07/10/2012	2012-11/6
R70-530	Food Protection	35920	5YR	03/07/2012	2012-7/63
R70-550	Utah Inland Shellfish Safety Program	35659	5YR	01/12/2012	2012-3/110
R70-560	Inspection and Regulation of Cottage Food Production Operations	35662	5YR	01/12/2012	2012-3/111

ALCOHOLIC BEVERAGE CONTROL

Administration

R81-1-3	General Policies	36271	AMD	07/31/2012	2012-12/11
R81-1-6	Violation Schedule	35588	AMD	03/01/2012	2012-2/20
R81-1-31	Duties of Commission Subcommittees	37114	EMR	12/18/2012	Not Printed
R81-2-12	Store Site Selection	37115	EMR	12/18/2012	Not Printed
R81-3-11	Application	35942	AMD	07/17/2012	2012-7/4
R81-4A-2	Application	35943	AMD	05/22/2012	2012-7/5
R81-4B-2	Application	35944	AMD	05/22/2012	2012-7/6
R81-4C-2	Application	35945	AMD	05/22/2012	2012-7/8
R81-4D-2	Application	35946	AMD	05/22/2012	2012-7/9
R81-4E-2	Application	35947	AMD	05/22/2012	2012-7/11
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R81-4F-7	Sale and Purchase of Alcoholic Beverages	36113	AMD	07/01/2012	2012-10/9
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R81-6-1	Application	35950	AMD	05/22/2012	2012-7/15
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R81-8-1	Application	35951	AMD	05/22/2012	2012-7/16
R81-9-1	Application	35952	AMD	05/22/2012	2012-7/17
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R81-10D-2	Application	35955	AMD	05/22/2012	2012-7/21
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R81-12-1	Application	35957	AMD	05/22/2012	2012-7/24

ATTORNEY GENERAL

Administration

R105-1	Attorney General's Selection of Outside Counsel, Expert Witnesses and Other Litigation Support Services	35904	NEW	04/24/2012	2012-6/6
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Administration

R123-3	State Auditor Adjudicative Proceedings	36506	5YR	07/18/2012	2012-16/183
R123-4	Public Petitions for Declaratory Orders	36509	5YR	07/18/2012	2012-16/183

R123-5	Audit Requirements for Audits of Political Subdivisions and Nonprofit Organizations	36510	5YR	07/18/2012	2012-16/184
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CAPITOL PRESERVATION BOARD (STATE)

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R131-3	Use of Magnetometers on Capitol Hill	36359	5YR	06/13/2012	2012-13/97
R131-9	State Capitol Preservation Board Art Program and Policy	35686	R&R	03/09/2012	2012-3/13
R131-10	Commercial Solicitations	35687	5YR	01/17/2012	2012-3/111
R131-11	Preservation of Free Speech Activities	35688	5YR	01/17/2012	2012-3/112
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R151-4-306	Motion to Recuse or Disqualify a Board or Commission Member	36416	AMD	08/21/2012	2012-14/4
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R152-20	New Motor Vehicle Warranties	35967	5YR	03/22/2012	2012-8/72
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R152-22-6	Application for Professional Fund Raiser, Fund Raising Counsel or Consultant Permit	36903	AMD	11/29/2012	2012-20/4
R152-23	Utah Health Spa Services	35971	5YR	03/22/2012	2012-8/73
R152-23	Utah Health Spa Services	36904	AMD	11/29/2012	2012-20/5
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R152-34	Postsecondary Proprietary School Act Rules	36905	AMD	12/05/2012	2012-20/8
R152-34-7	Rules Relating to the Operation of Proprietary Schools under Section 13-34-107	37035	NSC	12/05/2012	Not Printed
R152-42	Uniform Debt-Management Services Act Rules	35972	5YR	03/22/2012	2012-8/73

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R156-1	General Rule of the Division of Occupational and Professional Licensing	36077	AMD	06/07/2012	2012-9/8
R156-1	General Rule of the Division of Occupational and Professional Licensing	36551	AMD	09/24/2012	2012-16/4
R156-1	General Rule of the Division of Occupational and Professional Licensing	36629	AMD	10/09/2012	2012-17/9
R156-1-109	Presiding Officers	36941	NSC	11/01/2012	Not Printed
R156-1-506	Supervision of Cosmetic Medical Procedures	36858	AMD	11/26/2012	2012-20/16
R156-3a	Architect Licensing Act Rule	36282	AMD	07/30/2012	2012-12/12
R156-9	Funeral Service Licensing Act Rule	36117	AMD	06/21/2012	2012-10/17

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R156-15A	State Construction Code Administration and Adoption of Approved State Construction Code Rule	36552	AMD	09/24/2012	2012-16/7
R156-16a	Optometry Practice Act Rule	35893	5YR	02/21/2012	2012-6/35
R156-17b	Pharmacy Practice Act Rule	36901	AMD	11/29/2012	2012-20/17
R156-17b-402	Administrative Penalties	37082	NSC	12/21/2012	Not Printed
R156-20a	Environmental Health Scientist Act Rule	35430	AMD	01/10/2012	2011-23/10
R156-20a	Environmental Health Scientist Act Rule	36484	AMD	09/11/2012	2012-15/8
R156-22	Professional Engineers and Professional Land Surveyors Licensing Act Rule	36090	AMD	06/21/2012	2012-10/19
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R156-24b	Physical Therapy Practice Act Rule	36759	AMD	11/13/2012	2012-19/8
R156-37	Utah Controlled Substances Act Rule	35892	5YR	02/21/2012	2012-6/36
R156-37-402	Continuing Professional Education for Controlled Substance Prescribers	36873	AMD	11/26/2012	2012-20/40
R156-38b	State Construction Registry Rule	36930	AMD	12/10/2012	2012-21/13
R156-40	Recreational Therapy Practice Act Rule	36892	AMD	11/26/2012	2012-20/42
R156-40a	Athletic Trainer Licensing Act Rule	36089	AMD	06/28/2012	2012-10/22
R156-46b	Division Utah Administrative Procedures Act Rule	36630	AMD	10/09/2012	2012-17/13
R156-47b	Massage Therapy Practice Act Rule	36132	5YR	05/01/2012	2012-10/87
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R156-55d	Burglar Alarm Licensing Rule	36191	NSC	05/30/2012	Not Printed
R156-56	Building Inspector and Factory Built Housing Licensing Act Rule	35735	5YR	01/31/2012	2012-4/62
R156-60	Mental Health Professional Practice Act Rule	36757	AMD	11/13/2012	2012-19/11
R156-60a	Social Worker Licensing Act Rule	36189	AMD	07/09/2012	2012-11/10
R156-60c	Professional Counselor Licensing Act Rule	36758	AMD	11/13/2012	2012-19/13
R156-60d	Substance Abuse Counselor Act Rule	36228	AMD	07/30/2012	2012-12/17
R156-60d	Substance Use Disorder Counselor Act Rule	36550	NSC	08/08/2012	Not Printed
R156-63b-102	Definitions	36192	NSC	05/30/2012	Not Printed
R156-64	Deception Detection Examiners Licensing Act Rule	35736	5YR	01/31/2012	2012-4/64
R156-67-503	Administrative Penalties	35389	AMD	03/09/2012	2011-22/14
R156-67-503	Administrative Penalties	35389	CPR	03/09/2012	2012-3/86
R156-68-503	Administrative Penalties	35388	AMD	03/09/2012	2011-22/19
R156-68-503	Administrative Penalties	35388	CPR	03/09/2012	2012-3/90
R156-69-302d	Licensing of Dentist-Educators	36181	AMD	07/09/2012	2012-11/14
R156-75	Genetic Counselors Licensing Act Rule	36183	AMD	07/09/2012	2012-11/15
R156-75-102	Definitions	36450	NSC	07/25/2012	Not Printed
R156-76	Professional Geologist Licensing Act Rule	35894	5YR	02/21/2012	2012-6/37
R156-78B	Prelitigation Panel Review Rule	35820	5YR	02/02/2012	2012-5/102
R156-83-502	Unprofessional Conduct	35585	AMD	02/21/2012	2012-2/28
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R162-2e	Appraisal Management Company Administrative Rules	36449	AMD	09/26/2012	2012-15/10
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R162-2f	Real Estate Licensing and Practices Rules	36390	AMD	08/21/2012	2012-14/5
R162-57a	Timeshare and Camp Resort Rules	36078	AMD	08/21/2012	2012-9/27
R162-57a	Timeshare and Camp Resort Rules	36078	CPR	08/21/2012	2012-14/48
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COMMUNITY AND CULTURE

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R182-2	Preservation Pro Fee	36353	NEW	08/31/2012	2012-13/14
R182-2 (Changed to R450-2)	Preservation Pro Fee	36751	NSC	10/01/2012	Not Printed

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R207-1 (Changed to R451-1)	Utah Arts Council General Program Rules	36252	NSC	07/09/2012	Not Printed
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R207-2 (Changed to R451-2)	Policy for Commissions, Purchases, and Donations to, and Loans from, the Utah State Art Collections	36253	NSC	07/09/2012	Not Printed
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R212-3 (Changed to R455-3)	Memberships, Sales, Gifts, Bequests, Endowments	36263	NSC	07/09/2012	Not Printed
R212-4 (Changed to R455-4)	Ancient Human Remains	36264	NSC	07/09/2012	Not Printed
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R212-11 (Changed to R455-11)	Historic Preservation Tax Credit	36268	NSC	07/09/2012	Not Printed
R212-12	Computerized Record of Cemeteries, Burial Locations and Plots, and Granting Matching Funds	36301	5YR	05/31/2012	2012-12/84
R212-12	Computerized Record of Cemeteries, Burials Location and Plots, and Granting Matching Funds	36305	NSC	06/29/2012	Not Printed
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R212-13 (Changed to R455-13)	Capital Funds Request Prioritization	36270	NSC	07/09/2012	Not Printed

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R195-1	Energy Assistance: General Provisions	36313	REP	09/11/2012	2012-13/15

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R195-4	Energy Assistance: Asset Standards	36316	REP	09/11/2012	2012-13/22
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R195-5	Energy Assistance: Program Benefits	36296	EXT	05/31/2012	2012-12/96
R195-5	Energy Assistance: Program Benefits	36317	REP	09/11/2012	2012-13/23
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R195-8	Energy Assistance: Special State Programs	35409	AMD	03/26/2012	2011-23/20
R195-8	Energy Assistance: Special State Programs	36302	EXT	05/31/2012	2012-12/96
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R251-106	Media Relations	35805	NEW	04/09/2012	2012-5/11
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R251-108	Adjudicative Proceedings	35807	NEW	04/09/2012	2012-5/15
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R251-305	Visiting at Community Correctional Centers	35754	EXT	01/31/2012	2012-4/121
R251-305	Visiting at Community Correctional Centers	36039	5YR	04/06/2012	2012-9/77
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R251-705	Inmate Mail Procedures	35810	NEW	04/09/2012	2012-5/19
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R251-706	Inmate Visiting	35811	NEW	04/09/2012	2012-5/22
R251-707	Legal Access	35756	EXT	01/31/2012	2012-4/121
R251-707	Legal Access	36041	5YR	04/06/2012	2012-9/78
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EDUCATION

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R277-101	Utah State Board of Education Procedures	36591	AMD	09/21/2012	2012-16/10
R277-102	Adjudicative Proceedings	35534	R&R	02/07/2012	2012-1/8
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R994-402	Extended Benefits (EB)	36095	5YR	04/25/2012	2012-10/98
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R994-403	Claim for Benefits	36619	AMD	10/01/2012	2012-16/159
R994-403-112c	Available	35448	AMD	01/17/2012	2011-23/98
R994-404	Payments Following Workers' Compensation	36256	5YR	05/22/2012	2012-12/92
R994-405	Ineligibility for Benefits	36224	AMD	07/09/2012	2012-11/164
R994-405-104	Quit to Accompany, Follow or Join a Spouse	36134	AMD	07/01/2012	2012-10/84
R994-406	Fraud, Fault and Nonfault Overpayments	36257	5YR	05/22/2012	2012-12/92
R994-406-302	Repayment and Collection of Fault Overpayments	36760	AMD	11/09/2012	2012-19/118
R994-508	Appeal Procedures	35455	AMD	02/01/2012	2011-23/101