

# 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, 4120 State Office Building, Salt Lake City, Utah 84114-1201, telephone 801-538-3764, FAX 801-359-0759. 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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# **SPECIAL NOTICES**

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## **Health Health Care Financing, Coverage and Reimbursement Policy**

### **Notice for September 2011 Medicaid Rate Changes**

Effective September 1, 2011, Utah Medicaid will adjust its rates consistent with approved methodologies. Rate adjustments include new codes priced consistent with approved Medicaid methodologies, potential adjustments to existing codes, and nursing home rate changes to case mix components consistent with adopted payment methodology. 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

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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 July 16, 2011, 12:00 a.m., and August 01, 2011, 11:59 p.m. are included in this, the August 15, 2011 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 September 14, 2011. 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 December 13, 2011, 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.

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**The Proposed Rules Begin on the Following Page**

**Alcoholic Beverage Control,  
Administration  
R81-1  
Scope, Definitions, and General  
Provisions**

**NOTICE OF PROPOSED RULE**

(Amendment)

DAR FILE NO.: 35098

FILED: 07/28/2011

**RULE ANALYSIS**

**PURPOSE OF THE RULE OR REASON FOR THE CHANGE:** This rule amendment is being proposed to implement S.B. 314, which was passed in the 2011 General Session, and to remove antiquated references to the state label. The rule amendment also makes nonsubstantive changes regarding statutory references subsequent to the recodification the Alcoholic Beverage Control Act that replaced Title 32A with Title 32B effective 07/01/2011.

**SUMMARY OF THE RULE OR CHANGE:** To implement S.B. 314, passed in the 2011 General Session, amendments are proposed to the following: in Section R81-1-2, definitions are made consistent with the new license types created in S.B. 314, and with the new warning sign language specified in S.B. 314; and in Section R81-1-22, Diplomatic Embassy Shipments and Purchases whereby references to the state label on bottles are removed because the Legislature eliminated the state label in S.B. 187 (2009 General Session). The rule amendment also makes nonsubstantive changes regarding statutory references subsequent to the recodification the Alcoholic Beverage Control Act that replaced Title 32A with Title 32B effective 07/01/2011.

**STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE:** Section 32B-2-202

**ANTICIPATED COST OR SAVINGS TO:**

- ◆ **THE STATE BUDGET:** None--This amendment deals with two definitions only and does not impose any costs or savings to the state budget. The state stopped using the state labels in 2009, so there is no further effect on the state budget.
- ◆ **LOCAL GOVERNMENTS:** None--This rule deals in areas that are regulated by state government and do not affect costs or savings of local governments.
- ◆ **SMALL BUSINESSES:** None--Many licensees are small businesses that are already operating under the rules that these definitions address in this amendment. There will be no additional costs or savings associated with this amended rule.

◆ **PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES:** None--These rules only affect licensed businesses and there is no cost or savings effect on other persons.

**COMPLIANCE COSTS FOR AFFECTED PERSONS:** None--Statutory requirements establish compliance parameters and any resulting costs. This rule does not impose any additional compliance costs.

**COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES:** This rule amendment makes changes to definitions that are consistent with S.B. 314, and removes an antiquated reference to state labels. There will be no fiscal impact on businesses.

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:**

◆ Neil Cohen by phone at 801-977-6800, by FAX at 801-977-6889, or by Internet E-mail at ncohen@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN AT 5:00 PM ON 09/14/2011

THIS RULE MAY BECOME EFFECTIVE ON: 09/22/2011

AUTHORIZED BY: Dennis Kellen, Director

**R81. Alcoholic Beverage Control, Administration.**

**R81-1. Scope, Definitions, and General Provisions.**

**R81-1-1. Scope and Effective Date.**

**R81-1-2. Definitions.**

Definitions of terms in the Act are used in these rules, except where the context of the terms in these rules clearly indicates a different meaning.

(1) "ACT" means the Alcoholic Beverage Control Act, Title [~~32A~~]32B.

(2) "COMMISSION" means the Utah Alcoholic Beverage Control Commission.

(3) "DECISION OFFICER" means a person who has been appointed by the commission or the director of the Department of Alcoholic Beverage Control to preside over the prehearing phase of all disciplinary actions, and, in all cases not requiring an evidentiary hearing.

(4) "DEPARTMENT" or "DABC" means the Utah Department of Alcoholic Beverage Control.



(5) "DIRECTOR" means the director of the Department of Alcoholic Beverage Control.

(6) "DISCIPLINARY ACTION" means the process by which violations of the Act and these rules are charged and adjudicated, and by which administrative penalties are imposed.

(7) "DISPENSING SYSTEM" means a dispensing system or device which dispenses liquor in controlled quantities not exceeding 1.5 ounces and has a meter which counts the number of pours served.

(8) "GUEST ROOM" means a space normally utilized by a natural person for occupancy, usually a traveler who lodges at an inn, hotel or resort.

(9) "HEARING OFFICER" or "PRESIDING OFFICER" means a person who has been appointed by the commission or the director to preside over evidentiary hearings in disciplinary actions, and who is authorized to issue written findings of fact, conclusions of law, and recommendations to the commission for final action.

(10) "LETTER OF ADMONISHMENT" is a written warning issued by a decision officer to a respondent who is alleged to have violated the Act or these rules.

(11) "MANAGER" means a person chosen or appointed to manage, direct, or administer the affairs of another person, corporation, or company.

(12) "POINT OF SALE" means that portion of a package agency, restaurant, limited restaurant, beer-only restaurant, airport lounge, on-premise banquet premises, reception center, ~~[private]~~ club, recreational amenity on-premise beer retailer, tavern, single event permitted area, temporary special event beer permitted area, or public service special use permitted area that has been designated by the department as an alcoholic beverage selling area. It also means that portion of an establishment that sells beer for off-premise consumption where the beer is displayed or offered for sale.

(13) "REASONABLE" means ordinary and usual thinking, speaking, or acting, which is fit and appropriate to the end in view.

(14) "RESPONDENT" means a department licensee, or permittee, or employee or agent of a licensee or permittee, or other entity against whom a letter of admonishment or notice of agency action is directed.

(15) "STAFF" or "authorized staff member" means a person duly authorized by the director of the department to perform a particular act.

(16) "UTAH ALCOHOLIC BEVERAGE CONTROL LAWS" means any Utah statutes, commission rules and municipal and county ordinances relating to the manufacture, possession, transportation, distribution, sale, supply, wholesale, warehousing, and furnishing of alcoholic beverages.

(17) "VIOLATION REPORT" means a written report from any law enforcement agency or authorized department staff member alleging a violation of the Utah Alcoholic Beverage Control Act or rules of the commission by a department licensee, or permittee, or employee or agent of a licensee or permittee or other entity.

(18) "WARNING SIGN" means a sign no smaller than ~~[six]~~eight and one half inches high by ~~[twelve]~~eleven inches wide, ~~[with print no smaller than one half inch bold letters and ]~~clearly readable, stating: "Warning: drinking alcoholic beverages during pregnancy can cause birth defects and permanent brain damage for

the child. Call the Utah Department of Health at (insert most current toll-free number) with questions or for more information" and "Warning: Driving under the influence of alcohol or drugs is a serious crime that is prosecuted aggressively in Utah." The two warning messages shall be in the same font size but different font styles that are no smaller than 36 point bold. The font size for the health department contact information shall be no smaller than 20 point bold.

#### **R81-1-22. Diplomatic Embassy Shipments and Purchases.**

(1) Purpose. The Vienna Conventions on Diplomatic and Consular Relations grant foreign diplomatic missions certain exemptions from federal, state and local taxes. The United States, by treaty, is a party to the Vienna Conventions, and is obligated under international law to grant these exemptions under these agreements to accredited diplomatic missions of those countries that grant the United States reciprocal privileges. These privileges include the purchase of alcoholic beverages duty and tax free subject to certain exceptions such as indirect taxes normally incorporated in the price of goods or services, and charges levied for specific services rendered to benefit the mission.

This rule establishes department guidelines for shipments and purchases of alcohol by a foreign diplomatic mission with an accredited embassy having full diplomatic privileges under the Vienna Conventions that establishes an embassy presence in the state of Utah (hereafter "accredited foreign diplomatic mission").

(2) Application of Rule.

(a) Shipments. An accredited foreign diplomatic mission that establishes an embassy presence in Utah may have or possess, for official diplomatic use, and not for sale or resale, alcoholic beverages that have not been purchased in the state of Utah. Such products may be shipped or transported into the state of Utah under the following conditions:

(i) The embassy must first obtain the approval of this department prior to shipping or transporting its alcoholic beverages into the state.

(ii) Alcoholic beverages shipped or transported into the state must clear U.S. Customs duty free.

~~[(iii) The department shall affix the official state label to the alcoholic beverages.]~~

(iv) The embassy shall pay the department an administrative handling fee of \$1.00 per smallest unit (bottle, can, or keg). Payment of handling fees shall be made by the embassy using an official embassy check or embassy credit card.

(v) The alcoholic beverages may be used by the embassy only for official diplomatic functions, and may not be sold or resold.

(b) Purchases.

(i) Special Orders. An accredited foreign diplomatic mission that establishes an embassy presence in Utah may special order from the department alcoholic beverage products not presently sold in the state of Utah under the following procedures:

(A) The company or importer supplying the product must submit a price quotation to the department indicating the case price (in US dollars) for which it will sell the product to the state.

(B) The quoted case price must be reasonable (a minimum of \$10.00 per case).

(C) The product will be marked up using the department's standard pricing formula (less the state sales tax).

(D) Special orders must be placed by the embassy at least two months in advance to allow the department sufficient time to purchase and receive the product for the embassy.

(E) The product must be paid for by the embassy using an official embassy check or embassy credit card.

(F) The product may be used by the embassy only for official diplomatic functions, and may not be sold or resold.

(ii) Presently Available Merchandise. An accredited foreign diplomatic mission that establishes an embassy presence in Utah may purchase alcoholic beverages that are presently sold in the state of Utah under the following procedures:

(A) Alcoholic beverage product purchases, other than large quantity purchases, may be made by the embassy at any state store. The store shall deduct state sales tax from the purchase price.

(B) Large quantity purchase orders must be placed by the embassy at the department's licensee warehouse. The warehouse shall deduct state sales tax from the purchase price.

(C) The products must be paid for by the embassy using an official embassy check or embassy credit card.

(D) The product may be used by the embassy only for official diplomatic functions, and may not be sold or resold.

**KEY: alcoholic beverages**

**Date of Enactment or Last Substantive Amendment: 2011**

**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  
R81-6-6**

**Religious Wine Permits**

**NOTICE OF PROPOSED RULE**

(Amendment)

DAR FILE NO.: 35099

FILED: 07/28/2011

**RULE ANALYSIS**

**PURPOSE OF THE RULE OR REASON FOR THE CHANGE:** The purpose of this amendment is to remove antiquated references to the "state label" which was previously eliminated from statute by S.B. 187 passed in the 2009 General Session, and to fix typographical errors.

**SUMMARY OF THE RULE OR CHANGE:** This rule amendment removes antiquated references to the "state label". The Legislature eliminated the use of state labels in S.B. 187 passed in the 2009 General Session.

**STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 32-2-202**

**ANTICIPATED COST OR SAVINGS TO:**

♦ **THE STATE BUDGET:** None--This is a housekeeping amendment to remove antiquated references to the "state label" that has not been in use since 2009 and will have no cost or savings to the state budget.

♦ **LOCAL GOVERNMENTS:** None--The Religious Wine Permit is a state permit and has no cost or savings effect on local governments.

♦ **SMALL BUSINESSES:** None--The Religious Wine Permit is for religious organizations to provide alcoholic product to a person as part of the religious organization's religious services. The rule has no effect on small businesses.

♦ **PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES:** None--This rule regulates religious organizations only and will have no effect on other persons.

**COMPLIANCE COSTS FOR AFFECTED PERSONS:** The housekeeping changes in this amendment will not impose any compliance costs for affected religious organizations.

**COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES:**

This is a housekeeping amendment to strike language that should have been removed after S.B. 187 became law in 2009. It is being done now and will have no fiscal impact on businesses.

**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:**

♦ Neil Cohen by phone at 801-977-6800, by FAX at 801-977-6889, or by Internet E-mail at ncohen@utah.gov

**INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN AT 5:00 PM ON 09/14/2011**

**THIS RULE MAY BECOME EFFECTIVE ON: 09/22/2011**

**AUTHORIZED BY: Dennis Kellen, Director**

**R81-1. Alcoholic Beverage Control, Administration.**

**R81-6. Special Use Permits.**

**R81-6-6. Religious Wine Permits.**

(1) Purpose. This rule outlines the procedures for a religious wine permit holder to purchase wine for religious purposes, and the procedures department personnel shall follow to process the purchase.

(2) Application of Rule.

(a) The permit holder may purchase any generally listed wine directly off of the shelf of any state store or package agency at a charge of cost plus freight. The cashier shall first verify that the purchasing religious organization is a holder of a permit on file in the department's licensee/permittee data base. The cashier shall determine the cost plus freight price of the wine. The wine may be purchased only with cash or a check belonging to the religious organization, and not with an individual's personal check or credit card. Checks shall be deposited in the ordinary course of business with other checks. ~~[If wines are purchased by the case, the cases must be opened and the individual bottles marked with the state label.]~~

(b) The permit holder may order wine for religious purposes directly from the winery and have the winery ship the wine prepaid at a charge of cost plus freight to the department's central administrative warehouse. The warehouse shall deliver the wine to the state store or package agency nearest to the permit holder's church. ~~[The state store or package agency shall open any cases and mark individual bottles with the state label.]~~ The state store or package agency shall notify the permit holder when the product is available for pick-up.

(c) The permit holder may place a special order for wines not generally listed by the department only if the winery will not sell directly to the permit holder. Special orders may be placed only with the special order clerk at the department's administrative office. No special orders may be placed with a state store or package agency. The special order clerk shall verify that the purchasing religious organization is on file in the department's licensee/permittee data base, place the order, assign it a special order code number, assess a charge of cost plus freight, and have the wine delivered to the state store or package agency nearest to the permit holder's church. The state store or package agency shall notify the permit holder when the product is available for pick-up. All procedures for processing the purchase that are outlined in (a) above shall be followed by the state store or package agency to complete the sale.

**KEY: alcoholic beverages**

**Date of Enactment or Last Substantive Amendment:** ~~[June 1, 2004]~~**2011**

**Notice of Continuation:** May 10, 2011

**Authorizing, and Implemented or Interpreted Law:** 32A-1-107

**Alcoholic Beverage Control,  
Administration  
R81-10D  
Tavern Beer Licenses**

**NOTICE OF PROPOSED RULE**

(New Rule)

DAR FILE NO.: 35097

FILED: 07/28/2011

**RULE ANALYSIS**

**PURPOSE OF THE RULE OR REASON FOR THE CHANGE:** This new rule provides a section for the "tavern" license type which was previously combined with the on-premise beer license and implements new provisions required by S.B. 314 that was passed in the 2011 General Session.

**SUMMARY OF THE RULE OR CHANGE:** This rule is proposed to ensure that taverns are regulated in a similar manner as holders of other licenses. As required by S.B. 314, it also clarifies the electronic age verification procedures required by pursuant to Section 32B-1-407.

**STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE:** Section 32B-2-202 and Subsection 32B-1-407(5)

**ANTICIPATED COST OR SAVINGS TO:**

- ◆ **THE STATE BUDGET:** None--This rule elaborates on the statutory mandates for this existing license type. Regarding the new requirement, the DABC is not required to fund the purchase of the electronic age verification devices therefore there will be no cost or savings to the state budget.
- ◆ **LOCAL GOVERNMENTS:** None--Taverns are regulated on the state level. Local governments will not be involved so there will no costs or savings to them.
- ◆ **SMALL BUSINESSES:** Many taverns are small businesses, however the purchase and use of electronic age verification devices is required by statute and the associated costs are therefore imposed by statute, so this rule does not impose any additional costs.
- ◆ **PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES:** None--The rule affects tavern license holders and not other persons, so this rule will have no fiscal impact on other persons.

**COMPLIANCE COSTS FOR AFFECTED PERSONS:** There are no compliance costs created by this rule. Any compliance costs associated with the purchase and use of the electronic age verification devices are imposed by the governing statutes: Sections 32B-1-407 and 32B-6-706.

**COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES:** This rule is written to clarify the operational guidelines for tavern licenses and to clarify the regulatory procedures for the use of the electronic age verification devices that S.B. 314 requires for taverns. These devices cost about \$1,000 each and some larger businesses may require more than one. However, the rule has no fiscal impact on businesses because the fiscal burdens are established by 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:

◆ Neil Cohen by phone at 801-977-6800, by FAX at 801-977-6889, or by Internet E-mail at ncohen@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN AT 5:00 PM ON 09/14/2011

THIS RULE MAY BECOME EFFECTIVE ON: 09/22/2011

AUTHORIZED BY: Dennis Kellen, Director

**R81. Alcoholic Beverage Control, Administration.**

**R81-10D. Tavern Beer Licenses.**

**R81-10D-1. Licensing.**

(1) Tavern beer licenses are issued to persons as defined in Section 32B-1-102(74). The department must be immediately notified of any action or transaction that may alter the organizational structure or ownership interest of the person to whom the license is issued to ensure there is no violation of Sections 32B-5-310.

**R81-10D-2. Application.**

A license application shall be included in the agenda of the monthly commission meeting for consideration for issuance of a tavern beer license when the requirements of Sections 32B-1-304, 32B-5-201, -204 and 32B-6-703 and -705 have been met, and a completed application has been received by the department and the restaurant premises have been inspected by the department.

**R81-10D-3. Bonds.**

No part of any corporate or cash bond required by Section 32B-5-204 and 32B-6-705(4) may be withdrawn during the time the license is in effect. If the tavern beer licensee fails to maintain a valid corporate or cash bond, the license shall be immediately suspended until a valid bond is obtained. Failure to obtain a bond within 30 days of notification by the department of the delinquency shall result in the automatic revocation of the license.

**R81-10D-4. Insurance.**

Public liability and dram shop insurance coverage required in Section 32B-5-201(2)(j) must remain in force during the time the license is in effect. Failure of the licensee to maintain the required insurance coverage may result in a suspension or revocation of the license by the commission.

**R81-10D-5. Identification Badge.**

Each employee of the licensee who sells, dispenses or provides alcoholic beverages shall wear a unique identification

badge visible above the waist, bearing the employee's first name, initials, or a unique number in letters or numbers not less than 3/8 inch high. The identification badge must be worn on the front portion of the employee's body. The licensee shall maintain a record of all employee badges assigned, which shall be available for inspection by any peace officer, or representative of the department. The record shall include the employee's full name and address and a driver's license or similar identification number.

**R81-10D-6. Age Verification - Taverns.**

(1) Authority. 32B-1-402, -405, and -407.

(2) Purpose.

(a) 32B-1-407 requires tavern licensees to verify proof of age of persons who appear to be 35 years of age or younger either by an electronic age verification device, or an acceptable alternate process established by commission rule.

(b) This rule:

(i) establishes the minimum technology specifications of electronic age verification devices; and

(ii) establishes the procedures for recording identification that cannot be electronically verified; and

(iii) establishes the security measures that must be used by the tavern licensee to ensure that information obtained is used only to verify proof of age and is not disclosed to others except to the extent authorized by Title 32B.

(3) Application of Rule.

(a) An electronic age verification device:

(i) shall contain:

(A) the technology of a magnetic stripe card reader;

(B) the technology of a two dimensional ("2d") stack symbology card reader; or

(C) an alternate technology capable of electronically verifying the proof of age;

(ii) shall be capable of reading:

(A) a valid state issued driver's license;

(B) a valid state issued identification card;

(C) a valid military identification card; or

(D) a valid passport;

(iii) shall have a screen that displays no more than:

(A) the individual's name;

(B) the individual's age;

(C) the number assigned to the individual's proof of age by the issuing authority;

(D) the individual's the birth date;

(E) the individual's gender; and

(F) the status and expiration date of the individual's proof of age; and

(iv) shall have the capability of electronically storing the following information for seven days (168 hours):

(A) the individual's name;

(B) the individual's date of birth;

(C) the individual's age;

(D) the expiration date of the proof of age identification card;

(E) the individual's gender; and

(F) the time and date the proof of age was scanned.

(b) An alternative method of verifying an individual's proof of age when proof of age cannot be scanned electronically:

(i) shall include a record or log of the information obtained from the individual's proof of age including the following information:

(A) the type of proof of age identification document presented;

(B) the number assigned to the individual's proof of age document by the issuing authority;

(C) the expiration date of the proof of age identification document;

(D) the date the proof of age identification document was presented;

(E) the individual's name; and

(F) the individual's date of birth.

(c) Any data collected either electronically or otherwise:

(i) may be used by the licensee, and employees or agents of the licensee, solely for the purpose of verifying an individual's proof of age;

(ii) may be acquired by law enforcement, or other investigative agencies for any purpose under Section 32A-5-107;

(iii) may not be retained by the licensee in a data base for mailing, advertising, or promotional activity;

(iv) may not be retained to acquire personal information to make inappropriate personal contact with the individual; and

(v) shall be retained for a period of seven days from the date on which it was acquired, after which it must be deleted.

(d) Any person who still questions the age of the individual after being presented with proof of age, shall require the individual to sign a statement of age form as provided under 32B-1-405.

**KEY: alcoholic beverages**

**Date of Enactment or Last Substantive Amendment: 2011**

**Authorizing, and Implemented or Interpreted Law: 32B-2-202; 32B-1-407(5)**

**Career Service Review Office,  
Administration  
R137-1-2  
Definitions**

**NOTICE OF PROPOSED RULE  
(Amendment)**

DAR FILE NO.: 35089  
FILED: 07/19/2011

**RULE ANALYSIS**

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: This amendment is mandated by legislative action pursuant to H.B. 328 in the 2011 General Session.

SUMMARY OF THE RULE OR CHANGE: The rule change is a result of H.B. 328. To comply with legislative mandates, the Career Service Review Office (CSRO) will return to operating hours of 8:00 to 5:00, Monday through Friday. Since many grievances and decisions on those grievances are required to be filed within prescribed days, the section defining working day to include Fridays must be changed to be in compliance with law. Specifically, Section R137-1-2 needs to be changed to include Friday as a working day.

STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 63G-4-401 and Section 67-19a-401 and Section 67-19a-402

ANTICIPATED COST OR SAVINGS TO:

◆ THE STATE BUDGET: Changing the days during the week that CSRO filings and decisions will be issued will have no fiscal impact on operating costs.

◆ LOCAL GOVERNMENTS: The CSRO has no interactions with the local governments.

◆ SMALL BUSINESSES: The CSRO has no interactions with small businesses.

◆ PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES: None--Employees will now be able to file on Fridays. This will generate no additional costs for them.

COMPLIANCE COSTS FOR AFFECTED PERSONS: Employees will simply be able to file grievances on Fridays. This will generate no additional costs to them.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: This change will have no impact on the CSRO operations. As said it simply sets forth the days that filings and decision will be issued.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:  
CAREER SERVICE REVIEW OFFICE  
ADMINISTRATION  
ROOM 1120 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:

◆ Robert Thompson by phone at 801-538-3047, by FAX at 801-538-3139, or by Internet E-mail at [bthompson@utah.gov](mailto:bthompson@utah.gov)

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN AT 5:00 PM ON 09/14/2011

THIS RULE MAY BECOME EFFECTIVE ON: 09/21/2011

AUTHORIZED BY: Robert Thompson , Administrator

**R137. Career Service Review Office, Administration.****R137-1. Grievance Procedure Rules.****R137-1-2. Definitions.**

Terms defined in Section 63G-4-103 of the Utah Administrative Procedures Act (UAPA) are incorporated by reference within this rule. In addition, other terms which are used in this rule are defined below:

"Abandonment of Grievance" means either the voluntary withdrawal of a grievance or the failure by an employee to properly pursue a grievance through these grievance procedures.

"Administrative Review of the File" means an informal adjudicative proceeding according to Subsection 67-19a-403(3)(b).

"Administrator" means the incumbent in the position defined at Subsection 67-19a-101(1).

"Affidavit" means a signed and sworn statement offered for consideration in connection with a grievance proceeding.

"Affirmative Defense" means a responsive answer asserting facts in addition to those alleged that are legally sufficient to rebut asserted allegations.

"Appeal" means a formal request to a higher level of review of an unacceptable lower level decision.

"Appointing Authority" means the officer, board, commission, person or group of persons authorized to make appointments on personnel/human resource management matters in their respective agency.

"Burden of Moving Forward" means a party's obligation to present evidence on a particular issue at a particular time. The burden of moving forward may shift back and forth between the parties based on certain legal principles.

"Burden of Proof" means the obligation to prove affirmatively a fact or set of facts at issue between two parties. If proven, the opposing party then has a burden of proving any affirmative defense.

CSRO means the agency of state government that statutorily administers these grievance procedures according to Sections 67-19a-101 through 67-19a-406.

"Closing Argument" means a party's final summation of evidence and argument, which is presented at the conclusion of the hearing.

"Consolidation" means the combining of two or more grievances involving the same controversy for purposes of holding a joint hearing, proceeding, or administrative review.

"Continuance" means an authorized postponement or adjournment of a hearing until a later date, whether the date is specified or not.

"Declaratory Order" means a ruling that is explanatory in purpose; it is designed to clarify what before was uncertain or doubtful. A declaratory order constitutes a declaration of rights between parties to a dispute and is binding as to both present and future rights. It is an administrative interpretation or explanation of a right, statute, order or other legal matter under a statute, rule, or an order.

"Default" means an omission of or untimely failure to take or perform a required act in the processing of a grievance. It is the failure to discharge an obligation which results in a forfeiture.

"Deposition" means a form of discovery in which testimony of a witness is given under oath, subject to cross-examination, and recorded in writing, prior to the hearing.

"Discovery" means the prehearing process whereby one party may obtain from the opposing party, or from other individuals or entities, information regarding the witnesses to be called, the documents and exhibits to be used at the hearing, and the facts and information about the case.

"Evidentiary Hearing" means a proceeding of relative formality, though much less formal than a trial, in which witnesses may be heard and evidence is presented and considered. Specific issues of fact and of law are tried. Afterwards, ultimate conclusions of fact and of law are set forth in a written decision or order.

"Excusable Neglect" means the exercise of due diligence by a reasonably prudent person and constitutes a failure to take proper steps at the proper time, not in consequence of the person's own carelessness, inattention, or willful disregard in the processing of a grievance, but in consequence of some unexpected or unavoidable hindrance or accident.

"Extraordinary Circumstances" means factors not normally incident to or foreseeable during an administrative proceeding. It includes circumstances beyond a party's control that normal prudence and experience could not foresee, anticipate or provide for.

"File" means to submit a document, grievance, petition, or other paper to the CSRO as prescribed by these rules. The term "file" includes faxing and E-mailing.

"Filing Date" means the day that a document, grievance, petition, or other paper is recorded as having been received by the CSRO.

"Grievance Procedures" mean the grievance and appeal procedures codified at Sections 67-19a-101 through 67-19a-406 and promulgated through this rule.

"Grievant" means the person or party advancing one or more issues as a petitioner through these grievance procedures to the evidentiary/step 4 level.

"Group Grievance" means a grievance submitted and signed by two or more aggrieved employees. The term does not include "class action."

"Hearing" means the opportunity to be heard or present evidence in an administrative proceeding.

"Hearing Officer" means an impartial trier of facts appointed by the CSRO administrator and assigned to decide a particular grievance case at the evidentiary/step 4 level.

"Hearsay Evidence" means evidence not based upon a witness's personal knowledge as a direct observer of an event. Rather, hearsay evidence stems from the repetition of what a witness heard another person say. Hearsay's value rests upon the credibility of the declarant. Hearsay is a statement made outside of the hearing that is offered as evidence of the truth of matters asserted in the hearing.

"Initial Hearing" means a hearing conducted by the administrator to make an initial determination regarding timeliness, authority, jurisdiction, direct harm, standing and eligibility to advance a grievance issue to the evidentiary/step 4 level.

"Issuance" means the date on which a decision, order or ruling is signed and dated; it is not the date of mailing, or the date of the mailing certificate, nor the postal date. Date of issuance is the date specified according to Subsection 63G-4-401, of the UAPA.

"Joint Hearing" means the uniting of two or more grievances involving the same, similar, or related circumstances or issues to conduct a single hearing; also see "Consolidation."

"Jurisdiction" means the legal right and authority to hear and decide issues and controversies.

"Management Representative" means a person of managerial or supervisory status who is not subject to exclusion. Legal counsel is not included within the meaning of the term.

"Motion" means a request offered verbally or in writing for a ruling or to take some action.

"Motion to Dismiss" means a motion requesting that a grievance or appeal be dismissed because it does not state a claim for which the CSRO provides a remedy, or is in some other way legally insufficient.

"Notice" and "Notification" mean a proper written notice to the parties involved in a grievance procedural hearing or conference, setting forth date, time, location, and the issue to be considered.

"Pleadings" mean the formal written allegations of the parties that set forth their respective claims and defenses.

"Presiding Hearing Officer" means either the Administrator or designated evidentiary/step 4 hearing officer.

"Pro Se" means in one's own behalf. A person is represented pro se in an administrative proceeding when acting without legal counsel or other representation.

"Quash" means to cancel, annul, or vacate a subpoena.

"Relevant" means directly applying to the matter in question; pertinent, germane. It is evidence that tends to make the existence of any facts more probable or certain than they would be without the evidence; and tending to prove the precise fact at issue.

"Remand" means to send back, as for further deliberation and judgment, to the presiding official or other tribunal from which a grievance was appealed.

"Standard of Proof" means the evidentiary standard, which in CSRO adjudications is the substantial evidence standard.

"Stay" means a temporary suspension of a case or of some designated proceeding within the case. A stay is different than a continuance or extension of time and can only be granted when agreed to by the parties and when the administrator or assigned hearing officer finds a stay necessary for judicial economy and the interest of justice.

"Submit" means to commit to the discretion of another; to present for determination.

"Subpoena" means a formal legal document issued under authority to compel the appearance of a witness at an administrative proceeding, the disobedience of which may be punishable as a contempt of court.

"Subpoena Duces Tecum" means a formal legal document issued under authority to compel specific documents, books, writings, papers, or other items.

"Substantial Evidence" means evidence possessing something of substance and relevant consequence, and which furnishes substantial basis of fact from which issues tendered can be reasonably resolved. It is evidence that a reasonable mind might accept as adequate to support a conclusion, but is less than a preponderance.

"Summary Judgment" means a ruling made upon motion by a party or the presiding hearing officer when there is no dispute as to either material fact or inferences to be drawn from undisputed facts, or if only a question of law is involved. The motion may be directed toward all or part of a claim or defense.

"Transcript" means an official verbatim written record of an adjudicative proceeding or any part thereof, which has been recorded and subsequently transcribed by a certified court reporter.

"UAPA" means the Utah Administrative Procedures Act found at Sections 63G-4-102 through 63G-4-601.

"Withdraw" means to recall or retract a grievance from further consideration under these grievance procedures.

"Witness Fee" means an appearance fee and may also include a mileage rate established by statutory provision pursuant to Section 78B-1-119.

"Working Days" means for purposes of the time periods for filing a grievance, advancing an appeal or responding to an employee's grievance or appeal, all days except [Fridays,] Saturdays, Sundays and recognized State holidays.

**KEY: grievance procedures**

**Date of Enactment or Last Substantive Amendment:** [~~July 1, 2010~~]**2011**

**Notice of Continuation:** July 18, 2011

**Authorizing, and Implemented or Interpreted Law:** 34A-5-106; 67-19-16; 67-19-30; 67-19-31; 67-19-32; 67-19a et seq.; 63G-4 et seq.

**Commerce, Occupational and  
Professional Licensing  
R156-38b  
State Construction Registry Rule**

**NOTICE OF PROPOSED RULE**

(Amendment)

DAR FILE NO.: 35102

FILED: 08/01/2011

**RULE ANALYSIS**

**PURPOSE OF THE RULE OR REASON FOR THE CHANGE:** This filing: 1) implements changes made by H.B. 115 and H.B. 260, passed by the Utah Legislature in the 2011 General Session; 2) updates the rule to codify current practices of Utah Interactive, the Division's designated agent for the State Construction Registry (SCR); 3) updates statutory citations; 4) revises rule numbering; and 5) makes other technical changes.

**SUMMARY OF THE RULE OR CHANGE:** In Section R156-38b-102, the definition of "private project" is added to reflect statutory changes. In Section R156-38b-103, updated statute citation reference. In Section R156-38b-402, existing language is modified to reflect recent technical improvements that have improved the SCR user account creation process. In Sections R156-38b-501 through R156-38b-504, the provisions rendered obsolete or redundant by current statute are removed. The scope of provisions is broadened to

describe all SCR notices. Provisions are consolidated into basic principles for better application to an expanded number of SCR filings. Remaining provisions are renumbered and reorganized. In Section R156-38b-505, adds references to reflect current statute. In Subsection R156-38b-507(2), there is a minor wording change. Section R156-38b-508 is being deleted due to obsolete language. In Section R156-38b-509, the term "cancel" is modified to "withdraw" to reflect changes in the governing statute. Section R156-38b-510 is being deleted due to obsolete language. In Section R156-38b-601, the subsection numbering is corrected. Subsection R156-38b-602(2) is deleted due to obsolete language. In Sections R156-38b-603 and R156-38b-604, minor wording corrections are made. Section R156-38b-701 is being deleted due to redundant language. In Subsection R156-38b-702(2)(c), the word "canceled" is replaced with "withdrawn".

STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Subsection 38-1-30(3)

ANTICIPATED COST OR SAVINGS TO:

◆ THE STATE BUDGET: The Division anticipates no costs or savings to the state budget as a result of this proposed rule filing. Development and administrative costs are born by the designated agent, Utah Interactive, and shall be offset by SCR filing fees.

◆ LOCAL GOVERNMENTS: The Division anticipates no costs or savings to local governments as a result of this proposed rule filing as the filing imposes no additional requirements for compliance.

◆ SMALL BUSINESSES: Original contractors who wish to maintain lien rights on private projects will be required to file a Preliminary Notice and pay a \$1.25 fee. Previously, an original contractor's lien rights were held inviolate by the SCR. This cost will translate into an additional \$15 annually for an original contractor who wishes to maintain lien rights on 12 projects. Protecting lien rights on 100 jobs would cost the original contractor \$125. Subcontractors and suppliers will pay \$1.25 to file a Preliminary Notice rather than \$1. This additional cost will translate into an additional \$30 annually for a subcontractor who wishes to maintain lien rights on 120 projects. Protecting lien rights on 3,000 jobs would cost a supplier an additional \$750. Office staff wages and other related overhead costs will decrease due to quicker filing procedures and decreased ambiguity. Wages and other related overhead costs for title companies will decrease due to increased reliability, decreased ambiguity, and the integration of tax parcel identification numbers. Construction lenders will be required to file a notice of construction loan after recording a mortgage or trust deed on a private project. This filing requires an \$8 fee and would translate into a cost of \$800 for a lender who files 100 notices and \$48,000 for a lender who files 6,000 notices.

◆ PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES: Original contractors who wish to maintain lien rights on private projects will be required to file a Preliminary Notice and pay a \$1.25 fee. Previously, an original contractor's lien rights were held inviolate by the SCR. This cost will translate

into an additional \$15 annually for an original contractor who wishes to maintain lien rights on 12 projects. Protecting lien rights on 100 jobs would cost the original contractor \$125. Subcontractors and suppliers will pay \$1.25 to file a Preliminary Notice rather than \$1. This additional cost will translate into an additional \$30 annually for a subcontractor who wishes to maintain lien rights on 120 projects. Protecting lien rights on 3,000 jobs would cost a supplier an additional \$750. Office staff wages and other related overhead costs will decrease due to quicker filing procedures and decreased ambiguity. Wages and other related overhead costs for title companies will decrease due to increased reliability, decreased ambiguity, and the integration of tax parcel identification numbers. Construction lenders will be required to file a notice of construction loan after recording a mortgage or trust deed on a private project. This filing requires an \$8 fee and would translate into a cost of \$800 for a lender who files 100 notices and \$48,000 for a lender who files 6,000 notices.

COMPLIANCE COSTS FOR AFFECTED PERSONS:

Original contractors who wish to maintain lien rights on private projects will be required to file a Preliminary Notice and pay a \$1.25 fee. Previously, an original contractor's lien rights were held inviolate by the SCR. This cost will translate into an additional \$15 annually for an original contractor who wishes to maintain lien rights on 12 projects. Protecting lien rights on 100 jobs would cost the original contractor \$125. Subcontractors and suppliers will pay \$1.25 to file a Preliminary Notice rather than \$1. This additional cost will translate into an additional \$30 annually for a subcontractor who wishes to maintain lien rights on 120 projects. Protecting lien rights on 3000 jobs would cost a supplier an additional \$750. Office staff wages and other related overhead costs will decrease due to quicker filing procedures and decreased ambiguity. Wages and other related overhead costs for title companies will decrease due to increased reliability, decreased ambiguity, and the integration of tax parcel identification numbers. Construction lenders will be required to file a notice of construction loan after recording a mortgage or trust deed on a private project. This filing requires an \$8 fee and would translate into a cost of \$800 for a lender who files 100 notices and \$48,000 for a lender who files 6,000 notices.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES:

This rule filing implements recent statutory amendments, including setting fees required by statute, corrects statutory references, renumbers and reorganizes provisions and makes other technical amendments. No fiscal impact to businesses is anticipated from these changes.

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

COMMERCE  
OCCUPATIONAL AND PROFESSIONAL  
LICENSING  
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:  
 ♦ Tom Harper by phone at 801-530-6288, by FAX at 801-530-6511, or by Internet E-mail at tharper@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN AT 5:00 PM ON 09/14/2011

INTERESTED PERSONS MAY ATTEND A PUBLIC HEARING REGARDING THIS RULE:  
 ♦ 09/12/2011 09:00 AM, Heber Wells Bldg, 160 E 300 S, Conference Room 210, Salt Lake City, UT

THIS RULE MAY BECOME EFFECTIVE ON: 09/21/2011

AUTHORIZED BY: Mark Steinagel, Director

**R156. Commerce, Occupational and Professional Licensing.**  
**R156-38b. State Construction Registry Rule.**  
**R156-38b-102. Definitions.**

In addition to the definitions in Section 38-1-27, State Construction Registry -- Form and contents of notice of commencement, preliminary notice, and notice of completion; Title 58, Chapter 1, Division of Occupational and Professional Licensing Act; and Rule R156-1, General Rule of the Division of Occupational and Professional Licensing; which shall apply to these rules, as used in the referenced statutes or this rule:

- (1) "Alternate method or process" means transmission by telefax, by U.S. mail, or by private commercial courier.
- (2) "Electronic" or "Electronically" means transmission by Internet or by electronic mail and does not mean a transmission by alternate methods or process.
- (3) "J2EE" means SUN Microsystem's Java 2 Platform, Enterprise Edition, for multi-tier server-oriented enterprise applications.
- (4) "Merge" means to link two or more filings together under a unique project number as required by Subsection [38-1-31(1)(d)]38-1-31.5(3)(a).
- (5) "Private project" means a construction project, commenced after July 31, 2011, that is not a government project.
- ([5]6) "SCR" means the State Construction Registry established in Sections 38-1-27 and 38-1-30 through 38-1-[37]36.

**R156-38b-103. Authority - Purpose.**

This rule is adopted by the Division under the authority of Sections 38-1-27 and 38-1-30 through 38-1-[37]36 to administer the SCR.

**R156-38b-402. User Identification and Password.**

- (1) All users are required to register with the SCR.
- (2) The Division shall issue [and be assigned] a unique user ID and password to each user who successfully registers to use [gain access to] the SCR.

\_\_\_\_\_ (3) The information gathered in the registration process shall be maintained in the SCR as the user profile.

\_\_\_\_\_ (4) The registration process shall include the following information and any other information established by the Division in collaboration with the designated agent:

- (a) first and last name of the individual registering; and
- (b) [entity name if the individual represents an entity, and any DBA name(s);
- ~~\_\_\_\_\_ (c) individual's position or title if the individual represents an entity;~~
- ~~\_\_\_\_\_ (d) mailing address;~~
- ~~\_\_\_\_\_ (e) phone number;~~
- ~~\_\_\_\_\_ (f) ]email address, if any[;~~
- ~~\_\_\_\_\_ (g) preferred method of submitting payment to the SCR, as defined in a pre-populated pick list].~~
- ([2]5) The SCR shall provide the ability for a user to view and modify the user's profile.
- ([3]6) The SCR shall provide an industry accepted secure method for a user to recover a forgotten user ID or password.
- ([4]7) The SCR shall pre-populate filings with any information available in the user's profile. [

~~\_\_\_\_\_ (5) The account will not be effective until the fee, established by the Division in collaboration with the designated agent, is received.]~~

**R156-38b-501. Required Information for SCR Filing Notices.**

(1) Electronic notice filings shall be input into the SCR entry screen by the person making the filing but shall not be accepted by the SCR unless the person complies with the content requirements for filing a preliminary notice.

(2) The SCR shall verify that data is submitted for each of the content requirements, but it is not responsible for the accuracy, suitability, or coherence of the data.

**R156-38b-[501]502. Merging Notices of Commencement.**

~~\_\_\_\_\_ (1) Content Requirements. The content of notices of commencement shall be in accordance with Subsection 38-1-31(2).~~

~~\_\_\_\_\_ (2) Persons Who Must File Notices. In accordance with Subsections 38-1-31(1)(a) and (b), the following are required to file a notice of commencement:~~

~~\_\_\_\_\_ (a) For a construction project where a building permit is issued, within 15 days after the issuance of the building permit, the local government entity issuing that building permit shall input the data and transmit the building permit information to the database electronically or by alternate method and such building permit information shall form the basis of a notice of commencement. The local government entity may not transfer this responsibility to the person who is issued or is to be issued the building permit.~~

~~\_\_\_\_\_ (b) For a construction project where a building permit is not issued, within 15 days after commencement of physical construction work at the project site, the original contractor shall file a notice of commencement with the SCR.~~

~~\_\_\_\_\_ (3) Persons Who May File Notices.~~

~~\_\_\_\_\_ (a) In accordance with Subsection 38-1-31(1)(c), an owner of a construction project or original contractor may but is not required to file a notice of commencement with the designated agent within the prescribed time set forth in Subsection 38-1-31(1)(a) or (b).~~

~~\_\_\_\_\_ (b) The parties identified in R156-38b-501(3)(a) may authorize a third party to file a notice of commencement on its behalf, as established in Subsection 38-1-27(9).~~

~~\_\_\_\_\_ (4) Methodology.~~

~~\_\_\_\_\_ (a) Electronic notice of commencement filings shall be input into the SCR by the person making the filing and shall not be accepted by the SCR unless the person complies with the content requirements for filing a notice of commencement.~~

~~\_\_\_\_\_ (b) Alternate method notice of commencement filings shall be in accordance with this Section and Section R156-38-505.~~

~~\_\_\_\_\_ (e)1) Checking for Existing Notices. In order to prevent duplicate filings of notices of commencement on government projects, [a search of]the SCR shall [be performed]search its database for any existing notices of commencement [and existing filed amendments]before allowing a use to create[creating] a new notice of commencement[for a project].~~

~~\_\_\_\_\_ (i)1a) If an existing notice of commencement is identified the following procedures apply:~~

~~\_\_\_\_\_ (A)1i) For an electronic filing[by the person attempting to file the new notice of commencement,]~~

~~\_\_\_\_\_ (A) the SCR shall indicate that a notice of commencement may have already been filed for the project and display the possible notice or notices of commencement that may match the existing project filing.~~

~~\_\_\_\_\_ (B) The SCR shall allow the user to review the content of any existing notices to determine whether a notice has already been filed for the project before allowing a new notice to be filed.~~

~~\_\_\_\_\_ (1) If a notice of commencement already exists for the project but the person attempting to file the notice of commencement believes the content of the filing is not accurate, the person shall be given the option of submitting amendments to the content of the notice. The SCR shall reflect the submission date of the amendments, but the filing date of the notice shall remain unchanged. If the person attempting to file the new notice of commencement believes the existing notice is accurate, the system shall permit the proposed new filing to be terminated.~~

~~\_\_\_\_\_ (B)1ii) For an alternate method filing, [input by the designated agent for the person filing the notice of commencement,]the designated agent shall notify the [person]filer by electronic or alternate method as specified by the filer, that a notice of commencement has already been filed for the particular project and include a copy of the existing notice of commencement.[—In addition, the user will be notified that the notice of commencement will be added to the construction project as an amendment to the original filing in the SCR and the appropriate fee will be charged.]~~

~~\_\_\_\_\_ (ii)1b) As part of the process described in Subsection R156-38b-[501(4)(e)(i)]502(1), the SCR search for an existing notice of commencement shall display, for review by the person who submitted the search parameters, all notice of commencement filings that fit the search parameters indicated by the submission that prompted the search.[—The purpose of this requirement is to enable the person to properly identify any existing notice of commencement before a new notice of commencement is created, to avoid duplicate notice of commencement filings.]~~

~~\_\_\_\_\_ (iii)1c) If no existing notice of commencement is identified for the particular project, the SCR shall allow the person who submitted the filing to file a new notice of commencement.~~

~~\_\_\_\_\_ (d) Creation of New Notices.~~

~~\_\_\_\_\_ (i) A new notice of commencement shall not be accepted into the SCR until the SCR system has checked for an existing notice in accordance with the procedures outlined in Subsection R156-38b-501(4).~~

~~\_\_\_\_\_ (ii) In accordance with Subsection 38-1-31(1)(d), when a new notice of commencement filing is accepted into the SCR, the SCR shall assign the project a unique project number that identifies the project and can be associated with all future notices of commencement, preliminary notices, notices of completion, and requests for notification applicable to the project.]~~

~~\_\_\_\_\_ (e)2) Merging of Duplicate Filings. Duplicate filings shall be avoided to the extent possible in accordance with the procedure outlined in this Subsection. The SCR shall include functionality to allow a person who has successfully filed[—amended or corrected] a notice of commencement which duplicates another notice of commencement already in the SCR to merge the notice of commencement with the existing notice of commencement filing.~~

~~\_\_\_\_\_ (i)1a) The SCR shall reflect the effective date of the merger.~~

~~\_\_\_\_\_ (ii)1b) The SCR shall provide notification of the merger to all persons who are associated with either notice of commencement filing, including those who have filed preliminary notices.~~

~~\_\_\_\_\_ (iii)1c) The effective date of a merger reflects the date the unique merger number was cross-referenced to duplicate notice of commencement filings. A merger does not dissolve or affect the filing dates, or the consequences of the filing dates, of the notices being combined.]~~

~~\_\_\_\_\_ (f) Resolving Multiple or Inconsistent Property Descriptions.]~~

~~\_\_\_\_\_ (i)2) The person making a notice [of commencement] filing shall be responsible for correctly identifying a project, and for the consequences of failing to correctly identify a project.]~~

~~\_\_\_\_\_ (ii) Neither the Division nor the designated agent shall be responsible for the consequences of a person making a notice of commencement filing that identifies a project in such a way that the SCR is unable to identify an existing notice of commencement for the project, according to the search criteria established by the Division in collaboration with the designated agent, nor for the SCR allowing the person to make a successful duplicate notice of commencement filing with a different description of the project.]~~

#### **R156-38b-502. Preliminary Notices.**

~~\_\_\_\_\_ (1) A person who wishes to file a preliminary notice may authorize a third party to file the notice on the person's behalf, as established in Subsection 38-1-27(9).~~

~~\_\_\_\_\_ (2) Content Requirements. The content of a Preliminary Notice shall be in accordance with Subsection 38-1-32(1)(d).~~

~~\_\_\_\_\_ (3) Methodology.~~

~~\_\_\_\_\_ (a) Electronic preliminary notice filings shall be input into the SCR entry screen by the person making the filing but shall not be accepted by the SCR unless the person complies with the content requirements for filing a preliminary notice. The SCR is responsible for requiring that some data be submitted for each of the content requirements, but it is not responsible for the accuracy, suitability or coherence of the data.~~

~~(b) Alternate method preliminary notice filings shall be in accordance with Section R156-38b-505.~~

~~(c) Preliminary notice filing submitted before notice of commencement filing.~~

~~(i) A preliminary notice for a project may not be filed until the project has an existing notice of commencement. A person who attempts to submit a preliminary notice filing before a notice of commencement has been filed may either:~~

~~(A) file the notice of commencement as an interested party to enable the filing of the preliminary notice; or~~

~~(B) wait for the notice of commencement to be filed by someone else to enable the filing of his or her preliminary notice.~~

~~(i) A person who attempts to submit a preliminary notice filing before a notice of commencement has been filed and who can identify the project, using the building permit number or other identifier adopted by the Division in collaboration with the designated agent, may request notification of the filing of a notice of commencement for the project.~~

~~(ii) A preliminary notice filing that is not accepted by the SCR because it is submitted before a notice of commencement has been filed shall be in accordance with Section R156-38b-507.~~

#### **R156-38b-503. Notices of Completion.**

~~(1) Persons Who May File Notices.~~

~~(a) In accordance with Subsection 38-1-33(1)(a)(i), the owner, original contractor, lender, title company or surety associated with the construction project may file a notice of completion.~~

~~(b) The parties identified in R156-38b-503(1)(a)(i) may authorize a third party to file the notice on its behalf, as established in Subsection 38-1-27(9).~~

~~(2) Content Requirements. The content of a Notice of Completion shall be in accordance with Section 38-1-33(1)(d).~~

~~(3) Methodology.~~

~~(a) Electronic notice of completion filings shall be input into the SCR input screen by the person making the filing but shall not be accepted by the SCR unless the person complies with the content requirements for filing a notice of completion. The SCR is responsible for requiring that some data be submitted for each of the content requirements, but it is not responsible for validating the accuracy, suitability or coherence of the data.~~

~~(b) Alternate method notice of completion filings shall be in accordance with Section R156-38b-505.~~

#### **R156-38b-504. Required Notifications and Requests for Notifications.**

~~(1) Required Notifications. The designated agent or the SCR shall send the following required notifications:~~

~~(a) notification of the filing of a notice of commencement to a person who has filed a notice of commencement for the project, as required by Subsection 38-1-31(4)(a);~~

~~(b) notification of the filing of a preliminary notice to the person who filed the preliminary notice, as required by Subsection 38-1-32(2)(a)(i);~~

~~(c) notification of the filing of a preliminary notice to each person who filed a notice of commencement for the project, as required by Subsection 38-1-32(2)(a)(ii);~~

~~(d) notification of the filing of a notice of completion to each person who filed a notice of commencement for the project, as required by Subsection 38-1-33(1)(d)(i)(A); and~~

~~(e) notification of the filing of a notice of completion to each person who filed a preliminary notice for the project, as required by Subsection 38-1-33(d)(d)(i)(B).~~

~~(2) Permissible Requests for Notifications. The following requests for notifications may be submitted to the SCR:~~

~~(a) requests by any interested person who requests notification of the filing of a notice of commencement for a project, as permitted by Subsection 38-1-31(4)(b);~~

~~(b) requests by any interested person who requests notification of the filing of a preliminary notice, as permitted by Subsection 38-1-32(2)(a)(iii); and~~

~~(c) requests by any interested person who requests notification of the filing of a notice of completion, as permitted by Subsection 38-1-33(1)(d)(i)(C).~~

~~(3) Content Requirements for Requests for Notification. The content of a request for notification shall include:~~

~~(i) identification of the project by a method designated by the Division in collaboration with the designated agent;~~

~~(ii) name of the requestor;~~

~~(iii) the filing for which notification is requested; and~~

~~(iv) an electronic or alternate method address or telefax number for a response;~~

~~(4) Methodology.~~

~~(a) Automatic Response System. The SCR shall, to the extent practicable, be designed to require or generate the necessary information to support an automatic response system and documentation of automatic response system in order to handle requests for and required sending of notifications.~~

~~(b) Necessary Information. The information to be required from filers or generated to enable an automatic response system and documentation of response system shall include:~~

~~(i) the date requests for notification were accepted;~~

~~(ii) the method by which requests for notification are to be sent;~~

~~(iii) unique identification of the construction project;~~

~~(iv) the date a notification is sent in response to a requests for notification; and~~

~~(v) the mailing address, electronic mail address, or telefax number used to respond to a request for notification.~~

~~(c) Electronic Requests. Electronic requests shall be responded to electronically unless directed otherwise by the person filing the request.~~

~~(d) Alternate Method or Process Requests. Alternate method requests shall be responded to in the method requested by the requestor.]~~

#### **R156-38b-505. Alternate Filings.**

~~(1) Alternate Methods of Filing. The alternate methods of filing are those established by Subsections 38-1-27(2)(c)(ii), [i.e.,]including U.S. Mail and telefax. Private commercial courier is established as an additional alternate method of receipt by the designated agent, but not dispatch from the designated agent.~~

~~(2) Content Requirements. The content requirements for alternate method filings shall be the same as for electronic filings as set forth for Notices [of Commencement, Preliminary Notices, and Notices of Completion] in Sections 38-1-30.5, 30-1-30.7, 38-1-31, 38-1-31.5, 38-1-32, 38-1-32.7, [and] 38-1-33, and 38-1-40 [respectively,] or this rule.~~

(3) Format Requirements. Alternate method filings shall be submitted in a standard format adopted by the Division in collaboration with the designated agent. Filings not submitted in the standard format, in the sole judgment of the designated agent, shall be rejected and dispatched to the submitter. The filing fee shall be retained by the designated agent as a processing fee for rejecting and dispatching the filing. An additional filing fee shall be due upon resubmission.

(4) Methodology.

(a) U.S. Mail. An alternate method filing by U.S. Mail shall be submitted to the designated agent's mailing address by any method of U.S. Mail.

(b) Express Mail. An alternate method filing by commercial private courier shall be submitted to the designated agent's mailing address by any commercially available method of express mail.

(c) Telefax. An alternate method filing by telefax shall be submitted to the designated agent's toll-free unique SCR fax number.

(5) Processing Requirements.

(a) Transaction Receipt. The designated agent shall confirm a successful alternate method filing and fee payment receipt by sending a transaction receipt as specified in Section R156-38b-602.

(b) Creation of Electronic Image. The designated agent shall create and maintain an electronic image of alternate method filings that are accepted into the SCR. Once an electronic image has been created and the accepted alternate method filing has been entered into the SCR, the original version of the accepted alternate method filing may be destroyed. The electronic image shall remain accessible for audit purposes.

(6) Data Entry Standards.

(a) The designated agent shall meet or exceed the following data entry standards for alternate filings:

(i) a primary operator shall manually input information required by Subsection 38-1-31~~(2)(a)~~(1)(a)(i);

(ii) a secondary operator shall independently input the construction project permit number and original contractor name;

(iii) the designated agent shall automatically compare all entries from the primary and secondary operators for consistency;

(iv) following the above procedures, the designated agent shall visually inspect at least 5% of all notices created by alternate filing; and

(v) these standards are to be met prior to Internet publication.

**R156-38b-507. Status of and Process for Filings Not Accepted by the SCR.**

(1) A filing that is not accepted by the SCR shall not be considered to be filed.

(2) The SCR shall electronically indicate to a person whose electronic filing is not accepted that the filing is not accepted and the reason or reasons why it is not accepted. The SCR shall allow the person making the electronic filing attempt to correct ~~the defect or~~ any defects, if possible.

(3) The designated agent shall notify a person whose alternate method filing is not accepted that the filing is not accepted and the reason or reasons why it is not accepted. The designated

agent shall allow the person making the alternate filing to correct the defect or defects.

(4) A fee payment received with a filing submitted by alternate process that is not accepted shall be retained by the designated agent as the processing fee for handling the incomplete filing.

(5) For auditing purposes, the SCR shall maintain a record of all processing fees received with filings submitted by alternate process that are not accepted.[]

**R156-38b-508. Correction of Filings.**

~~\_\_\_\_\_ (1) A person who submits a filing may submit a correction of the filing electronically or by alternate filing.~~

~~\_\_\_\_\_ (2) A correction of filing shall not require a new fee payment unless submitted by alternate process or by a method of electronic process that requires manual input by the designated agent.~~

~~\_\_\_\_\_ (3) A correction of filing shall not affect the date of filing for the filing being corrected. The date of filing for the correction of filing shall be as specified in Section R156-38b-506.~~

~~\_\_\_\_\_ (4) Notification of the correction of filing shall be provided to the same persons as required for the filing being corrected.]~~

**R156-38b-509. [Cancellation]Withdrawal of Filings.**

(1) In accordance with Subsections 38-1-32([3]6) and 38-1-33(2), the SCR shall, upon request of a person who filed an accepted ~~[preliminary]notice filing [or notice of completion,]~~ allow[:

~~\_\_\_\_\_ (i) a]the person [who completed a filing who electronically requests cancellation of the filing-]to designate the filing as withdrawn.~~[canceled; and~~~~

~~\_\_\_\_\_ (ii) a person who completed a filing who by alternate process requests cancellation of the filing to have the filing placed in a canceled by the designated agent.]~~

(2) Notification of ~~[the cancellation of-]~~a filing withdrawal shall be provided to the same persons as required for the original successful filing.

(3) A ~~[canceled]~~withdrawn filing shall indicate that the filing is no longer given effect.

(4) A ~~[canceled]~~withdrawn filing may not be restored, but must be filed as a new filing in accordance with Sections 38-1-32 or 38-1-33.[]

**R156-38b-510. Data Contained in the SCR.**

~~\_\_\_\_\_ The SCR is intended as a public repository of the information contained in the filings required or permitted by law. The SCR has the responsibility to post but not validate the accuracy, suitability or coherence of the information received in filings included within the SCR.]~~

**R156-38b-601. Fee Payment Methods.**

(1) Pay-as-you-go Account. Payments may be made online by a credit card transaction in the amount established by the Division in collaboration with the designated agent. For alternate method filings, users will have the option of sending in a check or credit card information with their filing.

(2) Monthly Accounts. Payments may be made by a monthly account as specified by the Division in collaboration with the designated agent, as follows:

(i)a) an account in which the designated agent charges monthly fees to a credit card or bank account designated and authorized by the registered user; or

(ii)b) an account, guaranteed by a credit card, in which the designated agent sends a monthly invoice to be paid by the registered user within 30 days.

**R156-38b-602. Transaction Receipts.**

(1) In accordance with Subsection 38-1-27(2)(g), the SCR shall make available a transaction receipt upon acceptance of a filing into the SCR. The receipt shall indicate:

- (a) the amount of any fee payment being processed;
- (b) that the filing is accepted by the SCR;
- (c) the date and time of the filing's acceptance; and
- (d) the content of the accepted filing.

(2) ~~It shall be the responsibility of the person making an electronic filing to print out a transaction receipt, if the person wishes a hard copy of the receipt.~~

~~(3)~~ The designated agent shall send a transaction receipt to a person who submits a filing by alternate method that is accepted.

**R156-38b-603. Fee Payment Accounting.**

The designated agent shall ~~be responsible for~~ keep ~~ing~~ accurate records to account for all fee payments, including filing fee payments and registration payments for access to SCR data. The designated agent shall make its accounting records available to the Division upon notification for auditing purposes.

**R156-38b-604. Fee Payment Collection.**

The designated agent shall ~~be responsible for~~ conduct ~~ing~~ or contract ~~ing~~ for all fee payment collection activities and shall document or require to be documented such activities. The designated agent shall make its collection activity records available to the Division upon notification, for auditing purposes.

**~~R156-38b-701. Indexing of State Construction Registry.~~**

~~The SCR shall be indexed in accordance with Subsection 38-1-27(3)(b).~~

**R156-38b-702. Archiving Requirements.**

(1) In accordance with Subsection 38-1-30(4)(a), the designated agent shall archive the SCR computer data files semi-annually for auditing purposes.

(2) In accordance with Subsection 38-1-30(4)(c), filings shall be archived as follows:

- (a) one year after the day on which a notice of completion is accepted into the SCR;
- (b) if no notice of completion is filed, two years after the last filing activity for a project; or
- (c) one year after the day on which a filing is ~~annulled~~ withdrawn under Subsection 38-1-32(~~3~~6)(c) or 38-1-33(2)(c).

(3) For purposes of this section, "archive" means to preserve an original or a copy of computer data files and filings separate from the active SCR.

(4) The designated agent shall maintain a transaction log of archived filings and make it available to the Division upon request for auditing purposes.

**KEY: electronic preliminary lien filing, notice of commencement, preliminary notice, notice of completion**  
**Date of Enactment or Last Substantive Amendment: ~~[August 16, 2010]~~2011**

**Notice of Continuation: February 8, 2010**

**Authorizing, and Implemented or Interpreted Law: 38-1-30(3)**

**Commerce, Real Estate**  
**R162-2g-304d**  
**Experience Hours**

**NOTICE OF PROPOSED RULE**

(Amendment)

DAR FILE NO.: 35090

FILED: 07/21/2011

**RULE ANALYSIS**

**PURPOSE OF THE RULE OR REASON FOR THE CHANGE:** The purpose of this amendment is to specify a requirement applicable to a mass appraiser applying for certification as a residential appraiser.

**SUMMARY OF THE RULE OR CHANGE:** In submitting sample appraisals for review, a mass appraiser who applies for certification as a residential appraiser must include at least one appraisal of each of the following residential property types: vacant property, a two- to four-unit dwelling, a non-complex single-family unit, and a complex single-family unit.

**STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE:** Subsection 61-2g-201(2)(h)

**ANTICIPATED COST OR SAVINGS TO:**

- ◆ **THE STATE BUDGET:** The Division already has in place the budget necessary to review appraisals that are submitted by mass appraisers seeking certification. No additional administrative burden is created by requiring those applicants to submit appraisals that represent a variety of property types. Therefore, no impact to the state budget is anticipated.
- ◆ **LOCAL GOVERNMENTS:** Local government is not required to comply with or enforce the appraisal rules. Therefore, no fiscal impact to local government is anticipated from this rule filing.

♦ **SMALL BUSINESSES:** Small businesses do not apply for appraiser licensure or certification. Therefore, this rule filing is inapplicable to small businesses, and no fiscal impact to small businesses is anticipated.

♦ **PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES:** An affected person must perform appraisals of several different property types. Doing so does not require the person to do anything with which a cost is associated—for example, taking specialized education or paying fees. Therefore, no cost to affected persons is anticipated.

**COMPLIANCE COSTS FOR AFFECTED PERSONS:** To comply, an affected person must perform appraisals of several different property types. There are no associated compliance costs.

**COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES:** This rule filing clarifies the types of appraisals a mass appraiser applicant for certification as a residential appraiser must submit along with the application. No fiscal impact to businesses is anticipated from this clarification.

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

COMMERCE  
REAL ESTATE  
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:**

♦ Jennie Jonsson by phone at 801-530-6706, by FAX at 801-526-4387, or by Internet E-mail at [jjonsson@utah.gov](mailto:jjonsson@utah.gov)

**INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN AT 5:00 PM ON 09/14/2011**

**THIS RULE MAY BECOME EFFECTIVE ON: 09/21/2011**

**AUTHORIZED BY: Deanna Sabey, Director**

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**R162. Commerce, Real Estate.**

**R162-2g. Real Estate Appraiser Licensing and Certification Administrative Rules.**

**R162-2g-304d. Experience Hours.**

(1)(a) Except as provided in this Subsection (1)(b), appraisal experience shall be measured in hours according to the appraisal experience hours schedules found in Appendices 1 through 3.

(b)(i) An applicant who has experience in categories other than those shown on the appraisal experience hours schedules, or who believes the schedules do not adequately reflect the applicant's experience or the complexity or time spent on an appraisal, may petition the board on an individual basis for evaluation and approval

of the experience as being substantially equivalent to that required for licensure or certification.

(ii) Upon a finding that an applicant's experience is substantially equivalent to that required for licensure or certification, the board may award the applicant an appropriate number of hours for the alternate experience.

(2) General restrictions.

(a) An applicant may not accrue more than 2,000 experience hours in any 12-month period.

(b) The board may not award credit:

(i) for appraisal experience earned more than five years prior to the date of application;

(ii) for appraisals that were performed in violation of:

(A) Utah law;

(B) the law of another jurisdiction; or

(C) the administrative rules adopted by the division and the board;

(iii) for appraisals that fail to comply with USPAP;

(iv) for appraisals of the value of a business as distinguished from the appraisal of commercial real estate; or

(v) for personal property appraisals.

(c) At least 50% of the appraisals submitted for experience credit shall be appraisals of properties located in Utah.

(d) With regard to experience hours claimed from the schedules found in Appendices 1 and 2:

(i) appraisals where only an exterior inspection of the subject property is performed shall be granted 25% of the credit awarded an appraisal that includes an interior inspection of the subject property; and

(ii) no more than 25% of the total experience required for licensure or certification may be earned from appraisals where the interior of the subject property is not inspected.

(e) A maximum of 250 experience hours may be earned from appraisal of vacant land.

(f) Appraisals on commercial or multi-unit form reports shall be awarded 75% of the credit normally awarded for the appraisal.

(g)(i) If an applicant's education was approved prior to January 1, 2008 and his or her experience was approved prior to January 1, 2011 (under a system referred to by the division and industry as a segmented application), but the applicant did not pass the applicable examination required for licensure or certification by December 31, 2010, the applicant shall, by December 31, 2011:

(A) complete all additional education, as required under the AQB standards;

(B) pass the required examination applicable to the license or certification being sought by the individual; and

(C) submit a complete application to the division.

(ii) An applicant who fails to comply with the December 31, 2011 deadline established in this Subsection (2)(g)(i) shall:

(A) complete all additional education as required under the AQB standards;

(B) pass the required examination applicable to the license or certification sought by the individual;

(C) submit recent appraisals that meet the requirements of all applicable statutes and rules for review by the experience review committee; and

(D) submit a complete application to the division according to deadlines established in Subsection R162-2g-304f(1).

(3) Specific restrictions applicable to trainees applying for licensure.

(a) A trainee and the trainee's supervisor who signs the experience log shall document on the log the specific duties that the trainee performs for each appraisal.

(b) For each duty performed, the trainee shall be awarded a percentage of the total experience hours that may be awarded for the property type being appraised:

(i) pursuant to the appraisal experience hour schedules found in Appendices 1 through 3; and

(ii) with the following limitations:

(A) participation in highest and best use analysis: 10% of total hours;

(B) participation in neighborhood description and analysis: 10% of total hours;

(C) property inspection: 20% of total hours, pursuant to this Subsection (3)(c);

(D) participation in land value estimate: 20% of total hours;

(E) participation in sales comparison property selection and analysis: 30% of total hours;

(F) participation in cost analysis: 20% of total hours;

(G) participation in income analysis: 30% of total hours;

(H) participation in the final reconciliation of value: 10% of total hours; and

(I) participation in report preparation: 20% of total hours.

(c) In order for a trainee to claim credit for an inspection pursuant to this Subsection (3)(b)(ii)(C):

(i) as to the first 100 residential appraisals or first 20 non-residential appraisals completed, as applicable to the license or certification being sought, the inspection must include:

(A) measurement of the exterior of a property that is the subject of an appraisal; and

(B) inspection of the exterior of a property that is used as a comparable in an appraisal; and

(ii) as to appraisals after the first 100 residential appraisals or first 20 non-residential appraisals completed, as applicable to the license or certification being sought, the inspection must satisfy all scope of work requirements.

(d) No more than one-third of the experience hours submitted toward licensure may come from any one of the categories identified in this Subsection (3)(b)(ii).

(4) Specific restrictions applicable to applicants for certification.

(a) An individual who obtained a license from the division through reciprocity shall provide to the division all records necessary for the division to verify that the individual satisfies the experience requirements outlined in these rules.

(b) The board may not award credit:

(i) for any appraisal where the applicant cannot prove more than 50% participation in the:

(A) data collection;

(B) verification of data;

(C) reconciliation;

(D) analysis;

(E) identification of property and property interests;

(F) compliance with USPAP standards; and

(G) preparation and development of the appraisal report;

or

(ii) to more than one licensed appraiser per completed appraisal, except as provided in this Subsection (5).

(c)(i) An individual applying for certification as a state-certified residential appraiser shall document at least 75% of the hours submitted from:

(A) the residential experience hours schedule found in Appendix 1; or

(B) the residential portion of the mass appraisal hours schedule found in Appendix 3.

(ii) No more than 25% of the total hours submitted may be from:

(A) the general experience hours schedule found in Appendix 2; or

(B) properties other than 1- to 4-unit residential properties identified in the mass appraisal hours schedule found in Appendix 3.

(d) An individual applying for certification as a state-certified general appraiser shall document at least 1,500 experience hours as having been earned from:

(i) the general experience hours schedule found in Appendix 2; or

(ii) properties other than 1- to 4-unit residential properties identified in the mass appraisal hours schedule found in Appendix 3.

(5) Specific restrictions applicable to mass appraisers.

(a) Single-property appraisals performed under USPAP Standards 1 and 2 by mass appraisers shall be awarded full credit pursuant to Appendices 1 and 2.

(b) Review and supervision of appraisals by mass appraisers shall be awarded credit pursuant to this Subsection (6)(b)-(c).

(c)(i) Mass appraisers and mass appraiser trainees who perform 60% or more of the appraisal work shall be awarded full credit pursuant to Appendix 3.

(ii) Mass appraisers and mass appraiser trainees who perform between 25% and 59% of the appraisal work shall be awarded 50% credit pursuant to Appendix 3.

(iii) Mass appraisers and mass appraisal trainees who perform less than 25% of the appraisal work shall be awarded no credit for the appraisal assignment.

(d) In addition to submitting proof of required experience and samples, randomly selected from the experience log, of work conforming to USPAP Standard 6:

(i) a state-licensed appraiser applicant whose experience is earned primarily through mass appraisal shall submit proof of having performed at least five appraisals conforming to USPAP Standards 1 and 2;

(ii) a state-certified residential appraiser applicant whose experience is earned primarily through mass appraisal shall submit proof of having performed at least eight ~~one-unit~~ residential appraisals;

          (A) conforming to USPAP Standards 1 and 2; and

          (B) including the following property types:

          (I) vacant property;

          (II) two- to four-unit dwelling;

          (III) non-complex single-family unit; and

          (IV) complex single-family unit; and

(iii) a state-certified general appraiser applicant whose experience is earned primarily through mass appraisal shall submit

proof of having performed at least eight appraisals from Appendix 2 conforming to USPAP Standards 1 and 2.

(e) No more than 60% of the total hours submitted for licensure or certification may be earned from any combination of appraisals of:

- (i) property types identified in Appendix 3(a)(i) and (ii);
- (ii) property types identified in Appendix 3 (b)(i) and (ii);
- (iii) property types identified in Appendix 3 (c)(i) and (ii);
- (iv) property types identified in Appendix 3 (d)(i) and (ii);
- (v) property types identified in Appendix 3 (e)(i) and (ii), and
- (vi) property types identified in Appendix 3 (f)(i).

(f) No more than 25% of the total hours submitted for licensure or certification may be earned from appraisals of property types identified in Appendix 3(f)(iii) and (iv) combined.

(g) No more than 20% of the total hours submitted for licensure or certification may have been earned from appraisals of property types identified in Appendix 3(g).

(h)(i) Mass appraisal of property with a personal property component of less than 50% of value shall be awarded full credit pursuant to Appendix 3 for the type of property appraised.

(ii) Mass appraisal of property with a personal property component of 50% to 85% of value shall be awarded 50% credit pursuant to Appendix 3 for the type of property appraised.

(iii) Mass appraisal of property with a personal property component greater than 85% shall be awarded no credit.

(i) The appraisals submitted for review pursuant to this Subsection (5) shall be selected from the applicant's most recent work.

(6) Special circumstances - condemnation appraisals, review appraisals, supervision of appraisers, other real estate experience, and government agency experience.

(a) Condemnation appraisals. A condemnation appraisal shall be awarded an additional 50% of the hours normally awarded for the appraisal if the condemnation appraisal includes a before-and-after appraisal because of a partial taking of the property.

(b) Review appraisals.

(i) Review appraisals shall be awarded experience credit when the appraiser performs technical reviews of appraisals prepared by employees, associates, or others, provided the appraiser complies with USPAP Standards Rule 3 when the appraiser is required to comply with the rule.

(ii) Except as provided in this Subsection (6)(e)(i), the following credit shall be awarded for review of appraisals:

(A) desk review: 30% of the hours that would be awarded if a separate written review appraisal report were prepared, up to a maximum of 500 hours; and

(B) field review: 50% of the hours that would be awarded if a separate written review appraisal report were prepared, up to a maximum of 500 hours.

(c) Supervision of appraisers. Except as provided in this Subsection (6)(e)(i), supervision of appraisers shall be awarded 20% of the hours that would be awarded to the appraisal, up to a maximum of 500 hours.

(d) Other real estate experience acceptable for certification.

(i) Provided that an applicant demonstrates to the satisfaction of the board that the applicant has the ability to arrive at a fair market value of property and to properly document value conclusions, the following activities may be used to satisfy up to 50% of the experience required for certification:

- (A) preliminary valuation estimates;
- (B) range of value estimates or similar studies;
- (C) other real estate-related experience gained by:
  - (I) bankers;
  - (II) builders;
  - (III) city planners and managers; or
  - (IV) other individuals.

(ii) A comparative market analysis by an individual licensed under Section 61-2f et seq. may be granted up to 100% experience credit toward certification if:

(A) the analysis conforms with USPAP Standards Rules 1 and 2; and

(B) the individual demonstrates to the board that the individual uses similar techniques as appraisers to value properties and effectively utilize the appraisal process.

(iii) The following activities, if performed in accordance with USPAP Standards Rules 4 and 5, may be used to satisfy up to 50% of the experience required for certification:

- (A) appraisal analysis;
- (B) real estate counseling or consulting services; and
- (C) feasibility analysis/study.

(iv) Except as provided in this Subsection (6)(e)(i), no more than 50% of the total experience required for certification may be earned through any combination of experience described in this Subsection (6)(b)-(d).

(e) Government agency experience.

(i) An individual who obtains experience hours in conjunction with investigation by a government agency is not subject to the hour limitations of this Subsection (6).

(ii) In addition to submitting proof of required experience, an applicant whose experience is earned primarily in conjunction with investigations by government agencies and through review of appraisals, with no opinion of value developed, shall submit proof of having complied with USPAP Standards 1 and 2 in performing appraisals as follows:

(A) if applying for state-licensed appraiser with experience reviewing residential appraisals, five appraisals of one-unit dwellings;

(B) if applying for state-certified residential appraiser with experience reviewing residential appraisals, eight appraisals of one-unit dwellings; and

(C) if applying for state-certified general appraiser with experience reviewing appraisals of property types listed in Appendix 2, at least eight appraisals of property types identified in Appendix 2.

(7) The board, at its discretion, may request the division to verify the claimed experience by any of the following methods:

- (a) verification with the clients;
- (b) submission of selected reports to the board; and
- (c) field inspection of reports identified by the applicant at the applicant's office during normal business hours.



**KEY: real estate appraisals, trainee registration, licensing and certification, enforcement**

**Date of Enactment or Last Substantive Amendment: 2011  
Authorizing, and Implemented or Interpreted Law: 61-2g-201(2)(h); 61-2g-202(1); 61-2g-205(5)(c)**

## Education, Administration

### **R277-404-3**

#### Board Responsibilities

#### **NOTICE OF PROPOSED RULE**

(Amendment)

DAR FILE NO.: 35101

FILED: 08/01/2011

#### **RULE ANALYSIS**

**PURPOSE OF THE RULE OR REASON FOR THE CHANGE:** The purpose of this amendment is to provide for specific timelines for administration of a benchmark reading assessment. This language was inadvertently omitted in the previous submission of the rule to the Division of Administrative Rules.

**SUMMARY OF THE RULE OR CHANGE:** New language is added to Subsection R277-404-3A(4) that provides specific timelines for administration of a benchmark reading assessment.

**STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE:** Sections 53A-1-603 through 53A-1-611

#### **ANTICIPATED COST OR SAVINGS TO:**

♦ **THE STATE BUDGET:** There are no anticipated costs or savings to the state budget. The new language provides specific timelines for administration of a benchmark reading assessment that was inadvertently omitted in the previous submission of the rule to the Division of Administrative Rules.

♦ **LOCAL GOVERNMENTS:** There are no anticipated costs or savings to local government. The new language provides specific timelines for administration of a benchmark reading assessment that was inadvertently omitted when the rule was submitted previously.

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

♦ **PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES:** There are no anticipated costs or savings to persons other than small businesses, businesses, or local government entities. The new language provides specific timelines for administration of a benchmark reading assessment that was inadvertently omitted when the rule was submitted previously.

**COMPLIANCE COSTS FOR AFFECTED PERSONS:** There are no compliance costs for affected persons. The new language provides specific timelines for administration of a benchmark reading assessment that was inadvertently omitted when the rule was previously submitted to the Division of Administrative Rules.

**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 09/14/2011**

**THIS RULE MAY BECOME EFFECTIVE ON: 09/21/2011**

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

#### **R277. Education, Administration.**

#### **R277-404. Requirements for Assessments of Student Achievement.**

#### **R277-404-3. Board Responsibilities.**

A. Beginning in the 2011-2012 school year, the Board shall implement a comprehensive assessment system for each student in grades K-12. This assessment system shall include:

(1) Criterion-Referenced tests in English language arts for grades 3 - 11; mathematics for grades 3 - 12 and science for grades 4 - 8, earth systems, biology, physics and chemistry OR summative adaptive assessments in reading, language arts, mathematics and science for grades 3-12;

(2) Direct Writing Assessment (DWA) for grades 5 and 8;

(3) Pre-post kindergarten assessment for kindergarten-age students as determined by the LEA;

(4) one benchmark reading assessment determined by USOE for 1st, 2nd and 3rd grade students at the midpoint of the year. Beginning in 2012-2013, this assessment shall be administered at [the] beginning, midpoint and end of year;

(5) Third grade summative end of year reading assessment;

(6) Utah Alternate Assessment (UAA);

(7) English Language Proficiency Test (ELPT); and

(8) National Assessment of Educational Progress (NAEP).

B. The Board shall provide specific rules, administrative guidelines, timelines, procedures, and testing ethics training and requirements for all required assessments.

C. Schools must declare their decision to replace the Criterion-Referenced tests with the adaptive summative test no later than August 1 for the coming year.

D. The Board shall provide resources to the extent available and recommendations for:

- (1) LEA implementation of the assessment system; and
- (2) professional development for teachers to administer assessments and interpret assessment results.

E. All Utah public school students shall participate in the comprehensive assessment system unless the UAA or ELPT is approved for specific students consistent with federal law.

**KEY: assessment, student achievement**

**Date of Enactment or Last Substantive Amendment:** ~~[July 11,]~~ 2011

**Authorizing, and Implemented or Interpreted Law:** Art X Sec 3; 53A-1-603 through 53A-1-611; 53A-1-401(3)

**Health, Family Health and  
Preparedness, WIC Services  
R406-100  
Special Supplemental Nutrition  
Program for Women, Infants and  
Children**

**NOTICE OF PROPOSED RULE**

(Amendment)

DAR FILE NO.: 35084

FILED: 07/18/2011

**RULE ANALYSIS**

**PURPOSE OF THE RULE OR REASON FOR THE CHANGE:** The purpose of the amendment is to update rule language and citations to current federal regulations and current Women, Infants and Children (WIC) policies, procedures, and methods of operation in WIC clinics.

**SUMMARY OF THE RULE OR CHANGE:** In Section R406-100-1, updates the revision date of federal regulation 7 CFR 246 to 01/01/2010 edition. In Section R406-100-2, corrects language to exclude all categorically ineligible participants from a 30-day extension of the certification period. Removal of requirement to conduct screenings in a particular priority order (both are current procedures). In Section R406-100-5, removes the requirement to serve Indians and migrant farmworkers at designated clinics regardless of residency status (these specially designated clinics closed in years past

and do not currently exist). Addition of residents of border towns with interstate agreements and homeless individuals as special populations that may be served at designated clinics regardless of residency status. Applicants who are not residents of the clinic service area may only be served after the clinic requests and receives approval to serve the client from the state WIC Office (current procedure). In Section R406-100-7, files of women, infants and children shall be retained for four years after the end of the fiscal year they were closed, all other records may be destroyed after four years (current procedures). In Section R406-100-8, removes WIC business volume as high risk criteria (current policy).

**STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE:** 7 CFR 246 and Section 26-1-15

**MATERIALS INCORPORATED BY REFERENCES:**

- ◆ Updates 7 CFR 246, published by Government Printing Office, 01/01/2010

**ANTICIPATED COST OR SAVINGS TO:**

- ◆ **THE STATE BUDGET:** None--WIC is fully federally funded, these changes do not have any expected financial impact to the state or to WIC's budget.
- ◆ **LOCAL GOVERNMENTS:** None--Local health departments are already funded by WIC to comply with these regulations. The changes are currently standard operating procedures. Some savings may be realized in storage costs due to reduced record retention periods.
- ◆ **SMALL BUSINESSES:** None--No businesses operate WIC clinics.
- ◆ **PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES:** None--No businesses operate WIC clinics.

**COMPLIANCE COSTS FOR AFFECTED PERSONS:** None--No businesses operate WIC clinics.

**COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES:** The Utah Department of Health, at the request of Governor Gary Herbert, undertook a review of all administrative rules adopted by the Department. The goal of the review was to evaluate each rule for its impact on business, and in addition, to clarify and simplify rules. This filing is a result of that review. Record retention policies are reduced and the fiscal impact on commerce in Utah should be positive.

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

HEALTH  
FAMILY HEALTH AND PREPAREDNESS,  
WIC SERVICES  
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:**

♦ Chris Furner by phone at 801-538-6199, by FAX at 801-538-6729, or by Internet E-mail at CFURNER@utah.gov  
 ♦ Rick Wardle by phone at 801-538-6897, by FAX at 801-538-6729, or by Internet E-mail at rwardle@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN AT 5:00 PM ON 09/14/2011

THIS RULE MAY BECOME EFFECTIVE ON: 09/21/2011

AUTHORIZED BY: David Patton, PhD, Executive Director

**R406. Health, Family Health and Preparedness, WIC Services.**  
**R406-100. Special Supplemental Nutrition Program for Women, Infants and Children.**

**R406-100-1. Incorporation of Federal Regulations.**

The State WIC Office adopts the standards of the Special Supplemental Nutrition Program for Women, Infants and Children provided in 7 CFR 246, 01/01/2010[+996] edition, which is incorporated by reference.

**R406-100-2. Processing Time Frames.**

(1) The standards of 7 CFR 246.7([e]f)(2) are adopted and incorporated by reference with the following exceptions:

(a) Extensions of the processing time frames may be granted in the following circumstances:

(i) Clinics operating only 2 days a month or less.

(ii) In emergency situations when, for example, an employer in a particular geographic area engages in mass lay-offs of personnel.

(iii) In cases where there is difficulty in appointment scheduling, a time variation of 30 days may be added to or subtracted from the certification intervals for all except participants who are categorically ineligible[~~pregnant or postpartum women~~].

~~[(b) All potential Priority I applicants must be screened before potential Priority III applicants, and all potential Priority III applicants must be screened before all potential Priority VI applicants.]~~

**R406-100-3. Uncertified Waiting List.**

(1) The standards of 7 CFR 246.7([e]f)(1) are adopted and incorporated by reference with the following exceptions:

(a) Uncertified Waiting List means a log of names of individuals who have applied for WIC benefits either by phone or walk in, but who have not been determined WIC eligible.

(b) When a clinic begins a priority system, the clinic must begin maintaining waiting lists by priority of individuals who visit or telephone the clinic to request program benefits. If screening appointments are not being taken, the clinic shall use the Uncertified Waiting List log. Applicants are to be placed on the highest potential priority of the uncertified log in chronological order by application date.

(c) For clinic convenience, there are three uncertified priority logs into which all potential applicants may be placed prior to certification. They are Priority I, III, and VI. Priorities II, IV,

and V cannot be determined until after the certification process has been completed.

**R406-100-4. Certified Waiting List.**

The standards of 7 CFR 246.7(e)(1) are adopted and incorporated by reference with the following exceptions:

(1) Certified Waiting List means chronological files of those persons who are determined by the State WIC Office to be WIC eligible, are assigned a priority, and are waiting for funds to become available so they can receive benefits.

(a) After applicants have been determined to be eligible through screening, and are certified, they are placed on the Certified Waiting List according to their highest potential priority. These files are to be placed by priority in chronological order by certification date.

(b) As case load decreases in each clinic, the clinic will send vouchering appointment letters to applicants who are certified and waiting. All individuals in the highest priorities must be served before individuals of a lower priority are served.

(c) All individuals within a priority must be served according to chronological date of their placement on the Waiting List.

**R406-100-5. Residence.**

The standards of 7 CFR 246.7(b)([+2]) are adopted and incorporated by reference with the following exceptions:

Each applicant must state that the address given to the clinic is the applicant's current address. The clinic's staff then determines that the address given is within the area served by the agency and within the jurisdiction of the state.

If the applicant is a member of a special population such as [Indians]homeless individuals or [migrant farmworkers,] residents of border towns with interstate agreements, these individuals may be served by designated clinics regardless of residency status.

If an applicant applies for services at a clinic and the address given is not within the county or group of counties served from this clinic, the applicant is eligible to be served from this clinic only after the clinic requests and has received approval from the State WIC Office to serve [these]this [populations]individual or family.

**R406-100-6. Inadequate Income.**

The standards of 7 CFR 246.7([e]d) are adopted and incorporated by reference with the following exceptions:

(1) Each applicant must submit income verification to the clinic regarding the family's income. This is usually determined by bringing in proof of the previous month's gross income, or [it may be an average]proof of the yearly gross income.

(2) The clinic staff shall determine whether the gross income given is at or below 185% of the Income Poverty Level established by the federal government.

**R406-100-7. Retention of WIC Files.**

The standards of 7 CFR 246.25(a)(2), (3) are adopted and incorporated by reference with the following exceptions:

WIC files shall be maintained for federal or state auditors review for the following retention periods:

(1) Files of women participants, infants and children shall be retained for a minimum four years following the end of the fiscal year that their files were closed.

~~[(2) Files of infants and children shall be retained until the end of the fiscal year of the child's tenth birthday.] All other records may be destroyed after four years.~~

**R406-100-8. Vendor Monitoring.**

The standards of 7 CFR 246.12(i) are adopted and incorporated by reference with the following exceptions:

(1) The State WIC Office may conduct vendor monitoring on all high risk vendors.

(2) The State WIC Office shall determine high risk vendors based on the following criteria:

(a) vendor's redeemed prices are higher than price list;

(b) unusually large percentage of high priced food instruments by vendor;

~~[(c) WIC business volume by vendor;~~

~~]~~ ~~[(d)]~~ participant complaints or complaints from the clinic or other vendors;

~~[(e)]~~ food instrument redemption errors;

~~[(f)]~~ accumulation of five or more sanctioning points as listed in each vendor's signed contract under the heading Vendor Sanctions;

~~[(g)]~~ vendor out of compliance during monitoring visit/redemption analysis;

~~[(h)]~~ complaints involving possible overcharging, fraud or any violation that would cause disqualification for food stamps.

(3) The United States Department of Agriculture, Food and Nutrition Service, Instruction 806-4, which clarifies 7 CFR 246.12(f), and states that federal agencies have immunity from state claims or review. The Department of Health will not conduct on-site monitoring reviews of commissaries or require claims to be paid.

(4) Copies of Instruction 806-4 are available at the State WIC Office.

**KEY: nutrition, women, children, infants**

**Date of Enactment or Last Substantive Amendment: [August 1, 1997] 2011**

**Notice of Continuation: April 27, 2007**

**Authorizing, and Implemented or Interpreted Law: 26-1-15**

Health, Family Health and  
Preparedness, WIC Services

**R406-200**

Program Overview

**NOTICE OF PROPOSED RULE**

(Amendment)

DAR FILE NO.: 35085

FILED: 07/18/2011

**RULE ANALYSIS**

**PURPOSE OF THE RULE OR REASON FOR THE CHANGE:** The purpose of this amendment is to update rule language and citations to current federal regulations and current Women, Infants and Children (WIC) policies, procedures, and methods of operation in WIC clinics.

**SUMMARY OF THE RULE OR CHANGE:** In Section R406-200-1, removes the Ute Indian Tribe, University of Utah Teen Mother and Child Program, and Migrant Worker health Program (agencies which have closed) as local WIC agencies. Participants must be certified approximately every six months to one year, the length of certification periods is determined by USDA federal regulation 7 CFR 246.7(g). Removal of language that WIC vouchers (checks) are issued once every 30 days (now 3 month issuance). Retailers must redeem vouchers (checks) they receive within 60 days of the first day to use (as per current vendor agreement and federal regulations). Proposed revisions to the Utah WIC Policy and Procedures Manual are posted annually to the Utah WIC web site for public comment.

**STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE:** 7 CFR 246 and Section 26-1-5

**MATERIALS INCORPORATED BY REFERENCES:**

- ◆ Updates 7 CFR 246, published by Government Printing Office, 01/01/2010

**ANTICIPATED COST OR SAVINGS TO:**

◆ **THE STATE BUDGET:** None--WIC is fully federally funded, these changes do not have any expected financial impact to the State or to WIC's budget.

◆ **LOCAL GOVERNMENTS:** None--Local health departments are already funded by WIC to comply with these regulations. The changes are current standard operating procedures.

◆ **SMALL BUSINESSES:** None--No businesses operate WIC clinics. WIC vendors are currently under agreement to comply with these rules.

◆ **PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES:** None--No businesses operate WIC clinics. WIC vendors are currently under agreement to comply with these rules.

**COMPLIANCE COSTS FOR AFFECTED PERSONS:** None--No businesses operate WIC clinics. WIC vendors are currently under agreement to comply with these rules.

**COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES:** The Utah Department of Health, at the request of Governor Gary Herbert, undertook a review of all administrative rules adopted by the Department. The goal of the review was to evaluate each rule for its impact on business, and in addition, to clarify and simplify rules. This filing is a result of that review. Redemption period for checks is clarified and the fiscal impact on commerce in Utah should be positive.

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

HEALTH  
FAMILY HEALTH AND PREPAREDNESS,  
WIC SERVICES  
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:

◆ Chris Furner by phone at 801-538-6199, by FAX at 801-538-6729, or by Internet E-mail at CFURNER@utah.gov  
◆ Rick Wardle by phone at 801-538-6897, by FAX at 801-538-6729, or by Internet E-mail at rwardle@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN AT 5:00 PM ON 09/14/2011

THIS RULE MAY BECOME EFFECTIVE ON: 09/21/2011

AUTHORIZED BY: David Patton, PhD, Executive Director

#### **R406. Health, Family Health and Preparedness, WIC Services.**

##### **R406-200. Program Overview.**

##### **R406-200-1. Introduction and Background.**

(1) Under the Child Nutrition Act of 1966 (42 U.S.C. Sec. 1786 et seq.), as amended, Congress has found that substantial numbers of pregnant, postpartum and breast-feeding women, infants and young children from families with inadequate income are a special risk with respect to their physical and mental health by reason of inadequate nutrition or health care, or both. The purpose of the program is to provide supplemental foods and nutrition education through clinics to eligible persons. The program serves as an adjunct to good health care, during critical times of growth and development, in order to prevent the occurrence of health problems and improve the health status of these persons.

(2) The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) is a supplemental foods and nutrition education program funded by U.S.D.A. and administered by the Utah [State] Department of Health, Division of Family Health [Services] and Preparedness, through local health departments [Ute Indian Tribe, University of Utah Teen Mother and Child Program and Community Health Center Inc./Migrant Worker health Program].

(3) WIC provides specified nutritious food supplements and nutrition education to pregnant, postpartum and breast-feeding women, infants and children (up to five years of age) from families with inadequate income and who are determined by competent professionals (physicians, nutritionists, nurses and other trained health officials) to be at "nutritional risk".

(4) The following criteria shall be met to be eligible to receive supplemental foods:

(a) Category and Age:

- (i) pregnant women for the duration of the pregnancy and up to six weeks postpartum;
- (ii) breast-feeding women up to 12 months past delivery;

(iii) postpartum women up to six months past delivery;

(iv) infants and children up to five years of age.

(b) Residence: Residents of areas or members of populations served by the clinic and within the jurisdiction of the state.

(c) Income: Determined to be a member of a family or family group which has a gross income at or below 185% of the poverty guideline established by the federal government.

(d) Nutritional Risk: Certified by a competent professional authority on the staff of the clinic to be at nutritional need through a medical or nutritional assessment.

(5) Participants must be certified approximately every six months to one year to determine their eligibility for the program, unless the participant is a pregnant women. Pregnant women are certified for the duration of their pregnancy. The length of certification periods for all categories of participants is determined by U.S.D.A. regulations as listed in 7CFR 246.7(g).

(6) Upon certification for the program, eligible women, infants and children are issued [~~vouchers~~] checks to use for obtaining prescribed supplemental foods.

(7) WIC participants may exchange their [~~vouchers~~] checks for prescribed foods at retail stores which have entered into signed vendor agreements with the State WIC Office. The [~~voucher~~] check front [~~is similar to a traveler's check and~~] is [~~counter~~] signed by the WIC participant at the retailer's check-out counter. The [~~voucher~~] check is then processed like any check through normal bank clearing procedures. WIC [~~vouchers~~] checks [~~are to be issued once every 30 days and~~] must be used within the timeframe of the first and last dates to use as specified on the check. [~~30 days from the date of issue.~~] Retailers must redeem any [~~vouchers~~] checks they receive within 60 days of the first date to use.

(8) The WIC Program represents more than just a [~~voucher~~] check for food. A primary concern of the program is to deliver preventive health care. Through dietary counseling and nutrition education, participants may come to understand the relationship between good nutrition and their health. In addition, participants needing other health or social services are identified at the time of certification and referred to the appropriate agency.

(9) The "State Plan of Program Operation and Administration" is submitted annually to the U.S. Department of Agriculture, Food and Nutrition Service, for approval. Many inclusions are mandated by the WIC program regulations while others are details specific to Utah's program. The state plan outlines general details concerning the operation and administration of the WIC Program in the state of Utah. The "Utah State WIC Policy[ies] and Procedures Manual" deals specifically with areas of Program operation and administration.

(10) Copies of the state plan may be obtained from the State WIC Office.

(11) Proposed revisions to the Utah WIC Policy and Procedures Manual are posted annually to the Utah WIC web site at [www.health.utah.gov/wic](http://www.health.utah.gov/wic) for public comment.

**KEY: nutrition, women, infants, children**

**Date of Enactment or Last Substantive Amendment:** [~~August 1, 1997~~] **2011**

**Notice of Continuation: April 27, 2007**

**Authorizing, and Implemented or Interpreted Law: 26-1-15**

Health, Family Health and  
Preparedness, WIC Services  
**R406-202-1**  
Certification and Eligibility

**NOTICE OF PROPOSED RULE**

(Amendment)

DAR FILE NO.: 35086

FILED: 07/18/2011

**RULE ANALYSIS**

**PURPOSE OF THE RULE OR REASON FOR THE CHANGE:** The purpose of this amendment is to update rule language to current Women, Infants and Children (WIC) procedures and technology.

**SUMMARY OF THE RULE OR CHANGE:** In Section R406-202-1, removes "certification forms" and replaces with "management information system" and add "which shall be used to electronically enter applications".

**STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE:** 7 CFR 246 and Section 26-1-15

**ANTICIPATED COST OR SAVINGS TO:**

- ◆ **THE STATE BUDGET:** None--WIC is fully federally funded, these changes do not have any expected financial impact to the State or to WIC's budget. WIC already has a funded Management Information System.
- ◆ **LOCAL GOVERNMENTS:** None--The changes are current standard operating procedures.
- ◆ **SMALL BUSINESSES:** None--No businesses operate WIC clinics.
- ◆ **PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES:** None--No businesses operate WIC clinics.

**COMPLIANCE COSTS FOR AFFECTED PERSONS:** None--No businesses operate WIC clinics.

**COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES:** The Utah Department of Health, at the request of Governor Gary Herbert, undertook a review of all administrative rules adopted by the Department. The goal of the review was to evaluate each rule for its impact on business, and in addition, to clarify and simplify rules. This filing is a result of that review. Electronic entry of applications are authorized and the fiscal impact on commerce in Utah should be positive.

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

HEALTH  
FAMILY HEALTH AND PREPAREDNESS,  
WIC SERVICES  
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:**

- ◆ Chris Furner by phone at 801-538-6199, by FAX at 801-538-6729, or by Internet E-mail at CFURNER@utah.gov
- ◆ Rick Wardle by phone at 801-538-6897, by FAX at 801-538-6729, or by Internet E-mail at rwardle@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN AT 5:00 PM ON 09/14/2011

THIS RULE MAY BECOME EFFECTIVE ON: 09/21/2011

AUTHORIZED BY: David Patton, PhD, Executive Director

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**R406. Health, Family Health and Preparedness, WIC Services.  
R406-202. Eligibility.**

**R406-202-1. Certification and Eligibility.**

- (1) The State WIC Office shall provide all clinics with:
  - (a) a uniform system for determining the eligibility of persons for the WIC program;
  - (b) uniform eligibility requirements and certification procedures;
  - (c) ~~[certification forms]~~ a management information system which shall be used to electronically enter applications, determine eligibility and document all nutritional risk, income and residency requirements for the certification process.
- (2) The certification process is described as follows:
  - (a) When there are adequate program funds, each clinic will accept applications, determine eligibility and notify the applicants of their eligibility.
  - (b) When there are not funds available to provide program benefits, all applicants shall be placed on a waiting list and shall be notified, in writing, within 20 days of their application date. The application date is the date the applicant visits the clinic during clinic office hours to request program benefits.

**KEY: nutrition, women, children, infants**

**Date of Enactment or Last Substantive Amendment:**  
~~[1993]~~**2011**

**Notice of Continuation: April 27, 2007**

**Authorizing, and Implemented or Interpreted Law: 26-1-15**

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**Health, Health Care Financing,  
Coverage and Reimbursement Policy  
R414-308  
Application, Eligibility Determinations  
and Improper Medical Assistance**

**NOTICE OF PROPOSED RULE**

(Amendment)

DAR FILE NO.: 35100

FILED: 08/01/2011

**RULE ANALYSIS**

**PURPOSE OF THE RULE OR REASON FOR THE CHANGE:** The purpose of this change is to update and clarify periodic eligibility review, change reporting requirements, and procedures that address improper medical coverage for Medicaid recipients.

**SUMMARY OF THE RULE OR CHANGE:** This amendment clarifies the requirements for a Medicaid recipient to complete a periodic review for continued eligibility and specifies the responsibility of the recipient to provide necessary verifications. This amendment also clarifies that the agency cannot stop eligibility while it is making a redetermination decision, and must provide advance notice of an adverse action to comply with federal due process requirements. It further clarifies the eligibility time line for a recipient who must meet a spenddown or pay another type of fee to become eligible for medical assistance. In addition, this amendment clarifies what improper medical coverage is and what a client has to repay for this occurrence. Finally, this amendment clarifies the refund policy for Medicaid recipients.

**STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE:** 42 CFR 435.911 and 42 CFR 435.916 and 42 CFR 435.919 and Section 26-18-3

**MATERIALS INCORPORATED BY REFERENCES:**

- ◆ Updates 42 CFR 435.911, published by Government Printing Office, 10/01/2010
- ◆ Removes 42 CFR 435.912, published by Government Printing Office, 10/01/2006

**ANTICIPATED COST OR SAVINGS TO:**

- ◆ **THE STATE BUDGET:** The Department does not anticipate any impact to the state budget because Medicaid recipients whose medical assistance ends for failure to complete a review usually complete the review process during the next month and their medical assistance is reinstated.
- ◆ **LOCAL GOVERNMENTS:** There is no impact to local governments because they do not fund Medicaid services and do not determine Medicaid eligibility.

◆ **SMALL BUSINESSES:** The Department does not anticipate any impact to small businesses because Medicaid recipients whose medical assistance ends for failure to complete a review usually complete the review process during the next month and their medical assistance is reinstated. In addition, this change does not impose new requirements on small businesses.

◆ **PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES:** The Department does not anticipate any impact to Medicaid providers and to Medicaid recipients because recipients whose medical assistance ends for failure to complete a review usually complete the review process during the next month and their medical assistance is reinstated. In addition, this change does not impose new requirements on providers and does not reduce Medicaid coverage for recipients.

**COMPLIANCE COSTS FOR AFFECTED PERSONS:** The Department does not anticipate any costs to a single Medicaid provider or to a Medicaid recipient because a recipient whose medical assistance ends for failure to complete a review usually completes the review process during the next month and the recipient's medical assistance is reinstated. In addition, this change does not impose new requirements on a provider and does not reduce Medicaid coverage for a recipient.

**COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES:** No costs for business are expected as Medicaid recipients' cost-sharing duties are better clarified by this 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 09/14/2011**

**THIS RULE MAY BECOME EFFECTIVE ON: 10/01/2011**

**AUTHORIZED BY: David Patton, PhD, Executive Director**

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

##### **R414-308. Application, Eligibility Determinations and Improper Medical Assistance.**

###### **R414-308-1. Authority and Purpose.**

(1) This rule is authorized by Section 26-18-3.

(2) ~~[This rule establishes]~~The purpose of this rule is to establish requirements for medical assistance applications, eligibility decisions and reviews, eligibility period, verifications, change reporting, notification and improper medical assistance for the following programs:

- (a) Medicaid;
- (b) Qualified Medicare Beneficiaries;
- (c) Specified Low-Income Medicare Beneficiaries; and
- (d) Qualified Individuals.

###### **R414-308-2. Definitions.**

(1) The definitions in Rules R414-1 and R414-301 apply to this rule.

(2) In addition, the following definitions apply~~[-]~~:

(a) "Cost~~[-]~~of~~[-]~~care" means the amount of income that an institutionalized individual must pay to the medical facility for long-term care services based on the individual's income and allowed deductions.

(b) "Department" means the Utah Department of Health.

(c) "Due date" means the date that a recipient is required to report a change or provide requested verification to the eligibility agency.

(d) "Due process month" means the month that allows time for the recipient to return all verification, and for the eligibility agency to determine eligibility and notify the recipient.

(e) "Eligibility agency" means the Department of Workforce Services (DWS) that determines eligibility for Medicaid under contract with the Department.

(f) "Eligibility review" means a process by which the eligibility agency reviews current information about a recipient's circumstances to determine whether the recipient is still eligible for medical assistance.

(g) "Open enrollment" means a period of time when the eligibility agency accepts applications.[

(b) "Re-certification" means the process of periodically determining that an individual or household continues to be eligible for medical assistance. ]

###### **R414-308-5. Eligibility Decisions or Withdrawal of an Application.**

(1) The eligibility agency shall determine whether[decides] the applicant[s] is [eligibility]eligible within the time limits established in 42 CFR 435.911, [and 435.912, 2006]2010 ed., which [are]is incorporated by reference. The eligibility changes in eligibility, and the recipient's right to request a fair hearing in accordance with the provisions of 42 CFR 431.206, 431.210, 431.211, 431.213, 431.214, 42 CFR 435.912, and 435.919.

(2) The eligibility agency shall extend[s] the time limit if the applicant asks for more time to provide requested information before the due date. The eligibility agency shall give[s] the applicant at least [40]ten more days after the original due date to provide verifications upon [request of]the applicant's request. The

eligibility agency [can]may allow a longer period of time for the [client]recipient to provide verifications if the agency determines that the delay is due to circumstances beyond the [client]recipient's control[,-an emergency, a client illness or a similar cause].

(3) An applicant may withdraw an application for medical assistance any time before the eligibility agency makes an eligibility decision on the application. An individual requesting an assessment of assets for a married couple under [Section 1924 of the Social Security Act,]42 U.S.C. 1396r-5[;] may withdraw the request any time before the eligibility agency [has-]complete[d]s the assessment.

###### **R414-308-6. Eligibility Period and [Re-Certification]Reviews.**

(1) The eligibility period begins on the effective date of eligibility as defined in Section R414-306-4, which may be after the first day of a month, subject to the following requirements.

(a) If a recipient must pay one of the following fees to receive Medicaid, the eligibility agency shall determine eligibility and notify the recipient of the amount owed for coverage. The eligibility agency shall grant eligibility when it receives the required payment, or in the case of a spenddown or cost of care contribution for waivers, the recipient must send proof of incurred medical expenses equal to the payment. The fees a recipient may owe include:

(i) a spenddown of excess income for medically needy Medicaid coverage;

(ii) a Medicaid Work Incentive (MWI) premium;

(iii) an asset copayment for poverty level, pregnant woman coverage; and

(iv) a cost of care contribution for home and community-based waiver services.

(b) A required spenddown, MWI premium, or cost of care contribution is due each month for a recipient to receive Medicaid coverage. A recipient must pay an asset copayment before eligibility is granted for poverty level, pregnant woman coverage.

~~[(a) If a client must pay a spenddown, the agency completes the eligibility process and grants eligibility when the agency receives the required payment or proof of incurred medical expenses equal to the required payment for the month or months, including partial months, for which the client wants medical assistance.~~

~~[(b) If a client must pay a Medicaid Work Incentive premium, the agency completes the eligibility process and grants eligibility when the agency receives the required payment for the month or months, including partial months, for which the client wants medical assistance.~~

~~[(c) If a client must pay an asset co-payment for prenatal coverage, the agency completes the eligibility process and grants eligibility when the agency receives the required payment for the period of prenatal coverage.~~

~~[(d)e] The [client]recipient must make the payment or provide proof of medical expenses[,-if applicable,] within 30 calendar days from the mailing date of the application approval notice, [that tells]which states how much the [client]recipient [the amount]owe[d]s.~~

~~[(e)d] For ongoing months of eligibility, the [client]recipient has until the close of business [of]on the [40]tenth day of the month after the benefit month to meet the spenddown or the cost of care contribution for waiver services, or to pay the~~



~~[Medicaid Work incentive]MWI premium. If the [10]tenth day of the month is a non-business day, the [client]recipient has until the close of business on the first business day after the [10]tenth [to meet the spenddown or pay the premium]. Eligibility begins on the first day of the benefit month once the recipient meets the required payment. If the recipient does not meet the required payment by the due date, the recipient may reapply for retroactive benefits if that month is within the retroactive period of the new application date.~~

~~[(f)g] [Residents who reside]A recipient who lives in a long-term care facility and [who]owes a cost[-]of[-]care contribution to the medical facility must pay the medical facility directly. The [resident]recipient may use unpaid past medical bills, or current incurred medical bills other than the charges from the medical facility, to meet some or all of the cost[-]of[-]care contribution subject to the limitations in Section R414-304-9. [The resident must pay any cost-of-care contribution not met with allowable medical bills to the medical facility.]An unpaid cost[-]of[-]care contribution is not allowed as a medical bill to reduce the amount that the [client]recipient owes the facility.~~

~~[(g)f] Even when the eligibility agency does not close a medical assistance case, [N]o eligibility exists in a month for which the [client]recipient fails to meet a required spenddown, [or fails to pay a required Medicaid Work Incentive] MWI premium, or cost of care contribution for home and community-based waiver services.~~

~~(g) Eligibility for the [Prenatal]poverty level, pregnant woman program does not exist when the [client]recipient fails to pay a required asset co[-]payment[ ~~for the Prenatal program~~].~~

~~(h) Eligibility for a resident of a nursing home continues even when a resident fails to pay the cost of care contribution to the nursing home.~~

~~(2) The eligibility period ends on:~~

~~(a) the last day of the [re-certification]month in which the eligibility agency determines that the recipient is no longer eligible for medical assistance and sends proper closure notice;~~

~~(b) the last day of the month in which the eligibility agency sends proper closure notice when the recipient fails to provide required information or verification to the eligibility agency by the due date;~~

~~[(b)c] the last day of the month in which the recipient asks the eligibility agency to discontinue eligibility, or if benefits have been issued for the following month, the end of that month;~~

~~[(c) the last day of the month the agency determines the individual is no longer eligible;~~

~~[(d) the last day of the month for time-limited programs, in which the time limit ends;~~

~~[(d)e] [~~for the Prenatal program,~~]the last day of the month for the poverty level, pregnant woman program, [that]which is at least 60 days after the date that the pregnancy ends, except that for [Prenatal]poverty-level, pregnant woman coverage for emergency services only, eligibility ends on the last day of the month in which the pregnancy ends; or~~

~~[(e)f] the date that the individual dies.~~

~~(3) Recipients must re-certify eligibility for medical assistance at least once every 12 months. The agency may require recipients to re-certify eligibility more frequently when the agency:~~

~~(a) receives information about changes in a recipient's circumstances that may affect the recipient's eligibility;~~

~~(b) has information about anticipated changes in a recipient's circumstances that may affect eligibility; or~~

~~(c) knows the recipient has fluctuating income.~~

~~(4) To receive medical assistance without interruption, a recipient must complete the re-certification process by the close of business on the date printed on the re-certification form. The client must also provide verifications by the due date specified by the agency and must continue to meet all eligibility criteria, including meeting a spenddown or paying a Medicaid Work Incentive premium if one is owed.~~

~~(a) If the recipient does not complete the re-certification process on time, eligibility ends on the last day of the re-certification month.~~

~~(b) If the recipient does not complete the re-certification process on time, but completes the recertification including providing verifications by the close of business on the last business day of the month after the review month, the agency will determine whether the recipient continues to meet all eligibility criteria.~~

~~(i) The agency will reinstate benefits effective the beginning of the month after the re-certification month if the recipient continues to meet all eligibility criteria and meets any spenddown or pays the Medicaid Work Incentive premium, if applicable. The client must meet the spenddown or pay the premium no later than the close of business on the 30th day after the date printed on the notice. Otherwise, the recipient remains ineligible for medical assistance.~~

~~(ii) If the recipient does not complete the re-certification process before the close of business of the last business day of the month following the re-certification month, eligibility will not be reinstated. The recipient will have to reapply for medical assistance.~~

~~(c) If the recipient does not meet the spenddown or pay the Medicaid Work Incentive premium on time, then eligibility ends effective the last day of the re-certification month and the recipient will have to reapply.~~

~~[(5)3] For individuals selected for coverage under the Qualified Individuals Program, eligibility extends through the end of the calendar year if the individual continues to meet eligibility criteria and the program still exists.~~

~~(4) The eligibility agency completes a periodic review of a recipient's eligibility for medical assistance in accordance with the requirements of 42 CFR 435.916, at least once every 12 months.~~

~~(5) The eligibility agency may complete an eligibility review when it:~~

~~(a) has information about anticipated changes in the recipient's circumstances that may affect eligibility;~~

~~(b) knows the recipient has fluctuating income;~~

~~(c) completes a review for other assistance programs that the recipient receives; or~~

~~(d) needs to meet workload demands.~~

~~(6) The periodic eligibility review is a review of eligibility factors that may be subject to change. The eligibility agency shall require the review to determine whether a recipient is still eligible for medical assistance. The eligibility agency shall use available, reliable sources to gather information needed to complete the review.~~

~~(7) The eligibility agency may ask the recipient to respond to a request to complete the review process during the review month. If the recipient fails to respond to the request, the~~

eligibility agency shall end eligibility after the review month ends. If the recipient responds to the review or reapplies in the month that follows the review month, the eligibility agency shall consider the response to be a new application. The application processing period shall apply for the new request for coverage.

(a) The eligibility agency may ask the recipient for verification to redetermine eligibility.

(b) Upon receiving the verification, the eligibility agency shall redetermine eligibility and notify the recipient. If the recipient fails to return verification within the application processing period or if the recipient is determined to be ineligible, the eligibility agency shall send a denial notice to the recipient.

(c) If the case is closed for one or more calendar months, the recipient must reapply.

(8) If the recipient responds to the request during the review month, the eligibility agency may request verification from the recipient.

(a) The eligibility agency shall send a written request for the necessary verification.

(b) The recipient has at least ten calendar days from the notice date to provide the requested verification to the eligibility agency.

(9) If the recipient responds to the review and provides all verification by the due date within the review month, the eligibility agency shall determine eligibility and notify the recipient of its decision.

(a) If the eligibility agency sends proper notice of an adverse decision in the review month, the agency shall change eligibility for the following month.

(b) If the eligibility agency does not send notice of an adverse change, the agency shall extend eligibility to the following month. This additional month of eligibility is called the due process month. The eligibility agency shall notify the recipient of the adverse decision that becomes effective after the due process month.

(10) If the recipient responds to the review in the review month and the verification due date is in the following month, the eligibility agency shall extend eligibility to the following month. This additional month of eligibility is called the due process month. The recipient must provide all verification by the verification due date.

(a) If the recipient provides all requested verification by the verification due date, the eligibility agency shall determine eligibility and send proper notice of the decision.

(b) If the recipient does not provide all requested verification by the verification due date, the eligibility agency shall end eligibility after the month in which the eligibility agency sends proper notice of the closure.

(c) If the recipient returns all verification after the verification due date and before the effective closure date, the eligibility agency shall treat the date that it receives the verification as a new application date. The agency shall then determine eligibility and send notice to the recipient.

(11) The eligibility agency shall provide ten-day notice of case closure if the recipient is determined ineligible or if the recipient fails to provide all verification by the verification due date.

(12) The eligibility agency may not extend coverage under certain medical assistance programs in accordance with state

and federal law. The agency shall notify the recipient before the effective closure date.

(a) If the eligibility agency determines that the recipient qualifies for a different medical assistance program, the agency shall notify the recipient. Otherwise, the agency shall end eligibility after the named time period.

(b) If the recipient provides information before the effective closure date that indicates that the recipient may qualify for another medical assistance program, the eligibility agency shall treat the information as a new application. If the recipient contacts the eligibility agency after the effective closure date, the recipient must reapply for benefits.

#### **R414-308-8. Case Closure and Redetermination.**

(1) The eligibility agency shall ~~terminate~~ end medical assistance ~~upon~~ when the recipient requests the agency to close his case, when the recipient fails to respond to a request to complete the eligibility review, when the recipient fails to provide all verification needed to determine continued eligibility, or ~~if~~ when the agency determines that the recipient is no longer eligible.

(2) ~~To maintain ongoing eligibility, a recipient must complete the re-certification process as provided in R414-308-6. Failure to complete the re-certification process makes the recipient ineligible.~~ If a recipient fails to complete the review process in accordance with Section R414-308-6, the eligibility agency shall close the case and notify the recipient.

(3) Before terminating a recipient's medical assistance, the eligibility agency ~~will~~ shall ~~decide if~~ determine whether the ~~client~~ recipient is eligible for any other available medical assistance provided under Medicaid, the Medicare Cost~~-~~ Sharing programs, the Children's Health Insurance Program (CHIP), the Primary Care Network (PCN), and ~~the~~ Utah's Premium Partnership for Health Insurance (UPP)~~-program~~.

(a) The eligibility agency ~~does~~ may not require a recipient to complete a new application~~-~~ to make the redetermination.~~but~~ The agency, however, may request more information from the recipient to ~~complete the redetermination~~ determine whether the recipient is eligible for other medical assistance programs. If the recipient does not provide the necessary information by the close of business on the due date, the recipient's medical assistance ends.

(b) When ~~redetermining~~ determining eligibility for other programs, the eligibility agency ~~cannot~~ may only enroll an individual in a medical assistance program ~~that is not~~ during ~~in~~ an open enrollment period, ~~unless~~ or when that program allows a person who becomes ineligible for Medicaid to enroll during a period when enrollment~~s are stopped~~ is closed.~~[An open enrollment period is a time when the agency accepts applications.]~~ Open enrollment applies only to ~~the Primary Care Network,~~ the PCN and ~~the~~ UPP ~~P~~ programs~~and the Children's Health Insurance Program~~.

#### **R414-308-9. Improper Medical Coverage.**

(1) Improper medical coverage occurs when:

(a) an individual receives medical assistance for which the individual is not eligible. This assistance includes benefits that an individual receives pending a fair hearing or during an undue hardship waiver when the individual fails to take actions required by the eligibility agency;

~~(b) an individual receives a benefit or service that is not part of the benefit package for which the individual is eligible;~~

~~(c) an individual pays too much or too little for medical assistance benefits; or~~

~~(d) the Department pays in excess or not enough for medical assistance benefits on behalf of an eligible individual.~~

~~([+]~~2~~) As ~~used~~ applied in this section, services and benefits include all amounts that the Department pays on behalf of the ~~client~~ recipient during the period in question and includes:~~

~~(a) premiums that the recipient pays ~~paid~~ to any Medicaid health plan[s] or managed care plan[s], including any payments for administration costs, Medicare, and private insurance plans;~~

~~(b) payments for prepaid mental health services; and~~

~~(c) payments made directly to service providers or to the ~~client~~ recipient.~~

~~(2) A client must repay the cost of services and benefits the client receives for which the client is not eligible.~~

~~([a]~~3~~) If the eligibility agency determines that a ~~client~~ recipient ~~was~~ is ineligible for the services ~~or~~ and benefits ~~received~~ that he receives, ~~the client must repay the Department the amount the Department paid for the services or benefits~~ the recipient must repay to the Department any costs that result from the services and benefits.~~

~~(4) The eligibility agency shall reduce ~~the~~ the amount that the ~~client~~ recipient must repay ~~will be reduced~~ by the amount that the ~~client paid~~ recipient pays to the eligibility agency for a Medicaid spenddown, a cost of care contribution, or a ~~Medicaid Work Incentive~~ MWI premium for the month.~~

~~(5) If a ~~woman~~ recipient who ~~has paid~~ pays an asset co[-]payment for coverage under Prenatal Medicaid is found to ~~have been~~ be ineligible for the entire period of coverage under Prenatal Medicaid, the eligibility agency shall reduce the amount ~~she~~ that the recipient must repay ~~will be reduced~~ by the amount that ~~she~~ the recipient ~~paid~~ pays to the agency in the form of the ~~P~~ prenatal asset co[-]payment ~~if applicable~~.~~

~~([b]~~6~~) If the ~~client~~ recipient is eligible but the overpayment ~~was~~ is because the spenddown, the ~~Medicaid Work Incentive~~ MWI premium, the asset co[-]payment for prenatal services, or the cost[-]of[-]care contribution ~~was~~ is incorrect, the ~~client~~ recipient must repay the difference between the correct amount that the ~~client should have paid and~~ recipient should pay and the amount that ~~what~~ the ~~client actually~~ recipient has paid.~~

~~(7) If the eligibility agency determines that the recipient is ineligible due to having resources that exceed the resource limit, the recipient must pay the lesser of the cost of services or benefits that the recipient receives, or the difference between the recipient's countable resources and the resource limit for each month resources exceed the limit.~~

~~([3]~~8~~) A ~~client~~ recipient may request a refund from the Department ~~for any month in which~~ if the ~~client~~ recipient believes that:~~

~~(a) the monthly spenddown, the asset co[-]payment for prenatal services, or cost[-]of[-]care contribution that the ~~client paid~~ recipient pays to receive medical assistance is less than what the Department ~~paid~~ pays for medical services and benefits for the ~~client~~ recipient; or~~

~~(b) the amount that the ~~client paid~~ recipient pays in the form of a spenddown, a ~~Medicaid Work Incentive~~ MWI premium,~~

a cost[-]of[-]care contribution for long-term care services, or an asset co[-]payment for prenatal services ~~was more than it should have been~~ exceeds the payment requirement.

~~([4]~~9~~) Upon receiving the request ~~for a refund~~, the Department ~~will~~ shall determine ~~if the client is owed~~ whether it owes the recipient a refund.~~

(a) In the case of an incorrect calculation of a spenddown, ~~Medicaid Work Incentive~~ MWI premium, cost[-]of[-]care contribution, or asset co[-]payment for ~~prenatal~~ poverty level, pregnant woman services, the refundable amount is the difference between the incorrect amount that the ~~client paid~~ recipient pays to the Department for medical assistance and the correct amount that the ~~client~~ recipient should ~~have paid~~ pay, less the amount that the ~~client~~ recipient owes to the Department for any other past due, unpaid claims.

(b) ~~If ~~in the case when~~ the spenddown, asset co[-]payment for ~~prenatal~~ poverty level, pregnant woman services, or a cost[-]of[-]care contribution for long-term care exceeds medical expenditures, the refundable amount is the difference between the correct spenddown, asset co[-]payment, or cost[-]of[-]care contribution that the ~~client paid~~ recipient pays for medical assistance and the ~~actual~~ amount that the Department ~~paid~~ pays on behalf of the ~~client~~ recipient for services and benefits, less the amount that the ~~client~~ recipient owes to the Department for any other past due, unpaid claims. The Department shall issue[s] the refund only after the 12-month time[-]period that medical providers have to submit claims for payment.~~

(c) ~~The ~~agency does~~ Department may not issue a cash refund for any portion of a spenddown or cost[-]of[-]care contribution that ~~was~~ is met with medical bills. Nevertheless, the Department may pay additional covered medical bills used to meet the spenddown or cost of care contribution equal to the amount of refund that the Department owes the recipient, or apply the bill amount toward a future spenddown or cost of care contribution.~~

~~([5]~~10~~) A ~~client~~ recipient who pays a premium for the ~~Medicaid Work Incentive~~ MWI program ~~cannot~~ may not receive a refund even ~~if~~ when the Department pays for services ~~paid by the Department~~ that are less than the premium that the ~~client~~ recipient pays for MWI.~~

~~([6]~~11~~) If the cost[-]of[-]care contribution that a ~~client~~ recipient pays a medical facility is more than the Medicaid daily rate for the number of days that the ~~client was~~ recipient is in the medical facility, the ~~client can~~ recipient may request a refund from the medical facility. The Department ~~will~~ shall refund the amount that it owe[s] the ~~client~~ recipient only ~~if~~ when the medical facility ~~has sent~~ sends the excess cost[-]of[-]care contribution to the Department.~~

~~([7]~~12~~) If the sponsor of an alien does not provide correct information, the alien and the alien's sponsor are jointly liable for any overpayment of benefits. The Department shall recover[s] the overpayment from both the alien and the sponsor.~~

**KEY: public assistance programs, applications, eligibility, Medicaid**

**Date of Enactment or Last Substantive Amendment: ~~November 1, 2010~~ 2011**

**Notice of Continuation: January 31, 2008**

**Authorizing, and Implemented or Interpreted Law: 26-18**

**Insurance, Administration**  
**R590-192**  
**Unfair Accident and Health Claims**  
**Settlement Practices**

**NOTICE OF PROPOSED RULE**

(Amendment)

DAR FILE NO.: 35103

FILED: 08/01/2011

**RULE ANALYSIS**

**PURPOSE OF THE RULE OR REASON FOR THE CHANGE:** The purpose of these amendments is to make changes proposed by members of the insurance industry in a hearing held 06/09/2011, during the comment period for an amendment to this rule published in the May 15, 2011, Bulletin under DAR No. 34769, and additional changes from the federal government.

**SUMMARY OF THE RULE OR CHANGE:** The proposed amendments to this rule are as follows: in Section R590-192-1 clarifies that the term "title" means Title 31A, of the insurance code; in Section R590-192-4 the term "Policy" is being deleted since it is no longer needed; revised the "Adverse benefit determination" definition to conform to definition in the federal Affordable Care Act of 2010; exempted grandfather plans from three requirements; clarified when continued coverage must be provided; urgent care claims require a benefit decision within 72 hours; and the enforcement date is changed to the date the amendments go into effect.

**STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE:** Section 31A-2-201 and Section 31A-2-203 and Section 31A-22-629 and Section 31A-4-116

**ANTICIPATED COST OR SAVINGS TO:**

◆ **THE STATE BUDGET:** The amendments to this rule will have no fiscal impact on the department since it will require no additional filings or change in the department's workload or change in expenditures or revenues. The amendments are for clarification, as well as procedural and formatting changes.

◆ **LOCAL GOVERNMENTS:** This rule will have no fiscal impact on local government. It only affects insurance companies licensed in Utah and their relationship with their insureds and claimants who have claims against them.

◆ **SMALL BUSINESSES:** There is no difference in the effect of this rule on large or small businesses. The changes allow a grandfather plan to be exempt from three requirements, which is a cost benefit to the insurer who does not need to make these changes. There is a cost savings because diagnostic and treatment codes only need to be provided when requested. There is a cost saving because continued

coverage only needs to be provided for ongoing course of treatment.

◆ **PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES:** Grandfather plans allow people to keep their existing coverage, which may be at a lower cost than a plan that must comply with the rule.

**COMPLIANCE COSTS FOR AFFECTED PERSONS:** There is no difference in the effect of this rule on large or small businesses. The changes allow a grandfather plan to be exempt from three requirements, which is a cost benefit to the insurer who does not need to make these changes. There is a cost savings because diagnostic and treatment codes only need to be provided when requested. There is a cost saving because continued coverage only needs to be provided for ongoing course of treatment.

**COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES:** The changes provide cost savings to insurers.

**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](mailto:jwhitby@utah.gov)

**INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN AT 5:00 PM ON 09/14/2011**

**INTERESTED PERSONS MAY ATTEND A PUBLIC HEARING REGARDING THIS RULE:**

◆ 09/08/2011 09:00 AM, State Office Building, 450 N State, Room 3112, Salt Lake City, UT

**THIS RULE MAY BECOME EFFECTIVE ON: 09/21/2011**

**AUTHORIZED BY: Jilene Whitby, Information Specialist**

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**R590. Insurance, Administration.**

**R590-192. Unfair Accident and Health Claims Settlement Practices[~~Rule~~].**

**R590-192-1. Authority.**

This rule is promulgated pursuant to Subsections 31A-2-201(1) and 31A-2-201(3)(a) in which the commissioner is empowered to administer and enforce ~~[this title]~~ Title 31A and to make rules to implement the provisions of ~~[this title]~~ Title 31A. Further authority to provide for timely settlement of claims is provided by Subsection 31A-26-301(1). Matters relating to proof

and notice of loss are promulgated pursuant to Section 31A-26-301 and Subsection 31A-21-312(5). Authority to promulgate rules defining unfair claims settlement practices or acts is provided in Subsection 31A-26-303(4). The authority to require a timely, accurate, and complete response to the commissioner is provided by Subsections 31A-2-202(4) and (6).

#### **R590-192-4. Definitions.**

For the purpose of this rule the commissioner adopts the definitions as set forth in Section 31A-1-301, 29 CFR 2560.503-1(m), and the following:

(1)(a) "Adverse benefit determination" means, for an accident and health insurance policy other than a health benefit plan, any of the following: a denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of ~~a participant's or beneficiary's~~ an insured's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of or failure to provide or make payment, in whole or in part, for a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise experimental or investigational or not medically necessary or appropriate; and

(b)(i) "Adverse benefit determination" means, for a health benefit plan~~[- that]~~:

~~(A)~~ based on the insurer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, the:

~~(I)~~ denial of a benefit;

~~(II)~~ reduction of a benefit;

~~(III)~~ termination of a benefit; or

~~(IV)~~ failure to provide or make payment, in whole or part, for a benefit; or

~~(B)~~ rescission of coverage.

(ii) "Adverse benefit determination" includes:

(A) denial, reduction, termination, or failure to provide or make payment~~[- or rescission]~~ that is based on a determination of an insured's eligibility to participate in a health benefit plan;

(B) failure to provide or make payment, in whole or part, for a benefit resulting from the application of a utilization review; and

~~(C)~~ failure to cover an item or service for which benefits are otherwise provided because it is determined to be:

~~(I)~~ experimental;

~~(II)~~ investigational; or

~~(III)~~ not medically necessary or appropriate.

(2) "Claim File" means any record either in its original form or as recorded by any process which can accurately and reliably reproduce the original material regarding the claim, its investigation, adjustment and settlement.

(3) "Claim Representative" means any individual, corporation, association, organization, partnership, or other legal entity authorized to represent an insurer with respect to a claim, whether or not licensed within the State of Utah to do so.

(4) "Claimant" means an insured, or legal representative of the insured, including a member of the insured's immediate family designated by the insured, making a claim under a policy.

(5) "Ongoing" or "Concurrent care" decision means an insurer has approved an ongoing course of treatment to be provided over a period of time or number of treatments.

(6) "Days" means calendar days.

(7) "Documentation" means a document, record, or other information that is considered relevant to a claimant's claim because such document, record, or other information:

(a) was relied upon in making the benefit determination;

(b) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; and

(c) in the case of an insurer providing disability income benefits, constitutes a statement of policy or guidance with respect to the insurer concerning the denied treatment option or benefit for the ~~claimant's~~ insured's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

(8) "General business practice" means a pattern of conduct.

(9) "Investigation" means all activities of an insurer directly or indirectly related to the determination of liabilities under coverage afforded by an insurance policy.

(10) "Medical necessity" means:

(a) health care services or product that a prudent health care professional would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is:

(i) in accordance with generally accepted standards of medical practice in the United States;

(ii) clinically appropriate in terms of type, frequency, extent, site, and duration;

(iii) not primarily for the convenience of the patient, physician, or other health care provider; and

(iv) covered under the contract; and

(b) when a medical question-of-fact exists, medical necessity shall include the most appropriate available supply or level of service for the individual in question, considering potential benefits and harms to the individual, and known to be effective.

(i) For an intervention not yet in widespread use, the effectiveness shall be based on scientific evidence.

(ii) For an established intervention, the effectiveness shall be based on:

(A) scientific evidence;

(B) professional standards; and

(C) expert opinion.

(11) "Notice of Loss" means that notice which is in accordance with policy provisions and insurer practices. Such notice shall include any notification, whether in writing or other means, which reasonably apprizes the insurer of the existence of or facts relating to a claim.

~~(12) ["Policy" includes a certificate issued under a group insurance contract.~~

~~(13) ]~~ "Pre-service claim" means any claim for a benefit under an accident and health policy with respect to which the terms of the plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

(14) "Post-service claim" means any claim for a benefit that is not a pre-service claim or urgent care claim.

(1[5]4) "Scientific evidence" is:

(a)(i) scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff; or

(ii) findings, studies or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes;

(b) scientific evidence shall not include published peer-reviewed literature sponsored to a significant extent by a pharmaceutical manufacturing company or medical device manufacturer or a single study without other supportable studies.

(1[6]5) "Urgent care claim" means any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determination:

(a) could seriously jeopardize the life or health of the insured or the ability of the insured to regain maximum function; or

(b) in the opinion of a physician with knowledge of the [claimant's]insured's medical condition, would subject the [claimant]insured to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

#### **R590-192-7. Notice of Loss.**

(1) Notice of loss to an insurer, if required, shall be considered timely if made according to the terms of the policy, subject to the definitions and provisions of this rule.

(2) Notice of loss may be given to the insurer or its claim representative unless the insurer clearly directs otherwise by means of policy provisions or a separate written notice mailed or delivered to the [insured]claimant.

(3) Subject to policy provisions, a requirement of any notice of loss may be waived by any authorized claim representative of the insurer.

(4) The general business practice of the insurer when accepting a notice of loss or notice of claim shall be consistent for all policyholders in accordance with the terms of the policy.

#### **R590-192-8. Notification.**

(1) The insurer shall provide notification of the benefit determination to the claimant which includes:

(a) the specific reason or reasons for the benefit determination, adverse or not;

(b) reference to the specific plan provisions on which the benefit determination is based;

(c) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; and

(d) a description of the insurer's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring civil action.

(2) For a health benefit plan, except for a grandfathered health benefit plan as defined in 45 CFR 147.140, [the notification] a notice of adverse benefit determination shall provide:

(a) starting with the plan year that begins on or after July 1, 2011:

(i) sufficient information to identify the claim involved, including the date of service, the health care provider, and the claim amount, if applicable; and

(ii) notification of assistance available at the Utah Insurance Department, Office of Consumer Health Assistance, Suite 3110, State Office Building, Salt Lake City UT 84114; and

(b) starting with the plan year that begins on or after January 1, 2012:

(i) the availability, upon request, of the diagnosis code and treatment code with the corresponding meaning for each; and

(ii) the content in a culturally and linguistically appropriate manner as required by 45 CFR 147.136 (e).

(3) An insurer and the insurer's claim representative, in the case of a failure by a claimant [~~or an authorized representative of a claimant~~]to follow the individual or group health plan's procedures for filing a pre-service claim, shall notify the claimant[~~or representative~~], of the failure and provide the proper procedures to be followed in filing a claim for benefits. This notification shall be provided to the claimant [~~or authorized representative, as appropriate,~~]as soon as possible, but not later than five days, or 24 hours for a claim involving urgent care, following the failure. Notification may be oral, unless written notification is requested by the claimant[~~or authorized representative~~].

(4) Disability income adverse benefit determinations must:

(a) if an internal rule, guideline, protocol, or other criterion was relied upon in making the adverse determination, provide either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request; or

(b) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, provide either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the [claimant's]insured's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

(5) Urgent care adverse benefit determination must:

(a) provide written or electronic notification to the claimant no later than three days after the oral notification; and

(b) provide a description of the expedited review process applicable to such claims.

#### **R590-192-9. Minimum Standards for Claim Benefit Determination and Settlement.**

(1) All benefit determination time limits begin once the insurer receives a claim, without regard to whether all necessary information was filed with the original claim. If the insurer requires an extension due to the claimant's failure to submit necessary information, the time for making a decision is [~~determined~~]tolled from the date the notice is sent to the claimant through:

(a) the date that the claimant provides the necessary information; or

(b) 48 hours after the end of the period afforded the claimant to provide the specified additional information.

(2) Urgent Care Claims:

(a) In a case of urgent care, an insurer shall notify the claimant of the insurer's benefit decision, adverse or not, as soon as

possible, taking into account the medical exigencies of the situation, but no later than:

(i) ~~[24]~~72 hours after the receipt of the claim for ~~[aH-]~~ health benefit plans, except for a grandfathered health benefit plan as defined in 45 CFR 147.140, starting with the plan year that begins on or after January 1, 2012; or

(ii) 72 hours after the receipt of the claim for all other accident and health coverage.

(b)(i) If the claimant does not provide sufficient information for the plan to make a decision, the plan must notify the claimant as soon as possible, but not later than 24 hours after receipt of the claim, of the specific information that is required. The claimant shall be given reasonable time, but not less than 48 hours, to provide that information.

(ii) The insurer must notify the claimant of the insurer's decision as soon as possible but not later than 48 hours after the earlier of the plan's receipt of the requested information or the end of the time given to the claimant to provide the information.

(3) Concurrent Care Decision:

(a) Reduction or termination of concurrent care:

(i) Any reduction in the course of treatment is considered an adverse benefit determination.

(ii) The insurer must give the claimant notice, with sufficient time to appeal that adverse benefit determination and sufficient time to receive a decision of the appeal before any reduction or termination of care occurs.

(b) Extension of concurrent care:

(i) A claimant may request an extension of treatment beyond what has already been approved.

(ii) If the request for an extension is made at least 24 hours before the end of the approved treatment, the insurer must notify the claimant of the insurer's decision as soon as possible but no later than 24 hours after receipt of the claim.

(iii) If the request for extension does not involve urgent care, the insurer must notify the claimant of the insurer's benefit decision using the response times for a post-service claim.

(4) Pre-Service Benefit Determination:

(a) An insurer must notify the claimant of the insurer's benefit decision within 15 days of receipt of the request for care.

(b) If the insurer is unable to make a decision within that time due to circumstances beyond the insurer's control, such as late receipt of medical records, it must notify the claimant before expiration of the original 15 days that it intends to extend the time and then the insurer may take as long as 15 additional days to reach a decision.

(c) If the extension is due to failure of the claimant to submit necessary information, the extension notice of delay must give specific information about what the claimant has to provide and the claimant must be given at least 45 days to submit the requested information.

(d) once the pre-service claim determination has been made and the medical care rendered, the actual claim filed for payment will be processed according to the time requirements of a post-service claim.

(5) Post-Service Claims:

(a) An insurer must notify the claimant of the insurer's benefit decision within 30 days of receipt of the request for claim.

(b) If the insurer is unable to make a decision within that time due to circumstances beyond the insurer's control, such as late

receipt of medical records, it must notify the claimant before expiration of the original 30 days that it intends to extend the time and then the insurer may take as long as 15 additional days to reach a decision.

(c) If the extension is due to failure of the claimant to submit necessary information, the extension notice of delay must give specific information about what the claimant has to provide and the claimant must be given at least 45 days to submit the requested information.

(6) A health benefit plan is required to provide continued coverage for an ongoing course of treatment pending the outcome of an internal appeal.

(7) ~~[An]~~Except for a grandfathered individual health benefit plan as defined in 45 CFR 147.140, an insurer offering an individual health benefit plan shall provide only one level of internal appeal before the final determination is made.

#### **R590-192-14. Enforcement Date.**

The commissioner will begin enforcing the revised provisions of this rule on ~~[July 1, 2011]~~the effective date.

#### **KEY: insurance law**

**Date of Enactment or Last Substantive Amendment:** ~~[June 30,] 2011~~

**Notice of Continuation:** June 25, 2009

**Authorizing, and Implemented or Interpreted Law:** 31A-1-301; 31A-2-201; 31A-2-204; 31A-2-308; 31A-21-312; 31A-26-303

## Insurance, Administration **R590-203** Health Grievance Review Process

### NOTICE OF PROPOSED RULE

(Amendment)

DAR FILE NO.: 35104

FILED: 08/01/2011

### RULE ANALYSIS

**PURPOSE OF THE RULE OR REASON FOR THE CHANGE:** This rule is being changed as a result of comments received from the insurance industry in a hearing held 06/09/2011 and during the comment period for an earlier amendment to this rule published in the May 15, 2011 Bulletin under DAR No. 34768.

**SUMMARY OF THE RULE OR CHANGE:** Amendments to the rule include: in Section R590-203-4, adds "Disability Income insurance" to the definition of "Carrier" because the rule applies to health insurance and disability income; "Urgent Care" has also been amended to refer to the opinion of the insured's attending provider; Subsection R590-203-6(1) has returned "medical necessity," which had previously been deleted; Section R590-203-9 has been eliminated since it is

no longer needed; and the enforcement date is changed to the date the amendments go into effect.

STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 31A-2-201 and Section 31A-2-203 and Section 31A-22-629 and Section 31A-4-116

ANTICIPATED COST OR SAVINGS TO:

◆ THE STATE BUDGET: The amendments to this rule will have no effect on the state or department's budget since they are mainly for clarification purposes and will not create additional filings or change in the department's revenues or expenditures.

◆ LOCAL GOVERNMENTS: The amendments to this rule will have no effect on local government since the changes are for clarification purposes only and deal solely with the relationship between a licensed insurance company and insured or other individual with a claim against the insurer.

◆ SMALL BUSINESSES: The return of "medical necessities" limits the need for independent reviews, which will be a cost savings to businesses.

◆ PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES: Disability income insurance is assured of the availability of independent review.

COMPLIANCE COSTS FOR AFFECTED PERSONS: The return of "medical necessities" limits the need for independent reviews, which will be a cost savings to businesses.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: This rule creates no costs but instead a savings for businesses.

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](mailto:jwhitby@utah.gov)

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN AT 5:00 PM ON 09/14/2011

INTERESTED PERSONS MAY ATTEND A PUBLIC HEARING REGARDING THIS RULE:

◆ 09/08/2011 03:00 PM, State Office Building, 450 N State, Room 3112, Salt Lake City, UT

THIS RULE MAY BECOME EFFECTIVE ON: 09/21/2011

AUTHORIZED BY: Jilene Whitby, Information Specialist

**R590. Insurance, Administration.**

**R590-203. Health Grievance Review Process.**

**R590-203-2. Purpose.**

The purpose of this rule is to ensure that a carrier's grievance review procedures for individual and group health insurance and disability income insurance plans comply with 29 CFR 2560.503-1, and Sections 31A-4-116 and 31A-22-629.

**R590-203-4. Definitions.**

In addition to the definitions in Section 31A-1-301, the following definitions shall apply for the purposes of this rule:

- (1)(a) "Adverse benefit determination" means the:
- (i) denial of a benefit;
  - (ii) reduction of a benefit;
  - (iii) termination of a benefit; or
  - (iv) failure to provide or make payment, in whole or in part, for a benefit.
- (b) "Adverse benefit determination" includes:
- (i) denial, reduction, termination, or failure to provide or make payment that is based on a determination of an insured's eligibility to participate in a plan;
  - (ii) a denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for, a benefit resulting from the application of a utilization review; and
  - (iii) failure to cover an item or service for which benefits are otherwise provided because it is determined to be:
    - (A) experimental;
    - (B) investigational; or
    - (C) not a medical necessity or appropriate.
- (2) "Carrier" means any person or entity that provides health insurance or disability income insurance in this state including:
- (a) an insurance company;
  - (b) a prepaid hospital or medical care plan;
  - (c) a health maintenance organization;
  - (d) a multiple employer welfare arrangement; and
  - (e) any other person or entity providing a health insurance or disability income insurance plan under Title 31A.
- (3) "Consumer Representative" may be an employee of the carrier who is a consumer of a health insurance or a disability income policy, as long as the employee is not:
- (a) the individual who made the adverse determination; or
  - (b) a subordinate to the individual who made the adverse determination.
- (4) "Medical Necessity" means:
- (a) health care services or products that a prudent health care professional would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is:
    - (i) in accordance with generally accepted standards of medical practice in the United States;



(ii) clinically appropriate in terms of type, frequency, extent, site, and duration;

(iii) not primarily for the convenience of the patient, physician, or other health care provider; and

(iv) covered under the contract; and

(b) that when a medical question-of-fact exists medical necessity shall include the most appropriate available supply or level of service for the individual in question, considering potential benefits and harms to the individual, and known to be effective.

(i) For interventions not yet in widespread use, the effectiveness shall be based on scientific evidence.

(ii) For established interventions, the effectiveness shall be based on:

(A) scientific evidence;

(B) professional standards; and

(C) expert opinion.

(5)(a) "Scientific evidence" means:

(i) scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff; or

(ii) findings, studies or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes.

(b) Scientific evidence shall not include published peer-reviewed literature sponsored to a significant extent by a pharmaceutical manufacturing company or medical device manufacturer or a single study without other supportable studies.

(6)(a) "Urgent care claim" means a request for a health care service or course of treatment with respect to which the time periods for making non-urgent care request determination:

(i) could seriously jeopardize the life or health of the insured or the ability of the insured to regain maximum function; or

(ii) in the opinion of ~~[a physician with knowledge of the insured's medical condition]~~the insured's attending provider, would subject the insured to severe pain that cannot be adequately managed without the health care service or treatment that is the subject of the request.

(b)(i) Except as provided in Subsection (6)(a)(ii), in determining whether a request is to be treated as an urgent care request, an individual acting on behalf of the carrier shall apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

(ii) Any request that a physician with knowledge of the insured's medical condition determines is an urgent care request within the meaning of Subsection (6)(a) shall be treated as an urgent care claim.

**R590-203-6. Independent and Expedited Adverse Benefit Determination Reviews for Health Insurance.**

(1) A carrier shall provide an independent review procedure as a voluntary option for the resolution of adverse benefit determinations of medical necessity.

(2) An independent review procedure shall be conducted by an independent review organization, person, or entity other than the carrier, the plan, the plan's fiduciary, the employer, or any employee or agent of any of the foregoing, that do not have any material professional, familial, or financial conflict of interest with

the health plan, any officer, director, or management employee of the health plan, the enrollee, the enrollee's health care provider, the provider's medical group or independent practice association, the health care facility where service would be provided and the developer or manufacturer of the service being provided.

(3) Independent review organizations shall be designated by the carrier, and the independent review organization chosen shall not own or control, be a subsidiary of, or in any way be owned or controlled by, or exercise control with a health insurance plan, a national, state, or local trade association of health insurance plans, and a national, state, or local trade association of health care providers.

(4) The submission to an independent review procedure is purely voluntary and left to the discretion of the claimant.

(5) A carrier's voluntary independent review procedure shall:

(a) waive any right to assert that a claimant has failed to exhaust administrative remedies because the claimant did not elect to submit a dispute of medical necessity to a voluntary level of appeal provided by the plan;

(b) agree that any statute of limitations or other defense based on timeliness is tolled during the time a voluntary appeal is pending;

(c) allow a claimant to submit a dispute of medical necessity to a voluntary level of appeal only after exhaustion of the appeals permitted under 29 CFR Subsection 2560.503-1(c)(2);

(d) upon request from any claimant, provide sufficient information relating to the voluntary level of appeal to enable the claimant to make an informed decision about whether to submit a dispute of medical necessity to the voluntary level of appeal. This information shall contain a statement that the decision to use a voluntary level of appeal will not [e]ffect the claimant's rights to any other benefits under the plan and information about the applicable rules, the claimant's right to representation, and the process for selecting the decision maker.

(e) An independent review conducted in compliance with Section 31A-22-629, and this rule, can be binding on both parties. A claimant's submission to a binding independent review is purely voluntary and appropriate disclosure and notification must be given as required by 29 CFR 2560.503-1.

(6) Standards for voluntary independent review:

(a) The carrier's internal adverse benefit determination process must be exhausted unless the carrier and claimant mutually agree to waive the internal process.

(b) Any adverse benefit determination of medical necessity may be the subject of an independent review.

(c) The claimant has 180 calendar days from the date of the final internal review decision to request an independent review.

(d) A carrier shall use the same minimum standards and times of notification requirement for an independent review that are used for internal levels of review, as set forth in 29 CFR Subsection 2560.503-1(h)(3), (i)(2) and (j).

(7) A carrier shall provide an expedited review process for cases involving urgent care claims.

(8) A request for an expedited review of an adverse benefit determination of medical necessity may be submitted either orally or in writing. If the request is made orally a carrier shall, within 24 hours, send written confirmation to the claimant acknowledging the receipt of the request for an expedited review.

(9) An expedited review requires:

(a) all necessary information, including the plan's original benefit determination, be transmitted between the plan and the claimant by telephone, facsimile, or other available similarly expeditious method;

(b) a carrier to notify the claimant of the benefit review determination, as soon as possible, taking into account the medical urgency, but not later than 72 hours after receipt of the claimant's request for review of an adverse benefit determination; and

(c) a carrier to use the same minimum standard for timing and notification as set forth in 29 CFR Subsection 2560.503-1(h), 503-1(i)(2)(i), and 503-1(j).

(10) This section, R590-203-6, does not apply to disability income policies.

**R590-203-9. [Relationship to Federal Rules.**

~~\_\_\_\_\_ If a carrier complies with the requirements of 29 CFR 2560.503-1, then this rule is not applicable to employer plans, except for Sections 4, 5, 6, 7, and 8 of this rule. All individual plans will remain subject to this rule in its entirety.~~

**R590-203-10.] Enforcement Date.**

commissioner shall begin enforcing the revised provisions of this rule [July 1, 2011] on the effective date.

**R590-203-[H]10. Severability.**

If a provision or clause of this rule or its application to any person or circumstance is for any reason held to be invalid, the remainder of the rule and the application of these provisions shall not be affected.

**KEY: insurance**

**Date of Enactment or Last Substantive Amendment:** [June 30,] 2011

**Notice of Continuation:** April 17, 2007

**Authorizing, and Implemented or Interpreted Law:** 31A-2-201; 31A-2-203; 31A-4-116; 31A-22-629

Insurance, Administration  
**R590-261**  
Health Benefit Plan Adverse Benefit  
Determination

**NOTICE OF PROPOSED RULE**

(Amendment)

DAR FILE NO.: 35105

FILED: 08/01/2011

**RULE ANALYSIS**

**PURPOSE OF THE RULE OR REASON FOR THE CHANGE:** This rule is being changed as a result of comments received from the insurance industry in a hearing

held 06/09/2011, during the comment period for the proposed new rule published in the May 15, 2011, Bulletin under DAR No. 34770, and additional changes from the federal government.

**SUMMARY OF THE RULE OR CHANGE:** The following amendments have been made to this rule: The scope has been changed so that an insurer can decide whether to use the rule for all grandfathered health plans; formatting changes have been made, as well as standardizing language; in Section R590-261-5, the "Adverse benefit determination" definition has been revised to conform with the federal Affordable Care Act (ACA) 2010 definition and broadened to apply to all adverse benefit determinations; a definition for "Independent Review" has been added; added a new federal requirement in Section R590-261-8 that de minimis violations of internal review process do not automatically allow an independent review; added a new Section R590-261-10 that contains general independent review requirements and amended the three sections to include the steps for each type of review; allowed for a substantially similar request form as in Appendix B; added language that carrier must provide Independent Review Organization (IRO) with claim documents; IRO must send information they receive from the claimant to the carrier; change requires carrier to approve coverage within one day of reversal by IRO; added language to experimental/investigational that addresses an expedited review; and clarified that an independent review is available for a rescission.

**STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE:** Section 31A-2-201 and Section 31A-2-212 and Section 31A-22-629

**ANTICIPATED COST OR SAVINGS TO:**

♦ **THE STATE BUDGET:** The changes to this rule will have no effect on the state or department's budget since the changes are mainly for clarification. There will be no additional filings required, no additional work required of department staff and no change in revenues or expenses.

♦ **LOCAL GOVERNMENTS:** The changes to this rule will have no effect on local government since the changes are for clarification purposes only and deal solely with the relationship between a licensed insurance company and insured or other claimant.

♦ **SMALL BUSINESSES:** The changes to this rule are for clarification purposes. Now that the insurer can decide whether they use the new review procedure process or remain under the old process may be a cost savings to them. As a result of the federal de minimis violation provision, fewer independent reviews may be required.

♦ **PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES:** Where there is a cost savings to the insurer, as there may be here, that savings may be passed on to the insured.

**COMPLIANCE COSTS FOR AFFECTED PERSONS:** The changes to this rule are for clarification purposes. Now that the insurer can decide whether they use the new review

procedure process or remain under the old process may be a cost savings to them. As a result of the federal de minimis violation provision, fewer independent reviews may be required.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: The changes to this rule may result in cost savings to insurers.

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](mailto:jwhitby@utah.gov)

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN AT 5:00 PM ON 09/14/2011

INTERESTED PERSONS MAY ATTEND A PUBLIC HEARING REGARDING THIS RULE:

♦ 09/08/2011 03:00 PM, State Office Building, 450 N State, Room 3112, Salt Lake City, UT

THIS RULE MAY BECOME EFFECTIVE ON: 09/21/2011

AUTHORIZED BY: Jilene Whitby, Information Specialist

#### **R590. Insurance, Administration.**

##### **R590-261. Health Benefit Plan Adverse Benefit Determinations.**

##### **R590-261-3. Scope.**

(1) ~~[This]~~ Except as provided in Subsection (2), this rule applies to all health benefit plans as defined in 31A-1-301 except for a grandfathered health plan as ~~[described]~~ defined in 45 CFR 147.140.

(2) ~~[A]~~ If all grandfathered health benefit plans are administered consistently, a carrier may, for the grandfathered health benefit plans, voluntarily comply with the independent review process set forth in this rule, otherwise a grandfathered health benefit plan is subject to R590-203 ~~[or may voluntarily comply with this rule upon the written consent of the policyholder].~~

(3) A self-funded health plan may voluntarily comply with the independent review process set forth in this rule.

##### **R590-261-4. Incorporation by Reference.**

The following appendices are hereby incorporated by reference within this rule and are available at [www.insurance.utah.gov/legalresources/currentrules.html](http://www.insurance.utah.gov/legalresources/currentrules.html):

(1) Appendix A, Independent Review Organization Application and Checklist, dated 09-2011.

(2) Appendix B, Independent Review Request Form, dated 09-2011.

##### **R590-261-5. Definitions.**

In addition to the definitions in Section 31A-1-301, the following definitions apply for purposes of this rule:

(1)(a) "Adverse benefit determination" means ~~[that]~~:  
(i) based on the carrier's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, the:

([i]A) denial of a benefit;  
([i]B) reduction of a benefit;  
([i]C) termination of a benefit; or  
([i]D) failure to provide or make payment, in whole or part, for a benefit; or

([v]ii) rescission of coverage.

(b) "Adverse benefit determination" includes:

(i) denial, reduction, termination, or failure to provide or make payment ~~[, or rescission]~~ that is based on a determination of an insured's eligibility to participate in a health benefit plan;

(ii) failure to provide or make payment, in whole or part, for a benefit resulting from the application of a utilization review; and

([e]iii) failure to cover an item or service for which benefits are otherwise provided because it is determined to be:

([i]A) experimental;  
([i]B) investigational; or  
([i]C) not medically necessary or appropriate.

(2) "Carrier" means any person or entity that provides health insurance in this state including:

(a) an insurance company;  
(b) a prepaid hospital or medical care plan;  
(c) a health maintenance organization;  
(d) a multiple employer welfare arrangement; and  
(e) any other person or entity providing a health insurance plan under Title 31A.

(3) "Claimant" means an insured or legal representative of the insured, including a member of the insured's immediate family designated by the insured, making a claim under a policy.

(4) "Clinical reviewer" means a physician or other appropriate health care provider who:

(a) is an expert in the treatment of the ~~[claimant's]~~ insured's medical condition that is the subject of the review

(b) is knowledgeable about the recommended health care service or treatment through recent or current actual clinical experience treating patients with the same or similar medical condition;

(c) holds an appropriate license or certification; and  
(d) has no history of disciplinary actions or sanctions.

(5) ~~(a)~~ "Independent review" means a process that:

(a) is a voluntary option for the resolution of an adverse benefit determination;

(b) is conducted at the discretion of the claimant;

(c) is conducted by an independent review organization designated by the commissioner;

(d) renders an independent and impartial decision on an adverse benefit determination; and

(e) may not require the claimant to pay a fee for requesting the independent review.

(6)(a) "Rescission" means a cancellation or discontinuance of coverage under a health benefit plan that has a retroactive effect.

(b) "Rescission" does not include a cancellation or discontinuance of coverage under a health benefit plan if the cancellation or discontinuance of coverage:

(i) has only a prospective effect; or

(ii) is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

**R590-261-6. Adverse Benefit Determination Procedure Compliance.**

An adverse benefit determination procedure shall be compliant with this rule and the requirements for adverse benefit determinations set forth in 29 CFR 2560.503-1 and 45 CFR 147.136.

**R590-261-7. Notice of Right to Independent Review.**

(1) With each notice of an ~~final~~ adverse benefit determination, the carrier shall provide written notice of the claimant's right for an independent review of the determination.

(2) The notice in Subsection (1) shall include the following, or substantially equivalent, statement:

"We have rescinded your coverage or denied your request for the provision of or payment for a health care service or course of treatment. You may have the right to have our decision reviewed by a health care professional who has no association with us if our decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment you requested. To receive additional information about an independent review, contact the Utah Insurance Commissioner by mail at Suite 3110 State Office Building, Salt Lake City UT 84114; by phone at 801 538-3077; or electronically at [healthappeals.uid@utah.gov](mailto:healthappeals.uid@utah.gov)."

**R590-261-8. Exhaustion of Internal Review Process.**

The carrier's internal review process shall be exhausted prior to an independent review unless:

(1) the carrier agrees to waive the internal review process;

(2) the carrier has not complied with the requirements for the carrier's internal review process except for those failures to comply that are based on de minimis violations that do not cause, and are not likely to cause, prejudice or harm to the claimant and are not part of a pattern or practice of violations; or

(3) the claimant has requested an expedited independent review pursuant to Section ~~10~~ 12 at the same time as requesting an expedited internal review.

**R590-261-9. Independent Review Organizations.**

(1) The commissioner shall compile and maintain a list of approved independent review organizations.

(2) To be considered for placement on the list of approved independent review organizations, an independent review organization shall:

(a) be accredited by a nationally recognized private accrediting entity;

(b) meet the requirements of this rule; and

(c) have written policies and procedures that ensure:

(i) that all reviews are conducted within the specified time frames;

(ii) the selection of qualified and impartial clinical reviewers;

(iii) the confidentiality of medical and treatment records and clinical review criteria; and

(iv) that any person employed by or under contract with the independent review organization adheres to the requirements of this rule.

(3) An applicant requesting placement on the list of approved independent review organizations shall submit for the commissioner's review:

(a) the application form attached to this rule as Appendix A;

(b) all documentation and information requested on the application, including proof of being accredited by a nationally recognized private accrediting entity; and

(c) the application fee.

(4) The commissioner shall terminate the approval of an independent review organization if the commissioner determines that the independent review organization has lost its accreditation or no longer satisfies the minimum requirements for approval.

(5)(a) An independent review organization may not own or control, or be owned or controlled by:

(i) a carrier;

(ii) a health benefit plan;

(iii) a health benefit plan's fiduciary;

(iv) an employer or sponsor of a health benefit plan;

(v) a trade association of:

(A) health benefit plans;

(B) carriers; or

(C) health care providers; or

(vi) an employee or agent of any one listed in Subsection (5)(a)(i) through (v).

(b) An independent review organization and the clinical reviewer assigned to conduct an independent review may not have a material professional, familial, or financial conflict of interest with:

(i) the carrier;

(ii) an officer, director, or management employee of the carrier;

(iii) the health benefit plan;

(iv) the plan administrator, plan fiduciaries, or plan employees;

(v) the insured or claimant;

(vi) the ~~claimant~~ insured's health care provider;

(vii) the health care provider's medical group or independent practice association;

(viii) a health care facility where the service would be provided; or

(ix) the developer or manufacturer of the service that would be provided.

**R590-261-10. ~~[Standard—Independent—Review]~~General Independent Review Requirements.**

The requirements of this section shall apply in addition to the requirements for a standard independent review, an expedited independent review and an independent review of experimental or investigational service or treatment.

(1) The carrier shall pay the cost of the independent review organization for conducting the independent review.

(2) ~~[The]An~~ independent review~~[of an adverse benefit determination]~~ is available to the claimant regardless of the dollar amount of the claim involved.

(3)(a) The claimant shall have 180 calendar days after the receipt of a notice of an adverse benefit determination to file a request with the commissioner for an independent review.

(b) The claimant shall use the Independent Review Request Form attached to this rule as Appendix B, or a substantially similar form, to file the request.

(c) A request for an independent review sent to the carrier instead of the commissioner shall be forwarded to the commissioner by the carrier within one business day of receipt.

(4) The independent review decision is binding on the carrier and claimant except to the extent that other remedies are available under federal or state law.

**R590-261-11. Standard Independent Review.**

(1)(a) Upon receipt of a request for an independent review, the commissioner shall send a copy of the request to the carrier for ~~[a preliminary]~~an eligibility review.

(b) Within five business days following receipt of the copy of the request, the carrier shall determine whether:

(i) the individual is or was ~~[a covered person]~~an insured in the health benefit plan at the time of rescission or the health care service was requested or provided;

(ii) ~~[the]~~if a health care service [that] is the subject of the adverse benefit determination, the health care service is a covered expense;

(iii) the claimant has exhausted the carrier's internal review process; and

(iv) the claimant has provided all the information and forms required to process an independent review.

(c)(i) Within one business day after completion of the ~~[preliminary]~~eligibility review, the carrier shall notify the commissioner and claimant in writing whether:

(A) the request is complete; and

(B) the request is eligible for independent review.

(ii) If the request:

(A) is not complete, the carrier shall inform the claimant and commissioner in writing what information or materials are needed to make the request complete; or

(B) is not eligible for independent review, the carrier shall;

(1) inform the claimant and commissioner in writing the reasons for ineligibility; and[-]

~~[(iii)]If the carrier determines that the request for independent review is ineligible, the carrier's notice of ineligibility shall~~ inform the claimant that the determination may be appealed to the commissioner.

(d)(i) The commissioner may determine that a request is eligible for independent review notwithstanding the carrier's initial

determination that the request is ineligible and require that the request be referred for independent review.

(ii) In making the determination in (d)(i), the commissioner's decision shall be made in accordance with the terms of the ~~[claimant's]~~insured's health benefit plan and shall be subject to all applicable provisions of this rule.

~~[(5)]2~~ Upon receipt of the carrier's ~~[preliminary-]~~ determination that the request is eligible for an independent review, the commissioner shall:

(a)~~[(+)]~~ assign on a random basis an independent review organization from the list of approved independent review organizations based on the nature of the health care service that is the subject of the review;

~~[(b)]b~~ notify the carrier of the assignment and that the carrier shall within five business days provide to the assigned independent review organization the documents and any information considered in making the adverse benefit determination; and

~~[(b)]c~~ notify the claimant that the request has been accepted and that the claimant may submit additional information to the independent review organization within five business days of receipt of the commissioner's notification. The independent review organization shall forward to the carrier within one business day of receipt any information submitted by the claimant.

~~[(5)]3~~ Within 45 calendar days after receipt of the request for an independent review, the independent review organization shall provide written notice of its decision to uphold or reverse the adverse benefit determination to:

(a) the claimant;

(b) the carrier; and

(c) the commissioner.

~~[(6)]The independent review decision is binding on the carrier and claimant except to the extent that other remedies are available under federal or state law.]~~

(4) Upon receipt of a notice reversing the adverse benefit determination, the carrier shall within one business day approve the coverage that was the subject of the adverse benefit determination.

**R590-261-~~[H]~~12. Expedited Independent Review.**

(1) An expedited independent review process shall be available if the adverse benefit determination:

(a) involves a medical condition of the ~~[claimant]~~insured which would seriously jeopardize the life or health of the ~~[claimant]~~insured or would jeopardize the ~~[claimant's]~~insured's ability to regain maximum function; ~~[-of]~~

(b) in the opinion of ~~[a physician with knowledge of-]~~the ~~[claimant's]~~insured's ~~[medical condition]~~attending provider, would subject the ~~[claimant]~~insured to severe pain that cannot be adequately managed without the care or treatment that is the subject of the adverse benefit determination; or

(c) concerns an admission, availability of care, continued stay or health care service for which the insured received emergency services, but has not been discharged from a facility.

~~[(2)](a)~~ Upon receipt of a request for an expedited independent review, the commissioner shall immediately send a copy of the request to the carrier for an eligibility review.

(b) Immediately upon receipt of the request, the carrier shall determine whether:

~~(i) the individual is or was an insured in the health benefit plan at the time the health care service was requested or provided;~~

~~(ii) the health care service that is the subject of the adverse benefit determination is a covered expense; and~~

~~(iii) the claimant has provided all the information and forms required to process an expedited independent review.~~

~~(c)(i) The carrier shall immediately notify the commissioner and claimant whether:~~

~~(A) the request is complete; and~~

~~(B) the request is eligible for an expedited independent review.~~

~~(ii) If the request:~~

~~(A) is not complete, the carrier shall inform the claimant and commissioner in writing what information or materials are needed to make the request complete; or~~

~~(B) is not eligible for independent review, the carrier shall:~~

~~(I) inform the claimant and commissioner in writing the reasons for ineligibility; and~~

~~(II) inform the claimant that the determination may be appealed to the commissioner.~~

~~(d)(i) The commissioner may determine that a request is eligible for an expedited independent review notwithstanding the carrier's initial determination that the request is ineligible and shall require that the request be referred for an expedited independent review.~~

~~(ii) In making the determination in (d)(i), the commissioner's decision shall be made in accordance with the terms of the insured's health benefit plan and shall be subject to all applicable provisions of this rule.~~

~~(3) Upon receipt of the carrier's determination that the request is eligible for an independent review, the commissioner shall immediately:~~

~~(a) assign an independent review organization from the list of approved independent review organizations;~~

~~(b) notify the carrier of the assignment and that the carrier shall within one business day provide to the assigned independent review organization all documents and information considered in making the adverse benefit determination; and~~

~~(c) notify the claimant that the request has been accepted and that the claimant may within one business day submit additional information to the independent review organization. The independent review organization shall forward to the carrier within one business day of receipt any information submitted by the claimant.~~

~~(4)(a) The independent review organization shall as soon as possible, but no later than 72 hours after receipt of the request for an expedited independent review, make a decision to uphold or reverse the adverse benefit determination and shall notify:~~

~~(i) the carrier; ~~and~~~~

~~(ii) the claimant; and~~

~~(iii) the commissioner.~~

~~(b) If notice of the independent review organization's decision is not in writing, the independent review organization shall provide written confirmation of its decision within 48 hours after the date of the notification of the decision.~~

~~(5) Upon receipt of a notice reversing the adverse benefit determination, the carrier shall within one business day, approve the coverage that was the subject of the adverse benefit determination.~~

### **R590-261-[12]13. Independent Review of Experimental or Investigational Service or Treatment Adverse Benefit Determinations.**

~~(1) [The claimant has 180 calendar days after the receipt of an adverse benefit determination that involves a denial of coverage based on a determination that the service or treatment recommended or requested is experimental or investigational to file a request with the commissioner for an independent review.~~

~~(2) In addition to the requirements for an independent review set forth in Sections 9 and 10, the following apply to an independent review involving experimental or investigational treatment:~~

~~(a) the]A request for an independent review based on experimental or investigational service or treatment shall be submitted with certification from the [claimant's]insured's physician that:~~

~~(i)a standard health care service[s] or treatment[s] [have]has not been effective in improving the [claimant's]insured's condition;~~

~~(ii)b standard health care service or treatment is not medically appropriate for the [claimant]insured; or~~

~~(iii)c there is no available standard health care service or treatment covered by the carrier that is more beneficial than the recommended or requested health care service or treatment.~~

~~(2)(a) Upon receipt of a request for an independent review involving experimental or investigational service or treatment, the commissioner shall send a copy of the request to the carrier for an eligibility review.~~

~~(b) Within five business days following receipt of the copy of the request, one business day for an expedited review, the carrier shall determine whether:~~

~~(i) the individual is or was an insured in the health benefit plan at the time the health care service was requested or provided;~~

~~(ii) the health care service or treatment that is the subject of the adverse benefit determination is a covered expense except for the carrier's determination that the service or treatment is experimental or investigational for a particular medical condition and is not explicitly listed as an excluded benefit under the insured's health benefit plan;~~

~~(iii) the claimant has exhausted the carrier's internal review process unless the request is for an expedited review; and~~

~~(iv) the claimant has provided all the information and forms required to process the independent review.~~

~~(c)(i) Within one business day after completion of the eligibility review, the carrier shall notify the commissioner and claimant in writing whether:~~

~~(A) the request is complete; and~~

~~(B) the request is eligible for independent review.~~

~~(ii) If the request:~~

~~(A) is not complete, the carrier shall inform the claimant and commissioner in writing what information or materials are needed to make the request complete; or~~

~~(B) is not eligible for independent review, the carrier shall:~~

~~(I) inform the claimant and commissioner in writing the reasons for ineligibility; and~~

~~(II) shall inform the claimant that the determination may be appealed to the commissioner.~~

(d)(i) The commissioner may determine that a request is eligible for independent review notwithstanding the carrier's initial determination that the request is ineligible and require that the request be referred for independent review.

(ii) In making the determination in (d)(i), the commissioner's decision shall be made in accordance with the terms of the health benefit plan and shall be subject to all applicable provisions of this rule.

(3) Upon receipt of the carrier's determination that the request is eligible for an independent review, the commissioner shall:

(a) assign an independent review organization from the list of approved independent review organizations;

(b) notify the carrier of the assignment and that the carrier shall within five business days, one business day for an expedited review, provide to the assigned independent review organization the documents and any information considered in making the adverse benefit determination; and

(c) notify the claimant that the request has been accepted and that the claimant may within five business days, one business day for an expedited review, submit additional information to the independent review organization. The independent review organization shall forward to the carrier within one business day of receipt any information submitted by the claimant.

(b)4) Within one business day after receipt of the request, the independent review organization shall select one or more clinical reviewers to conduct the review.

(e)5) The clinical reviewer shall provide to the independent review organization a written opinion within 20 calendar days, five calendar days for an expedited review, after being selected.

(d)6) The independent review organization shall make a decision based on the clinical reviewer's opinion within 20 calendar days, 48 hours for an expedited review, of receiving the opinion and shall notify ~~the~~:

(i)a) the claimant;

(i)b) the carrier; and

(i)c) the commissioner.

(7) Upon receipt of a notice reversing the adverse benefit determination, the carrier shall within one business day approve the coverage that was the subject of the adverse benefit determination.

#### **R590-261-[13]14. Disclosure Requirements.**

(1) Each carrier shall include a description of the independent review procedure in or attached to the policy and certificate, and may include a description with other evidence of coverage provided to the insured.

(2) The description required in Subsection (1) shall include a statement that informs the insured:

(a) of the right to file a request for an independent review of an ~~final~~ adverse benefit determination and include the contact information for the commissioner; and

(b) that an authorization to obtain medical records ~~may~~ shall be required for the purpose of reaching a decision.

#### **R590-261-[14]15. Records.**

(1) An independent review organization shall maintain a written record of each independent review for the current year plus 5 years.

(2) The records of an independent review organization shall be available for review by the commissioner upon request.

#### **R590-261-[15]16. Penalties.**

A person found to be in violation of this rule shall be subject to penalties as provided under Section 31A-2-308.

#### **R590-261-[16]17. Enforcement Date.**

The commissioner shall begin enforcing the revised provisions of this rule ~~[July 1, 2011]~~ on the effective date.

#### **R590-261-[17]18. Severability.**

If any provision of this rule or its application to any person or situation is held to be invalid, that invalidity shall not affect any other provision or application of this rule which can be given effect without the invalid provision or application, and to this end the provisions of this rule are declared to be severable.

#### **KEY: health benefit plan insurance**

**Date of Enactment or Last Substantive Amendment: ~~[June 30,] 2011~~**

**Authorizing, and Implemented or Interpreted Statutes: 31A-22-629; 31A-2-201; 31A-2-212**

## Labor Commission, Administration R600-3 Definitions Applicable to Construction Licensees

### NOTICE OF PROPOSED RULE

(New Rule)

DAR FILE NO.: 35093

FILED: 07/22/2011

### RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: Pursuant to the rulemaking authority granted to the Labor Commission by S.B. 35 (2011 General Session), the purpose of this rule is to define certain terms used within S.B. 35 and to establish a procedure by which an unincorporated entity licensed to perform construction by the Division of Professional Licensing (DOPL) can challenge the presumption created by S.B. 35 that such an entity is an employer for purposes of Utah laws dealing with payment of wages, employment discrimination, and occupational safety and health.

SUMMARY OF THE RULE OR CHANGE: The proposed rule defines the following terms: a) "active manager"; b) "directly holds at least an 8% ownership interest"; c) "indirectly holds at least an 8% ownership interest"; and d) "subject to supervision or control in the performance of work." The

proposed rule also identifies two methods by which an unincorporated entity may challenge the presumption created by S.B. 35 that the entity is an employer for purposes of payment of wages, employment discrimination, and occupational safety and health: 1) by requesting a declaratory determination from the Commission; or 2) as part of an existing adjudicatory proceeding.

STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Subsection 34-28-2(2) and Subsection 34A-5-102(2) and Subsection 34A-6-103(2)

ANTICIPATED COST OR SAVINGS TO:

◆ THE STATE BUDGET: By defining terms and clarifying procedures, the proposed rule should facilitate the Labor Commission's ability to resolve disputes regarding an unincorporated entity's status as an employer. However, in view of the fact that such disputes are relatively infrequent, the Commission does not anticipate appreciable costs or savings to the state budget as a result of the proposed rule.

◆ LOCAL GOVERNMENTS: The definitions and procedures of the proposed rule have no application to local government and will not result in any costs or savings to local government budgets.

◆ SMALL BUSINESSES: Pursuant to S.B. 35, unincorporated entities licensed to perform construction by DOPL are presumed to be employers of all their workers and staff. The proposed rule defines terms and establishes procedures to simplify the manner by which such entities can challenge that presumption. While the proposed rule should tend to make the above-described process simpler and therefore, less expensive to participants, such proceedings are relatively infrequent. Consequently, the Commission does not anticipate that the proposed rule will result in any appreciable cost or savings to the affected small businesses.

◆ PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES: Individual workers who are presumed under S.B. 35 to be employees of unincorporated entities may also be affected by the proposed rule's definitions and procedures. The proposed rule defines terms and establishes procedures to simplify the manner by which such entities can challenge that presumption. While the proposed rule should tend to make the above-described process simpler and therefore less expensive to all participants, including workers, such proceedings are relatively infrequent. Consequently, the Commission does not anticipate that the proposed rule will result in any appreciable cost or savings to other persons affected by the proposed rule.

COMPLIANCE COSTS FOR AFFECTED PERSONS: The proposed rule's definitions and procedures do not impose any compliance costs on affected persons.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: The proposed rule deals with the relatively infrequent

situation in which an unincorporated entity licensed by DOPL to perform construction seeks to rebut the presumption created by S.B. 35 that the unincorporated entity is an employer. The proposed rule's definitions and procedures should render these proceedings simpler and more efficient for all the participants and for the Commission. Consequently, the Commission does not anticipate that the proposed rule will have any negative fiscal impact on businesses.

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

LABOR 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:

◆ Alan Hennebold by phone at 801-530-6937, by FAX at 801-530-6390, or by Internet E-mail at [ahennebold@utah.gov](mailto:ahennebold@utah.gov)

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN AT 5:00 PM ON 09/14/2011

THIS RULE MAY BECOME EFFECTIVE ON: 09/21/2011

AUTHORIZED BY: Sherrie Hayashi, Commissioner

**R600. Labor Commission, Administration.**

**R600-3. Definitions Applicable to Construction Licensees.**

**R600-3-1. Authority and Scope.**

A. The Commission enacts this rule pursuant to authority granted by 34-28-2(2), 34A-5-102(2) and 34A-6-103(2).

B. This rule defines terms and establishes procedures by which an unincorporated entity that is a construction licensee may rebut its status as an employer for purposes of Title 34, Chapter 28, Payment of Wages; Title 34A, Chapter 5, Utah Antidiscrimination Act, and Title 34A, Chapter 6, Utah Occupational Safety and Health Act.

**R600-3-2. Definitions.**

A. An "active manager" is one who directs or causes the direction of the management and policies of the unincorporated entity, whether through the ownership of voting shares, by contract, or otherwise. Status as an active manager requires a documented history of voting on, approving, or otherwise deciding a substantial matter involving the business of the unincorporated entity, including without limitation:

1. Authorizing a member or any other person to do any act on behalf of the company that is not in the ordinary course of the company's business or business of the kind carried on by the company;

2. Making a distribution to members;

3. Resolving a dispute connected with the company's business;



4. Making a substantial change in the business purpose of the unincorporated entity;

5. Authorizing the unincorporated entity to acquire or merge with another entity; or

6. Authorizing a sale, lease, exchange or other disposition of a substantial asset of the unincorporated entity, other than in the usual and regular course of the business.

B. "Directly holds at least an 8% ownership interest" means that the individual owns in his or her individual capacity at least 8% of the stock, capital, or equity of the unincorporated entity, or is entitled to at least 8% of the unincorporated entity's profits.

C. "Indirectly holds at least an 8% ownership interest" means that the individual's total aggregate ownership interest from all sources, including a corporation, partnership, estate, trust or some other form of beneficial interest, totals at least 8% of the unincorporated entity's stock, capital, equity, or profits.

1. For example, if an individual owns 50% of company A which in turns owns 20% of the subject unincorporated entity, then the individual holds a 10% indirect ownership interest in the unincorporated entity.

D. "Subject to supervision or control in the performance of work" means that:

1. The unincorporated entity has the right to control what the worker does and how he or she does it, regardless of whether the unincorporated entity actually exercises that authority; or

2. The unincorporated entity has the right to control the business aspects of the work, such as:

a. How the worker is paid;

b. Whether expenses are reimbursed;

c. Who is responsible to provide tools and supplies;

d. Who arranges for administrative support, advertising, and similar functions.

**R600-3-3. Procedures to Challenge Presumption that Unincorporated Entity is the Employer.**

A. Declaratory Actions. An interested party may request a determination regarding an unincorporated entity's status as an employer by filing a petition for declaratory order in accordance with Rule R600-1.

B. In Connection with Other Adjudicative Proceedings.

1. In proceedings to adjudicate a claim of unpaid wages, employment discrimination, or violation of occupational safety and health standards, an unincorporated entity may submit evidence that rebuts the presumption that the unincorporated entity is an employer.

2. Notwithstanding the burden of proof required to prove the underlying claim, the unincorporated entity may only rebut the presumption that it is the employer by clear and convincing evidence.

**KEY: labor commission, unincorporated entity, construction licensees**

**Date of Enactment or Last Substantive Amendment: 2011**

**Authorizing, and Implemented or Interpreted Law: 34A-1-104**

**Labor Commission, Adjudication  
R602-2-4  
Attorney Fees**

**NOTICE OF PROPOSED RULE**

(Amendment)

DAR FILE NO.: 35092

FILED: 07/22/2011

**RULE ANALYSIS**

**PURPOSE OF THE RULE OR REASON FOR THE CHANGE:** The purpose of the proposed rule change is to increase the maximum attorneys' fees in workers' compensation cases, to match the increase in benefit amounts over the last four years.

**SUMMARY OF THE RULE OR CHANGE:** The amendment increases the amount of attorney fees by 12.123% to reflect benefit increases over the last four years.

**STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE:** Section 34A-1-301 et seq. and Section 63G-4-102 et seq.

**ANTICIPATED COST OR SAVINGS TO:**

♦ **THE STATE BUDGET:** This amendment does not affect the state in its capacity as an employer nor does it increase the state's cost of administering the workers' compensation system, consequently no costs or savings to the state budget are anticipated.

♦ **LOCAL GOVERNMENTS:** This amendment does not affect local governments in their capacity as employers, consequently no costs or savings to local government budgets are anticipated.

♦ **SMALL BUSINESSES:** This amendment does not affect small businesses in their capacity as employers, consequently no costs or saving to small businesses are anticipated.

♦ **PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES:** This increase of 12.123% above previous attorney fee limits is offset by a similar increase in weekly benefits that injured workers are now receiving.

**COMPLIANCE COSTS FOR AFFECTED PERSONS:** The only compliance costs are the higher attorneys' fees that injured workers may be required to pay. As noted, this increase is due to (and offset by) increase in benefits paid to injured workers over the last four years.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: The attorneys' fees subject to this rule are paid by the injured worker, not the employer. The change should therefore have no fiscal impact on businesses.

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

LABOR COMMISSION  
ADJUDICATION  
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:

◆ Alan Hennebold by phone at 801-530-6937, by FAX at 801-530-6390, or by Internet E-mail at ahennebold@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN AT 5:00 PM ON 09/14/2011

THIS RULE MAY BECOME EFFECTIVE ON: 09/21/2011

AUTHORIZED BY: Sherrie Hayashi, Commissioner

**R602. Labor Commission, Adjudication.**

**R602-2. Adjudication of Workers' Compensation and Occupational Disease Claims.**

**R602-2-4. Attorney Fees.**

A. Pursuant to Section 34A-1-309, the Commission adopts the following rule to regulate and fix reasonable fees for attorneys representing applicants in workers' compensation or occupational illness claims.

1. This rule applies to all fees awarded after ~~[July 1, 2007]~~ October 1, 2012.

2. Fees awarded prior to the effective date of this rule are determined according to the prior version of this rule in effect on the date of the award.

B. Upon written agreement, when an attorney's services are limited to consultation, document preparation, document review, or review of settlement proposals, the attorney may charge the applicant an hourly fee of not more than \$125 for time actually spent in providing such services, up to a maximum of four hours.

1. Commission approval is not required for attorneys fees charged under this subsection B. It is the applicant's responsibility to pay attorneys fees permitted by this subsection B.

2. In all other cases involving payment of applicants' attorneys fees which are not covered by this subsection B., the entire amount of such attorneys fees are subject to subsection C. or D. of this rule.

C. Except for legal services compensated under subsection B. of this rule, all legal services provided to applicants shall be compensated on a contingent fee basis.

1. For purposes of this subsection C., the following definitions and limitations apply:

a. The term "benefits" includes only death or disability compensation and interest accrued thereon.

b. Benefits are "generated" when paid as a result of legal services rendered after Adjudication Form 152 Appointment of Counsel form is signed by the applicant. A copy of this form must be filed with the Commission by the applicant's attorney.

c. In no case shall an attorney collect fees calculated on more than the first 312 weeks of any and all combinations of workers' compensation benefits.

2. Fees and costs authorized by this subsection shall be deducted from the applicant's benefits and paid directly to the attorney on order of the Commission. A retainer in advance of a Commission approved fee is not allowed.

3. Attorney fees for benefits generated by the attorney's services shall be computed as follows:

a. For all legal services rendered through final Commission action, the fee shall be 25% of weekly benefits generated for the first \$25,000, plus 20% of the weekly benefits generated in excess of \$25,000 but not exceeding \$50,000, plus 10% of the weekly benefits generated in excess of \$50,000, to a maximum of ~~[\$15,250]~~ 17,125.

b. For legal services rendered in prosecuting or defending an appeal before the Utah Court of Appeals, an attorney's fee shall be awarded amounting to 30% of the benefits in dispute before the Court of Appeals. This amount shall be added to any attorney's fee awarded under subsection C.3.a. for benefits not in dispute before the Court of Appeals. The total amount of fees awarded under subsection C.3.a. and this subsection C.3.b. shall not exceed ~~[\$22,000]~~ 24,706;

c. For legal services rendered in prosecuting or defending an appeal before the Utah Supreme Court, an attorney's fee shall be awarded amounting to 35% of the benefits in dispute before the Supreme Court. This amount shall be added to any attorney's fee awarded under subsection C.3.a. and subsection C.3.b. for benefits not in dispute before the Supreme Court. The total amount of fees awarded under subsection C.3.a, subsection C.3.b. and this subsection C.3.c shall not exceed ~~[\$27,000]~~ 30,321.

D. The following expenses, fees and costs shall be presumed to be reasonable and necessary and therefore reimbursable in a workers compensation claim:

1. Medical records and opinion costs;
2. Deposition transcription costs;
3. Vocational and Medical Expert Witness fees;
4. Hearing transcription costs;
5. Appellate filing fees; and
6. Appellate briefing expenses.

F. Other reasonable expenses, fees and costs may be awarded as reimbursable as the Commission may in its discretion decides in a particular workers compensation claim.

E. In "medical only" cases in which awards of attorneys' fees are authorized by Subsection 34A-1-309(4), the amount of such fees and costs shall be computed according to the provisions of subsection C and D.

**KEY: workers' compensation, administrative procedures, hearings, settlements**

**Date of Enactment or Last Substantive Amendment: ~~[June 22,]~~ 2011**

**Notice of Continuation: August 15, 2007**  
**Authorizing, and Implemented or Interpreted Law: 34A-1-301 et seq.; 63G-4-102 et seq.**

**Labor Commission, Antidiscrimination  
 and Labor, Fair Housing  
 R608-1-17  
 Assistance Animals**

**NOTICE OF PROPOSED RULE**  
 (Amendment)  
 DAR FILE NO.: 35094  
 FILED: 07/22/2011

**RULE ANALYSIS**

**PURPOSE OF THE RULE OR REASON FOR THE CHANGE:** This rule defines circumstances in which state and federal fair housing laws authorize an individual with a disability to possess an assistance animal as a reasonable accommodation. The rule also addresses the relationship of fair housing standards for use of service animals to standards found at 62A-5b-101 et seq. for use of service animals in public areas, common carriers, and similar locations.

**SUMMARY OF THE RULE OR CHANGE:** The rule clarifies that federal and state fair housing laws entitle an individual with a disability to have an assistance animal in a housing facility that would otherwise restrict such animals, provided that the service animal is necessary to the disabled individual's use and enjoyment of the housing. The rule allows a housing provider to verify the need for such an assistance animal, and to disallow a service animal on the grounds of undue financial or administrative burden, safety, or other such reasons. The rule also clarifies that use of a service animal as a reasonable accommodation is limited to tenants and prospective tenants and does not extend to visitors or guests.

**STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE:** Section 57-21-1 et seq. and Section 63G-4-102 et seq.

**ANTICIPATED COST OR SAVINGS TO:**  
 ♦ **THE STATE BUDGET:** The rule will not have any appreciable effect on the state's costs in administering and enforcing fair housing laws, nor is the rule expected to have any other fiscal impact on the state budget.  
 ♦ **LOCAL GOVERNMENTS:** To the extent that local governments provide housing to disabled individuals, such governments may be subject to this rule's requirements.

Because the rule merely restates and clarifies the existing requirements of state and federal statutes, adoption of the rule will not result in any cost or savings to local governments.

♦ **SMALL BUSINESSES:** To the extent that small businesses provide housing to disabled individuals, such small businesses may be subject to this rule's requirements. Because the rule merely restates and clarifies the existing requirements of state and federal statutes, adoption of the rule will not result in any cost or savings to small businesses.

♦ **PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES:** In addition to local governments and small businesses, other entities that provide housing to disabled individuals may be subject to this rule's requirements. Because the rule merely restates and clarifies the existing requirements of state and federal statutes, adoption of the rule will not result in any cost or savings to small businesses.

**COMPLIANCE COSTS FOR AFFECTED PERSONS:** This rule imposes no compliance costs on affected persons. The rule's substantive provisions are already part of state and federal Fair Housing law. Consequently, housing providers and housing consumers are already subject to the requirements contained in the rule.

**COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES:** By clarifying and explaining to housing providers and housing consumers the rules that apply to assistance animals, the proposed rule should avoid conflict and reduce the number of adjudicative proceedings on this issue. To that extent, the proposed rule will reduce litigation costs for businesses and individuals.

**THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:**  
 LABOR COMMISSION  
 ANTIDISCRIMINATION AND LABOR,  
 FAIR HOUSING  
 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:**  
 ♦ Alan Hennebold by phone at 801-530-6937, by FAX at 801-530-6390, or by Internet E-mail at ahennebold@utah.gov

**INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN AT 5:00 PM ON 09/14/2011**

**THIS RULE MAY BECOME EFFECTIVE ON: 09/21/2011**

**AUTHORIZED BY: Sherrie Hayashi, Commissioner**

**R608. Labor Commission, Antidiscrimination and Labor, Fair Housing.****R608-1. Utah Fair Housing Rules.****R608-1-17. Assistance Animals.****A. General**

1. Pursuant to the Utah Fair Housing Act and the federal Fair Housing Act, this rule defines the circumstances in which an individual with a disability is entitled to an assistance animal as a reasonable accommodation in a housing facility that would otherwise restrict or prohibit the presence of an animal. This rule applies only to tenants, prospective tenants and those authorized by the housing provider to live at the housing facility.

2. The proposed assistance animal must be necessary to afford the individual an equal opportunity to use and enjoy a dwelling or to participate in the housing service or program. This requires a demonstrable relationship between the individual's disability and the assistance the animal provides.

a. Housing providers are entitled to verify the existence of the individual's disability as well as the need for the assistance animal as an accommodation for that disability if either is not readily apparent. Accordingly, an individual proposing an assistance animal as a reasonable accommodation for a disability may be required to provide documentation from a physician, psychiatrist, or other qualified healthcare professional that the animal provides support that alleviates a symptom or effect of the disability.

b. Housing providers need not permit an assistance animal as an accommodation to a person with a disability if the provider demonstrates that allowing the assistance animal would

impose an undue financial or administrative burden or would fundamentally alter the nature of the housing facility, program or service.

c. Housing providers are not required to provide an accommodation that poses a direct threat to the health or safety of others. Thus, if a particular assistance animal has a history of dangerous behavior, if the animal is out of control and its handler does not take effective action to control it, or if the animal is not housebroken, the provider is not required to accept the animal into the housing.

B. Relationship of this rule to other laws addressing service animals.

While federal and state fair housing laws and this rule establish the standards for assistance animals as a reasonable accommodation in housing, this rule does not apply to use of service animals in public areas, common carriers, public conveyances, public accommodations or places of amusement, which are governed by standards set forth in Utah Code Ann. Section 62A-5b-101 et seq., "Rights and Privileges of a Person with a Disability."

**KEY: housing, fair housing, discrimination, time**

**Date of Enactment or Last Substantive Amendment: [~~October 7, 2005~~2011]**

**Notice of Continuation: November 30, 2006**

**Authorizing, and Implemented or Interpreted Law: 57-21-1 et seq.; 63G-4-102 et seq.**

**End of the Notices of Proposed Rules Section**

# FIVE-YEAR NOTICES OF REVIEW AND STATEMENTS OF CONTINUATION

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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.

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## Career Service Review Office, Administration **R137-1** Grievance Procedure Rules

### FIVE-YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION

DAR FILE NO.: 35083  
FILED: 07/18/2011

### NOTICE OF REVIEW AND STATEMENT OF CONTINUATION

CONCISE EXPLANATION OF THE PARTICULAR STATUTORY PROVISIONS UNDER WHICH THE RULE IS ENACTED AND HOW THESE PROVISIONS AUTHORIZE OR REQUIRE THE RULE: Section 67-19a-203 grants the Career Service Review Office rulemaking authority to carry out the statutory provisions of the state's grievance and appeal procedures.

SUMMARY OF WRITTEN COMMENTS RECEIVED DURING AND SINCE THE LAST FIVE YEAR REVIEW OF THE RULE FROM INTERESTED PERSONS SUPPORTING OR OPPOSING THE RULE: No written comments have been received over 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: The rule subject to this review is essential to carry out the legislative intent of the state grievance and appeal procedures codified at Title 67, Chapter 19a. The grievance process is functioning well and state employees, as well as management expect it to continue. This rule is necessary to assure that the process continues to address employee grievances in a fair and judicious manner, and therefore, this rule should be continued.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:  
CAREER SERVICE REVIEW OFFICE  
ADMINISTRATION  
ROOM 1120 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:  
♦ Robert Thompson by phone at 801-538-3047, by FAX at 801-538-3139, or by Internet E-mail at [bthompson@utah.gov](mailto:bthompson@utah.gov)

AUTHORIZED BY: Robert Thompson, Administrator

EFFECTIVE: 07/18/2011

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**End of the Five-Year Notices of Review and Statements of Continuation Section**



## NOTICES OF RULE EFFECTIVE DATES

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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.

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### Abbreviations

AMD = Amendment  
CPR = Change in Proposed Rule  
NEW = New Rule  
R&R = Repeal & Reenact  
REP = Repeal

### Commerce

Occupational and Professional Licensing  
No. 34885 (AMD): R156-1. General Rule of the Division of Occupational and Professional Licensing  
Published: 06/15/2011  
Effective: 07/26/2011

No. 34887 (AMD): R156-17b-310. Exemption from Licensure - Physicians Dispensing Cosmetic Drug or Injectable Weight Loss Drug  
Published: 06/15/2011  
Effective: 07/26/2011

No. 34888 (REP): R156-39a. Alternative Dispute Resolution Providers Certification Act  
Published: 06/15/2011  
Effective: 07/26/2011

No. 34886 (AMD): R156-46b. Division Utah Administrative Procedures Act Rule  
Published: 06/15/2011  
Effective: 07/26/2011

### Governor

Economic Development, Pete Suazo Utah Athletic Commission  
No. 34901 (AMD): R359-1-501. Promoter's Responsibilities in Arranging a Contest  
Published: 06/15/2011  
Effective: 07/26/2011

No. 34900 (AMD): R359-1-515. Competing in an Unsanctioned Unarmed Combat Event  
Published: 06/15/2011  
Effective: 07/26/2011

### Health

Health Care Financing, Coverage and Reimbursement Policy  
No. 34894 (REP): R414-4A. Outpatient Hospital Services: Payment of Triage Fee  
Published: 06/15/2011  
Effective: 08/01/2011

### Family Health and Preparedness, Emergency Medical Services

No. 34902 (AMD): R426-16. Emergency Medical Services Ambulance Rates and Charges  
Published: 06/15/2011  
Effective: 07/26/2011

### Human Services

Child and Family Services  
No. 34779 (NEW): R512-205. Child Protective Services, Investigation of Domestic Violence Related Child Abuse  
Published: 06/01/2011  
Effective: 07/28/2011

### Natural Resources

Parks and Recreation  
No. 34864 (AMD): R651-201-6. Tow(ed)(ing)  
Published: 06/15/2011  
Effective: 07/27/2011

No. 34865 (AMD): R651-206-2. Outfitting Company Responsibilities  
Published: 06/15/2011  
Effective: 07/27/2011

No. 34866 (AMD): R651-224-3. Flag Required  
Published: 06/15/2011  
Effective: 07/27/2011

No. 34889 (AMD): R651-606-5. Time-Limit in Campsite may not be Exceeded  
Published: 06/15/2011  
Effective: 07/27/2011

No. 34890 (AMD): R651-611-3. Camping Fees  
Published: 06/15/2011  
Effective: 07/27/2011

NOTICES OF RULE EFFECTIVE DATES

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Pardons (Board Of)

Administration

No. 34867 (AMD): R671-102. Americans with Disabilities Act  
Complaint Procedures Rule

Published: 06/15/2011

Effective: 07/26/2011

Public Safety

Highway Patrol

No. 34895 (AMD): R714-600. Performance Standards for  
Tow Truck Motor Carriers

Published: 06/15/2011

Effective: 08/01/2011

**End of the Notices of Rule Effective Dates Section**



# RULES INDEX BY AGENCY (CODE NUMBER) AND BY KEYWORD (SUBJECT)

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The Rules Index is a cumulative index that reflects all effective changes to Utah's administrative rules. The current Index lists changes made effective from January 2, 2011 through August 01, 2011. 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).

**DAR NOTE:** A processing error caused the exclusion of 110 nonsubstantive changes from the Index. These nonsubstantive changes reflect changed agency names in the Department of Health. The Division is working to correct the error.

Questions regarding the index and the information it contains should be addressed to Nancy Lancaster (801-538-3218), Mike Broschinsky (801-538-3003), or Kenneth A. Hansen (801-538-3777).

A copy of the Rules Index is available for public inspection at the Division of Administrative Rules (4120 State Office Building, Salt Lake City, UT), or may be viewed online at the Division's web site (<http://www.rules.utah.gov/>).

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## 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
<b>ADMINISTRATIVE SERVICES</b>					
<u>Administration</u>					
R13-3	Americans with Disabilities Act Grievance Procedures	34347	AMD	03/10/2011	2011-3/4
R13-3-2	Definitions	34674	NSC	04/27/2011	Not Printed
<u>Facilities Construction and Management</u>					
R23-23	Health Reform - Health Insurance Coverage in State Contracts - Implementation	34801	EMR	05/10/2011	2011-11/105
R23-23	Health Reform - Health Insurance Coverage in State Contracts - Implementation	34803	AMD	07/11/2011	2011-11/6
R23-31	Executive Residence Commission	34802	NEW	07/11/2011	2011-11/8
<u>Finance</u>					
R25-7	Travel-Related Reimbursements for State Employees	34764	AMD	07/01/2011	2011-10/6
<u>Fleet Operations</u>					
R27-3	Vehicle Use Standards	34256	AMD	01/25/2011	2010-24/6
R27-3-4	Authorized and Unauthorized Use of State Vehicles	34786	AMD	07/12/2011	2011-11/10
R27-4-11	Capital Credit or Reservation of Vehicle Allocation for Surrendered Vehicles	34257	AMD	01/25/2011	2010-24/7
<b>AGRICULTURE AND FOOD</b>					
<u>Administration</u>					
R51-3	Government Records Access and Management Act	34491	5YR	03/03/2011	2011-7/43
R51-4	ADA Complaint Procedure	34492	5YR	03/03/2011	2011-7/43
<u>Animal Industry</u>					
R58-1	Admission and Inspection of Livestock, Poultry and Other Animals	34343	AMD	03/24/2011	2011-3/7
R58-2	Diseases, Inspections and Quarantines	34352	AMD	03/24/2011	2011-3/13
R58-2	Diseases, Inspections and Quarantines	34975	5YR	06/23/2011	2011-14/135
R58-4	Use of Animal Drugs and Biologicals in the State of Utah	34976	5YR	06/23/2011	2011-14/135
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R58-20	Domesticated Elk Hunting Park	34906	EMR	06/07/2011	2011-13/79
<u>Marketing and Development</u>					
R65-8	Management of the Junior Livestock Show Appropriation	34489	5YR	03/03/2011	2011-7/44

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R68-7	Utah Pesticide Control Act	34488	5YR	03/02/2011	2011-7/44
R68-7	Utah Pesticide Control Act	34430	AMD	06/02/2011	2011-5/2
R68-7	Utah Pesticide Control Rule	34711	AMD	06/21/2011	2011-10/10
R68-7-10	Responsibilities of Business and Applicator	34456	NSC	06/02/2011	Not Printed
R68-7-10	Responsibilities of Business and Applicator	34498	AMD	06/02/2011	2011-7/2
R68-8	Utah Seed Law	34345	5YR	01/05/2011	2011-3/55
R68-18	Quarantine Pertaining to Karnal Bunt	34412	5YR	02/08/2011	2011-5/107
R68-21-2	Authority	34558	NSC	04/27/2011	Not Printed

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R70-370	Butter	34519	5YR	03/16/2011	2011-8/29
R70-380	Grade A Condensed and Dry Milk Products and Condensed and Dry Whey	34517	5YR	03/16/2011	2011-8/30
R70-410	Grading and Inspection of Shell Eggs with Standard Grade and Weight Classes	34378	5YR	01/24/2011	2011-4/35

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R81-1	Scope, Definitions, and General Provisions	34787	5YR	05/10/2011	2011-11/123
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R81-2	State Stores	34788	5YR	05/10/2011	2011-11/124
R81-3	Package Agencies	34789	5YR	05/10/2011	2011-11/125
R81-3-13	Operational Restrictions	34340	AMD	02/24/2011	2011-2/6
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R81-5	Private Clubs	34791	5YR	05/10/2011	2011-11/126
R81-6	Special Use Permits	34792	5YR	05/10/2011	2011-11/127
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R81-8	Manufacturers (Distillery, Winery, Brewery)	34794	5YR	05/10/2011	2011-11/128
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Administration

R131-4	Capitol Preservation Board General Procurement Rule	34675	5YR	04/11/2011	2011-9/117
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R137-1	Grievance Procedure Rules	35083	5YR	07/18/2011	Not Printed
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COMMERCE

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R151-14-3	Adjudicative Proceedings	34735	NSC	05/25/2011	Not Printed
R151-35-3	Adjudicative Proceedings	34736	NSC	05/25/2011	Not Printed
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R156-3a Architect Licensing Act Rule 34396 5YR 01/31/2011 2011-4/35

R156-9a Uniform Athlete Agents Act Rules 34499 5YR 03/10/2011 2011-7/45

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R156-46b Division Utah Administrative Procedures Act Rule 34397 5YR 01/31/2011 2011-4/36

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R156-46b Division Utah Administrative Procedures Act Rule 34886 AMD 07/26/2011 2011-12/27

R156-50 Private Probation Provider Licensing Act Rules 34282 NSC 01/06/2011 Not Printed

R156-55a Utah Construction Trades Licensing Act Rule 34470 AMD 04/25/2011 2011-6/35

R156-55c-102 Definitions 34338 AMD 02/24/2011 2011-2/10

R156-55e-303a Continuing Education - Standards 34673 NSC 04/27/2011 Not Printed

R156-60a Social Worker Licensing Act Rule 34310 AMD 02/10/2011 2011-1/6

R156-60c Professional Counselor Licensing Act Rule 34339 AMD 02/24/2011 2011-2/12

R156-60d Substance Abuse Counselor Act Rule 34395 5YR 01/31/2011 2011-4/37

R156-63a Security Personnel Licensing Act Contract Security Rule 34370 AMD 03/24/2011 2011-4/12

R156-63a-302f Qualifications for Licensure - Good Moral Character - Disqualifying Convictions 34360 NSC 01/26/2011 Not Printed

R156-63b Security Personnel Licensing Act Armored Car Rule 34542 AMD 05/26/2011 2011-8/11

R156-67 Utah Medical Practice Act Rule 34504 5YR 03/14/2011 2011-7/46

R156-69 Dentist and Dental Hygienist Practice Act Rule 34283 AMD 02/07/2011 2011-1/8

R156-69 Dentist and Dental Hygienist Practice Act Rule 34500 5YR 03/10/2011 2011-7/46

R156-72 Acupuncture Licensing Act Rules 34543 AMD 05/26/2011 2011-8/14

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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	

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	34326	R861-1A-43	AMD	02/23/2011	2011-2/42
	34687	R861-1A-43	AMD	06/23/2011	2011-9/102
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