

PENDING FEE RULES

COMMITTEE RULES

REVIEW BOOK

Submitted for Review Before
**House Commerce &
Human Resources Committee**

66th Idaho Legislature
Second Regular Session – 2022



Prepared by:

*Office of the Administrative Rules Coordinator
Division of Financial Management*

January 2022



State of Idaho
DIVISION OF FINANCIAL MANAGEMENT
Executive Office of the Governor

BRAD LITTLE
Governor

ALEX J. ADAMS
Administrator

January 10, 2022

MEMORANDUM

TO: Members of the 2022 Idaho State Legislature

FROM: Alex J. Adams, Administrator *Alex J. Adams*
Bradley A. Hunt, Rules Coordinator *Bradley A. Hunt*

SUBJECT: Overview of Executive Agency Rulemaking in 2021

Background. Governor Little maintains and continues to stress the importance of an efficiently functioning government along with ensuring continuity of the services citizens expect and implemented through executive administrative rules. Nearly all rules published in the Legislative Rules Review books are simply re-published because the 2021 Legislature adjourned *sine die* without passing a concurrent resolution approving any pending fee rules as specified in Section 67-5224, Idaho Code, as well as not extending any effective rule on July 1 by statute as outlined in Section 67-5292, Idaho Code. The necessary rules were re-published in the following special bulletins:

- [July 21](#) – Temporary Rules
- [October 20](#) – Proposed Rules
- [December 22](#) – Pending Rules

Changes in Existing Rules. Since the vast majority of rules either expired or were not approved, there is no existing rule available to amend. Therefore, only a clean version of the rule chapter is able to be presented to the Legislature in January 2022. In some cases, rules were modified based on public comment, or to implement Executive Order [2020-01](#), Zero-Based Regulation (ZBR), among other reasons. Given the unprecedented volume, edits are incorporated within a single omnibus docket, or in the case of ZBR rulemaking a standalone docket, and presented as a clean rule chapter. There are several ways that legislators may view previous rules for comparison purposes:

- An [archive of any rule](#) since 1996 is available on the DFM website. This allows legislators to see the evolution of a rule over time.
- The Legislative Services Office analyzes all proposed rules. You can find their analysis of proposed rules which, in some cases, may discuss changes between previous rules and the proposed rules. These may be found on the [Legislature's website](#).
- Changes made between the proposed and pending rule stages for omnibus rulemaking were noted in the [December 22](#) bulletin where applicable.

Process for Approving Rules. Below, you will find a brief description on legislative actions and outcomes regarding the rules review process and contents of the Legislative Rules Review Books:

- Pending Fee Rules must be affirmatively approved by both bodies via adoption of concurrent resolution to become final.
- Pending Rules become final and effective *sine die* unless rejected, in whole or in part, via concurrent resolution adopted by both bodies.
 - Pending rules may be approved, in whole or in part, or rejected if determined to be inconsistent with legislative intent of the governing statute.
 - If rejected, new or amended language must be identified at a numerical or alphabetical designation within the rule and specified in the concurrent resolution.
- A link to LSO's proposed rule analysis is provided at the beginning of each docket and includes any required supporting documentation (e.g. Cost Benefit Analysis (CBA), Incorporation By Reference Synopsis (IBRS)) as part of the analysis.
- All 2022 review books can be accessed on the DFM website [here](#).

Contact Information. If questions arise during the rules review process, please do not hesitate to contact the Rules Coordinator, Brad Hunt: Brad.Hunt@dfm.idaho.gov; 208-854-3096.

HOUSE COMMERCE & HUMAN RESOURCES COMMITTEE

ADMINISTRATIVE RULES REVIEW

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IDAPA 17 – INDUSTRIAL COMMISSION

DOCKET NO. 17-0000-2100F

NOTICE OF OMNIBUS RULEMAKING – ADOPTION OF PENDING FEE RULE

[LINK: LSO Rules Analysis Memo and Cost/Benefit Analysis \(CBA\)](#)

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2022 Idaho State Legislature for final approval. Pursuant to Section 67-5224(5)(c), Idaho Code, this pending rule will not become final and effective until it has been approved by concurrent resolution of the legislature because of the fee being imposed or increased through this rulemaking. The pending fee rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution unless the rule is rejected.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending fee rule. The action is authorized pursuant to Sections 72-301, 72-301A, 72-304, 72-327, 72-432, 72-508, 72-528, 72-602, 72-803, and 72-806, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending fee rule and a statement of any change between the text of the proposed rule and the text of the pending fee rule with an explanation of the reasons for the change.

This pending fee rule adopts and publishes the following rule chapter previously submitted to and reviewed by the Idaho Legislature under IDAPA 17, rules of the Industrial Commission:

IDAPA 17

- 17.01.01, *Administrative Rules Under the Worker's Compensation Law.*

The text of the pending fee rule has been amended in accordance with Section 67-5227, Idaho Code. The original text of the proposed rule was published in the October 20, 2021 Idaho Administrative Bulletin (Special Edition), [Vol. 21-10SE, pages 2751-2780](#). The Commission has decided not to go forth with proposed language regarding medical records based on stakeholder feedback.

FEE SUMMARY: The following identifies the fee or charge imposed or increased through this rulemaking:

This rulemaking does not impose a new fee or charge, or increase an existing fee or charge, beyond what has been previously submitted for review in the prior rules. The \$250 application fees charged to employers seeking approval to become self-insured is needed to defray added costs incurred by the Commission in evaluating these applications. This fee or charge is being imposed pursuant to Section 72-301, Idaho Code.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars (\$10,000) during the fiscal year: This rulemaking is not anticipated to have any fiscal impact on the state general fund because the FY2022 budget has already been set by the Legislature, and approved by the Governor, anticipating the existence of the rule and fee being reauthorized by this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending fee rule, contact Kamerron Slay, Commission Secretary, (208) 334-6017 or kamerron.slay@iic.idaho.gov.

Dated this 22nd day of December, 2021.

Mindy Montgomery, Director
Industrial Commission
11321 W. Chinden Blvd.
P.O. Box 83720
Boise, Idaho 83720-0041
Phone: 208-334-6000
Fax: 208-334-2321

THE FOLLOWING NOTICE PUBLISHED WITH THE OMNIBUS PROPOSED RULE

AUTHORITY: In compliance with Sections 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 72-301, 72-301A, 72-304, 72-327, 72-432, 72-508, 72-528, 72-602, 72-803, and 72-806, Idaho Code.

PUBLIC HEARING SCHEDULE: Oral comment concerning this rulemaking will be scheduled in accordance with Section 67-5222, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

This proposed rulemaking publishes the following rule chapters previously submitted to and reviewed by the Idaho Legislature under IDAPA 17, rules of the Industrial Commission:

IDAPA 17

- 17.01.01, *Administrative Rules Under the Worker's Compensation Law*.

FEE SUMMARY: This rulemaking does not impose a fee or charge, or increase a fee or charge, beyond what was previously submitted to and reviewed by the Idaho Legislature in the prior rules. The \$250 application fees charged to employers seeking approval to become self-insured is needed to defray added costs incurred by the Commission in evaluating these applications.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars (\$10,000) during the fiscal year: This rulemaking is not anticipated to have any fiscal impact on the state general fund because the FY2022 budget has already been set by the Legislature, and approved by the Governor, anticipating the existence of the rule and fee(s) being reauthorized by this rulemaking.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not feasible because engaging in negotiated rulemaking for all previously existing rules will inhibit the agency from carrying out its ability to serve the citizens of Idaho and to protect their health, safety, and welfare.

Negotiated rulemaking conducted outside of this omnibus rulemaking under docket 17-0101-2101 published in the June 2021 Idaho Administrative Bulletin, Vol. 21-6, pages 54-55, and docket 17-0101-2102 published in the July 2021 Idaho Administrative Bulletin, Vol. 21-7 pages 27-28 and affects the following rule chapter included in this proposed rulemaking: IDAPA 17.01.01.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, incorporated material may be obtained or electronically accessed as provided in the text of the proposed rule attached hereto.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Kamerron Slay, Commission Secretary, (208) 334-6017 or kamerron.slay@iic.idaho.gov.

Anyone may submit written comments regarding the proposed rulemaking. All written comments must be directed to the undersigned and must be delivered within twenty-one (21) days after publication of this Notice in the Idaho Administrative Bulletin. Oral presentation of comments may be requested pursuant to Section 67-5222(2), Idaho Code, and must be delivered to the undersigned within fourteen (14) days of the date of publication of this Notice in the Idaho Administrative Bulletin.

DATED this October 20, 2021.

Substantive changes have been made to the pending fee rule.
Italicized red text indicates changes between the text of the proposed rule as adopted in the pending fee rule.

THE FOLLOWING IS THE TEXT OF OMNIBUS PENDING FEE DOCKET NO. 17-0000-2100F

IDAPA 17 – INDUSTRIAL COMMISSION

17.01.01 – ADMINISTRATIVE RULES UNDER THE WORKER'S COMPENSATION LAW

000. LEGAL AUTHORITY.

This chapter is adopted under the legal authority of 72-301, 72-301A, 72-304, 72-327, 72-432, 72-508, 72-528, 72-602, 72-803, and 72-806, Idaho Code. ()

001. TITLE AND SCOPE.

01. Title. The title of this chapter is “Administrative Rules Under the Worker's Compensation Law” IDAPA 17, Title 01, Chapter 01. ()

02. Scope. This chapter includes the Industrial Commission's worker's compensation rules. ()

002. WRITTEN INTERPRETATIONS.

The Industrial Commission uses the following guidelines for implementing the EDI reporting requirements set out in this Chapter: ()

01. EDI Guide and Tables. The Idaho Industrial Commission Claims EDI Implementation Guide and Trading Partner Tables (“EDI Guide and Tables”). The Idaho Industrial Commission Claims EDI Implementation Guide and Trading Partner Tables are available on the Commission's website at <https://iic.idaho.gov/>. ()

02. EDI Implementation Guide. International Association of Industrial Accidents Boards and Commissions (IAIABC) EDI Claims Release 3.0 or, after December 1, 2022, Release 3.1, Implementation Guide (“EDI Implementation Guide”). The IAIABC Claims Release 3.0 and Release 3.1 Implementation Guides are available at the IAIABC website at <https://www.iaabc.org>. ()

003 – 009. (RESERVED)

010. DEFINITIONS.

The definitions set forth in Chapter 72, Idaho Code apply to these rules. In addition, the following terms have the meaning set forth below: ()

01. Adjustor. Means an individual who adjusts worker's compensation claims. ()

02. Ambulatory Payment Classification. Means the payment system adopted by CMS for outpatient services ()

03. Available Funds. Means a sum of money to which a Charging Lien may attach. It does not include any compensation paid or not disputed to be owed prior to Claimant's agreement to retain the attorney. ()

04. Ambulatory Surgery Center. Means a facility providing medical services on an outpatient basis only. ()

05. Approval by Commission. Means the Commission has approved attorney fees in conjunction with an award of compensation or an LSS or otherwise in accordance with Section 802 of this rule upon a proper showing by the attorney seeking to have the fees approved. ()

06. Average Wholesale Price. Means the average wholesale price for medicine obtained from pricing data provided by the original manufacturer of that medicine to industry-wide compilers of drug prices, e.g., Red Book and Medi-Span. ()

07. Charge. Means the expense or cost. For hospitals and ASCs, “charge” means the total charge. ()

a. Acceptable charge. Means a charge calculated in compliance with Section 803 of this rule or as billed by the Provider, whichever is lower, or the charge agreed to pursuant to a written contract. ()

b. Customary charge. Means a charge that has an upper limit no higher than the 90th percentile, as determined by the Commission, of usual charges made by Idaho Providers for a given medical service. ()

c. Reasonable charge. Means a charge that does not exceed the Provider's “usual” charge and does not exceed the “customary” charge. ()

d. Usual charge. Means the most frequent charge made by an individual Provider for a given medical service to non-industrially injured patients. ()

08. Charging Lien. Means a lien against a Claimant's right to any compensation under the Worker's Compensation Law, which may be asserted by an attorney who is able to demonstrate that: ()

a. There are compensation benefits available for distribution on equitable principles; ()

b. The services of the attorney operated primarily or substantially to secure the fund out of which the attorney seeks to be paid; ()

c. It was agreed that counsel anticipated payment from compensation funds rather than from the client; ()

d. The Claim is limited to costs, fees, or other disbursements incurred in the case through which the fund was raised; and ()

e. There are equitable considerations that necessitate the recognition and application of the Charging Lien. ()

09. Claim. Means filing for worker's compensation benefits through a Form 1A-1, First Report of Injury or Illness (FROI) or an application for hearing, referred to as a Complaint, with the Commission. ()

10. Claims Administrator. Means an organization, including insurers, third party administrators, independent adjusters, or self-insured employers, that services worker's compensation claims. ()

11. Claimant. Means a person who has filed a Claim for worker's compensation benefits and includes their agents, such as attorneys. ()

12. Commission. Means the Idaho Industrial Commission. ()

13. Critical Access Hospital. Means a hospital currently designated as a critical access hospital by CMS. ()

14. Current Procedural Terminology. Means the medical code published by the American Medical Association. ()

15. Death Claim. Means a Claim arising from the death of a worker as a result of a work-related injury or occupational disease. ()

16. Electronic Data Interchange. Means a computer to computer exchange of data in a standardized format. ()

17. Fee Agreement. Means a written agreement between a worker and an attorney in conformity with the Idaho Rules of Professional Conduct. ()

a. Reasonable, as used in Section 802 of this rule, means that an attorney's fees are consistent with the fee agreement and are to be satisfied from Available Funds, subject to the element of reasonableness contained in Idaho Rules of Professional Conduct 1.5. ()

18. First Degree of Consanguinity. Means the relationship between parents and their children whether related by blood or affinity. Adopted or step children and their adoptive or step parents are deemed to be within the first degree of consanguinity. ()

19. **First Report of Injury.** Means the first filing of information with the Industrial Commission that a reportable workplace injury has occurred or an occupational disease has been manifested, as required by Section 72-602(1), Idaho Code; filed in accordance with these rules. ()
20. **Gross Direct Premiums Written.** Means the gross sum of premiums on policies written, without any deduction for refunds or repayments resulting from cancellations. It does not include premiums on contracts between insurers or reinsurers. For all policies written, gross direct premiums written may reflect experience modifications, deviations, and retrospective rating. ()
21. **Healthcare Common Procedure Coding System.** Means the set of healthcare procedure codes based on the American Medical Association's Current Procedural Terminology. ()
22. **Hospital.** Means an acute care facility providing medical or rehabilitation services on an inpatient and outpatient basis. ()
23. **IAIABC EDI Release 3.0 or 3.1.** Means the IAIABC authored EDI *Claims* Release 3.0 or 3.1 standards that cover the transmission of claims (FROI and SROI) information through electronic reporting. ()
24. **Impairment Rated Claim.** Means those claims in which the Provider establishes an impairment rating for the injured worker. ()
25. **Implantable Hardware.** Means objects or devices that are made to support, replace, or act as a missing anatomical structure or to support or manage proper biological functions or disease processes and where surgical or medical procedures are needed to insert or apply such devices and surgical or medical procedures are required to remove such devices. The term also includes equipment necessary for the proper operation of the implantable hardware, even if not implanted in the body. ()
26. **Indemnity Benefits.** Means payments made to or on behalf of worker's compensation Claimants, including temporary or permanent total or partial disability benefits, death benefits paid to dependents, retraining benefits, and any other type of income benefits, but excluding medical and related benefits. ()
27. **Indemnity Claim.** Means any claim made for the payment of indemnity benefits. ()
28. **Legacy Claim.** Means a FROI that was either filed on paper or electronically prior to the EDI Claims Release 3.1 implementation. ()
29. **Litigated Case.** Means a case in which a complaint has been filed. ()
30. **Medical Only Claim.** Means the injured worker will not suffer a disability lasting more than five (5) calendar days as a result of a job-related injury or occupational disease, nor be admitted to a hospital as an inpatient. ()
31. **Medical Report.** Means *and includes* without limitation, all bills, chart notes, surgical records, testing results, treatment records, hospital records, prescriptions, and medication records. ()
32. **Medicare Severity - Diagnosis Related Group.** Means a system adopted by CMS that groups hospital admissions based on diagnosis codes, surgical procedures, and patient demographics. ()
33. **Net Premiums Written.** Means the amount of gross direct premiums on policies written less returned premiums and premiums on policies not taken. Paid dividends shall not be deducted for the purposes of calculating net premiums written. ()
34. **Payor.** Means the entity that is responsible for making payment to a Provider for services rendered to treat an industrially injured patient and includes self-insured employers, sureties, adjusters, and their agents. ()

35. Payroll. Means the gross amount paid by an employer for salaries, wages, or commissions earned by its own direct employees, but not including any money paid to another entity or received from another entity for leased employees. ()

36. Pharmacy. Means a facility as defined in Section 54-1705(29), Idaho Code. ()

37. Supplemental or Subsequent Report of Injury. Means the filing of additional information with the Industrial Commission, regarding benefits paid or changes in the status or condition of an injured worker, of a Claim for benefits, as required by Sections 72-602(2), (3), and (4), Idaho Code; filed in accordance with these rules. ()

38. Termination of Disability. Means the date upon which the obligation of the Employer/Surety becomes certain as to duration and amount whether by settlement, decision, or periodic payments in the ordinary course of claims processing. If resolved by LSS, the termination of disability shall occur on the date the LSS is approved and an order approving is filed by the Industrial Commission. If resolved by decision, the termination of disability shall occur on the date the decision resolving all issues becomes final. ()

39. Time Loss Claim. Means the injured worker will suffer, or has suffered, a disability that lasts more than five (5) calendar days as a result of a job-related injury or occupational disease, or the injured worker requires, or required, in-patient treatment as a result of such injury or disease. ()

40. Trading Partner. Means an insurance carrier, self-insured employer, or Claims Administrator that has entered into a Trading Partner Agreement with the Industrial Commission. ()

41. Trading Partner Agreement. Means an agreement between the Industrial Commission and a Trading Partner that sets out the terms and conditions for the electronic reporting of information to the Commission. ()

011. ABBREVIATIONS.

The following abbreviations have the meaning set forth below: ()

01. APC. Means Ambulatory Payment Classification. ()

02. ASC. Means Ambulatory Surgery Center. ()

03. AWP. Means Average Wholesale Price. ()

04. CMS. Means Centers for Medicare and Medicaid Services. ()

05. CPT. Means Current Procedural Terminology. ()

06. EDI. Means Electronic Data Interchange. ()

07. FROI. Means First Report of Injury. ()

08. HCPCS. Means Healthcare Common Procedure Coding System. ()

09. IAIABC. Means International Association of Industrial Accident Boards and Commissions. ()

10. ISIF. Means the Industrial Special Indemnity Fund, which is commonly referred to as the Second Injury Fund. ()

11. LSS. Means Lumps Sum Settlement. ()

12. MSDRG. Means Medicare Severity Diagnosis Related Group. ()

13. NCCI. Means National Council on Compensation Insurance. ()

- 14. NDC. Means National Drug Code. ()
- 15. RBRVS. Means Resource-Based Relative Value Scale. ()
- 16. RVU. Means Relative Value Unit. ()
- 17. SROI. Means Supplemental or Subsequent Report of Injury. ()

012. LIBERAL CONSTRUCTION.

Rulemaking before the Industrial Commission should be just, speedy, and economical; unless prohibited by statute, the Industrial Commission may permit deviation from these rules when it finds compliance with them is impracticable, unnecessary, or not in the public interest. ()

013. -- 200. (RESERVED)

201. RULE GOVERNING 72-212(5) EXEMPTIONS.

01. Exemptions. Each person who elects to exempt themselves from coverage or revoke their exemption under Section 72-212(5), Idaho Code, must file an IC53 Declaration form with the Industrial Commission. The form is available on the Commission's website. ()

02. Form. The form must be signed by both the employee and the employer. An original and one (1) copy of the IC53 form shall be filed with the Commission. Upon approval by the Commission, the copy will be returned to the employee filing for an exemption or revocation of an exemption. ()

03. Approval by Commission. The Commission must approve the exemption or revocation of exemption. The Commission may require verification of information submitted. Fraud or misrepresentation in the information provided will void the exemption or revocation. ()

04. IC53 Form. If the employer is insured, it is the employer's responsibility to file a copy of the IC53 form with the employer's insurance company. ()

05. Effective Date. The effective date of the exemption or revocation of exemption shall be the date the properly completed form is received by the Commission. ()

06. Exemption Effective. The exemption shall remain in effect until a revocation of exemption is filed with the Commission, or, termination of employment with the designated employer, or upon the death of the employee, whichever occurs first. ()

202. -- 300. (RESERVED)

301. RULES GOVERNING QUALIFICATIONS TO WRITE INSURANCE OR SELF-INSURE.

01. Insurance Carriers. In order to gain approval from the Industrial Commission to underwrite worker's compensation insurance under Section 72-301, Idaho Code, an insurance carrier shall comply with the following requirements: ()

a. Deposit With State Treasurer. The carrier must receive approval from the Director of the Idaho Department of Insurance to underwrite casualty and surety insurance under Sections 41-506 and 41-507, Idaho Code, and shall initially deposit security in the amount of two hundred fifty thousand dollars (\$250,000) with the State Treasurer, under the provisions of Section 72-302, Idaho Code. ()

b. Application. To receive approval from the Industrial Commission, an insurance carrier must supply an application with: ()

- i. A statement from the Director of the Idaho Department of Insurance documenting compliance with

- Paragraph 01.a, above; ()
- ii. The latest audited financial statement of said carrier; ()
 - iii. The name and address of the agent for service of process in Idaho; ()
 - iv. The name and address of the Claims Administrator employing an Idaho licensed resident adjuster or the insurance carrier's own in-house Idaho adjusting staff with authority to make compensation payments and adjustments of claims arising under the Act. Each Claims Administrator shall have only one (1) mailing address on record at the Commission for claims adjusting purposes. If more than one (1) Claims Administrator is utilized in Idaho, a list of every such Claims Administrator and all corresponding policyholders shall be provided; ()
 - v. A statement that the carrier will distribute blank forms that are prescribed by the Commission to its insured; ()
 - vi. A statement that all surety bonds covering the payment of compensation will be filed with the Idaho State Treasurer for all employers insured. All carriers will use the continuous bond form set out on the Commission's website. ()
 - vii. A statement that renewal certificates on said bonds will be issued and filed with the Industrial Commission immediately, when and if renewed; ()
 - viii. A statement that all surety contract cancellations will be canceled in compliance with Section 72-311, Idaho Code; ()
 - ix. A statement that said carrier will deposit, in addition to other security required by this rule, further security equal to all unpaid outstanding awards of compensation; ()
 - x. A statement that said carrier will comply with the statutes of the state of Idaho and rules of the Industrial Commission and that payments of compensation shall be sure and certain and not unnecessarily delayed; and ()
 - xi. A statement that the carrier will make reports to the Commission as are required. ()
- 02. Self-Insured Employers.** In order to gain approval from the Industrial Commission to self-insure under Section 72-301, Idaho Code, an employer shall comply with the following requirements: ()
- a.** Payroll. Have an average annual Idaho Payroll over the preceding three (3) years of at least four million dollars (\$4,000,000). ()
 - b.** Application. Submit a completed application, available from the Industrial Commission's Fiscal Department, along with the application fee of two hundred fifty dollars (\$250), to the Idaho Industrial Commission, Attention: Fiscal Department. ()
 - c.** Documentation. Submit documentation demonstrating the sound financial condition of the employer, such as the most recent CPA reviewed or, if available, audited, financial statement. ()
 - d.** Claims Adjusting. Designate in writing a Claims Administrator employing an Idaho licensed resident adjuster including name and address. Each Claims Administrator shall have only one (1) mailing address on record at the Commission for claims adjusting purposes. ()
 - e.** Previous Claims. Provide a history of all worker's compensation claims filed with the employer or the employer's worker's compensation carrier, as well as all compensation paid, during the previous five (5) calendar years. ()
 - f.** Excess Insurance. Provide an insurance plan that must include excess insurance coverage and copies of all proposed policies of excess worker's compensation insurance coverage. ()

- g.** Actuarial Study. Provide an actuarial study prepared by a qualified actuary determining adequate rates for the proposed self-funded worker's compensation plan based upon a fifty percent (50%) confidence level. ()
- h.** Feasibility Study. Provide a self-insurance feasibility study that includes an analysis of the advantages and disadvantages of self insurance as compared to current coverage, and the related costs and benefits. ()
- i.** Custodial Agreement. Set up a custodial agreement with the State Treasurer for securities required to be deposited under Sections 72-301 and 72-302, Idaho Code. ()
- j.** Supplemental Information. Provide supplemental information as requested. ()
- k.** Initial Security Deposit. Prior to final approval, deposit an initial security deposit with the Idaho State Treasurer in the form permitted by Section 72-301, Idaho Code, or a self-insurer's bond in substantially the form as the Commission's self-insurer's compensation bond, available on the Commission's website, in the amount of one hundred fifty thousand dollars (\$150,000), plus five percent (5%) of the first ten million dollars (\$10,000,000) of the employer's average annual Payroll in the state of Idaho for the three (3) preceding years; along with such additional security as may be required by the Commission based on prior claims history. ()
- l.** Initial Guaranty Agreement. The Commission may allow or, where financial reports or other factors such as the high risk industry of the employer indicate the need, require an employer that is organized as a joint venture or a wholly owned subsidiary to provide a guaranty agreement from each member of the joint venture or the parent company. This guaranty agreement confirms the continuing agreement of each of the joint venture members or the parent company to guarantee the payment of all Idaho worker's compensation claims of employees of that joint venture or subsidiary employer. The guaranty agreement shall be in substantially the same form as the current sample Indemnity and Guaranty Agreement and, as applicable, the companion Consent of the Board of Directors, available on the Commission's website. ()
- m.** Written Approval. Obtain written approval from the Industrial Commission. ()
- n.** Idaho National Laboratory. An employer meeting the requirements of Section 72-301A, Idaho Code, does not have to comply with the requirements of Paragraphs 302.02.a., 02.f., 02.i., and 02.k., above. ()

302. RULES GOVERNING CONTINUING REQUIREMENTS TO UNDERWRITE INSURANCE OR SELF-INSURE.

- 01. Insurance Carriers.** An insurance carrier approved under IDAPA 17.01.01.301.01 shall comply with the following requirements: ()

 - a.** Maintain Statutory Security Deposits with the State Treasurer. ()

 - i.** Each insurance carrier shall maintain with the Idaho State Treasurer a security deposit in the amount of twenty-five thousand dollars (\$25,000) if approved by the Commission prior to July 15, 1988, or two hundred and fifty thousand dollars (\$250,000) if approved subsequently. ()
 - ii.** In addition to the security required in Subsection 01.a.i, of this rule, each insurance carrier shall deposit an amount equal to the total unpaid outstanding awards of said insurance carrier. Such deposit shall be in the form permitted by Section 72-301, Idaho Code. Surety bonds shall be in the form available on the Commission's website. If a surety bond is deposited, the surety company shall be completely independent of the principal and authorized to transact such business in the state of Idaho. A partial release of security deposited hereunder must be requested in writing and approved by the Commission. ()
 - iii.** Securities which are maintained to satisfy the requirements of this rule may be held in the federal reserve book-entry system, as defined in Section 41-2870(4), Idaho Code, and interests in such securities may be transferred by bookkeeping entry in the federal reserve book-entry system without physical delivery of certificates

representing such securities. ()

b. Appoint Agent for Service of Process. Each insurance carrier shall appoint the Director of the Department of Insurance as its agent to receive service of legal process. ()

c. Maintain Resident Idaho Office. Each insurance carrier shall maintain a Claims Administrator employing an Idaho licensed resident adjuster or the carrier's own adjusting offices or officers residing in Idaho. ()

i. Each authorized insurance carrier shall notify the Commission Secretary in writing of any change of the designated resident adjuster(s) for every insured Idaho employer within fifteen (15) days of such change. ()

ii. Each authorized insurance carrier will ensure that every in-state adjuster can classify and identify all claims adjusted on behalf of said insurance carrier, and that the in-state adjuster will provide such information to the Industrial Commission upon request. Further each in-state Adjustor must have full authority to: ()

(1) Investigate and adjust all claims for compensation; ()

(2) Pay all compensation benefits due; ()

(3) Accept service of claims, applications for hearings, orders of the Commission, and all process which may be issued under the Worker's Compensation Law; ()

(4) Enter into compensation agreements and LSSs with Claimants; ()

(5) Provide at the employer's expense necessary forms to any employee who wishes to file a Claim under the Worker's Compensation Law. ()

d. Supply Forms. Each insurance carrier shall distribute the required forms prescribed by the Commission to all employers it insures. A list of required forms is available on the Commission's website. ()

e. Comply with Industrial Commission Reporting Requirements. Each insurance carrier shall, within the time prescribed, file such reports and respond to such information requests as the Commission may require from time to time concerning matters under the Worker's Compensation Law. ()

f. Report Proof of Coverage. ()

i. Each insurance carrier shall report all proof of coverage to NCCI. NCCI is the designated agent to receive, process, and forward the proof of coverage information required by these rules to the Commission. The address of the Commission's designated agent is available on the Commission's website. ()

ii. The Industrial Commission adopts the IAIABC's electronic proof of coverage record layout and transaction standards as the required reporting mechanism for new policies, renewal policies, endorsements, cancellations, and non-renewals of policies. A copy of the record layout, data element requirements, and transaction standards is available on the Commission's website. Each insurance carrier shall report data for all mandatory elements in the current IAIABC proof of coverage record layout and transaction standards on each policy reported. ()

iii. The most recent proof of coverage information contained in the Industrial Commission's database shall be presumed to be correct for the purpose of determining the insurance carrier providing coverage. ()

g. Report New Policy, Renewal Policy, and Endorsement Information Within Thirty Days. Each insurance carrier shall report the issuance of any new worker's compensation policy, renewal policy, or endorsement to the Industrial Commission or its designated agent within thirty (30) days of the effective date of the transaction. ()

h. Report Cancellation and Non-Renewal of Policy Within Time Prescribed by Statute. Each insurance carrier shall report the cancellation and/or nonrenewal of any worker's compensation insurance policy to the Industrial Commission or its designated agent within the time frames prescribed by Section 72-311, Idaho Code. Receipt of cancellation or nonrenewal notices by the Commission's designated agent shall be deemed to have been received by the Commission. ()

i. Report Election of Coverage on Form IC52 or Similar Format. Each insurance carrier shall report election of coverage or revocation of election of coverage on or in a format substantially the same as Form IC52, "Election of Coverage," available on the Commission's website. ()

j. Report Deductible Policy. On or before March 3rd of each year, every insurance carrier shall submit a report of all deductible policies that were issued and in effect during the previous calendar year. That report shall be submitted in a form substantially similar to the current "Deductible Policy Report" available on the Commission's website. The report shall include the following information: insured name, policy number, effective and expiration dates, deductible amount, the premium charged for the policy before credit for the deductible, and the final premium after credit for the deductible. ()

k. Report Outstanding Awards. Each insurance carrier shall report to the Industrial Commission at the end of each calendar quarter, or more often as required by the Commission, any outstanding award. ()

i. The report of outstanding awards shall be filed with the Industrial Commission by the end of the month following the end of each calendar quarter. ()

ii. The report shall be filed even if there are no outstanding awards. In that event, the carrier shall certify the fact that there are no outstanding awards to be reported. ()

iii. The report shall be submitted on or in a format that is substantially the same as the current Form IC36A, "Report of Outstanding Awards - Insurance Carriers" available on the Commission's website. The report may be produced as a computerized spreadsheet or database printout. ()

iv. The report shall be signed and certified to be correct by a corporate officer. If an insurance carrier has designated more than one adjuster for worker's compensation claims in Idaho, a corporate officer of the insurance carrier shall prepare, certify, and file a consolidated report of outstanding awards. ()

v. The report shall list all outstanding awards, commencing with the calendar quarter during which the award is made or benefits are first paid, whichever occurs earlier. ()

l. Comply with Law and Rules. Each insurance carrier shall comply with the statutes of the state of Idaho and the rules of the Industrial Commission to ensure that payments of compensation shall be sure and certain and not unnecessarily delayed. ()

02. Self-Insured Employers. A self-insured employer approved under Subsection 301.02 shall comply with the following requirements: ()

a. Payroll Requirements. Maintain an average annual Idaho Payroll over the preceding three (3) years of at least four million dollars (\$4,000,000). Any self-insured employer that does not meet the Payroll requirement of this rule for two consecutive semi-annual premium tax reporting periods shall be allowed to maintain their self-insured status for six (6) months from the end of the last reporting period in order to permit them time to increase their Payroll or obtain worker's compensation coverage with an insurance carrier authorized to write worker's compensation insurance in the state of Idaho. ()

b. Security Deposit with Treasurer. ()

i. Maintain a primary security deposit with the Idaho State Treasurer in the form permitted by Section 72-301, Idaho Code, a self-insurer's bond form available on the Commission's website, or in substantially the same form, or in such other form approved by the Commission, in the amount of one hundred fifty thousand dollars (\$150,000), plus five percent (5%) of the employers' average annual Payroll in the state of Idaho for the three (3)

preceding years, not in excess of ten million dollars (\$10,000,000). If a surety bond is deposited, the surety company shall be completely independent of the principal and authorized to transact such business in the state of Idaho. In addition thereto, the self-insured employer shall deposit additional security in such amount as the Commission determines is necessary to secure the self-insured employer's total unpaid liability for compensation under the Worker's Compensation Law. No approved security shall be accepted for deposit above its par value. Additional deposits of approved security may be required semi-annually if the market value of an approved investment falls below its par value or if the total value of the employer's security deposit falls below the total security required to be maintained on deposit when calculated in accordance with this rule. ()

ii. Self-insured employers shall receive a credit for the primary security deposit against the self-insured employer's obligation to post the additional security required by Subparagraph 302.02.b.i. of this rule. ()

iii. Excess insurance coverage approved by the Commission may apply as a credit against the self-insured employer's obligation to post the additional security required by Subparagraph 302.02.b.i. of this rule. The Commission must be provided with thirty (30) days advance written notice of any change or cancellation of an approved excess insurance policy. No credit will be given for any excess insurance coverage provided by a surplus lines carrier, as described in Chapter 12, Title 41, Idaho Code. ()

iv. All security deposited by the self-insured employer shall be maintained as provided by Section 72-302, Idaho Code. ()

v. Any withdrawal or partial release of security deposited hereunder must be requested in writing and approved by the Commission. ()

c. Continue or Provide Guaranty Agreement. ()

i. A self-insured employer that is organized as a joint venture or a wholly owned subsidiary shall continue in effect any guaranty agreement that the Commission has previously allowed or required, until termination is permitted by the Commission. ()

ii. Where an adverse change in financial condition or other relevant factors such as claims history or industry risk indicates the need, a self-insured employer that is organized as a joint venture or a wholly owned subsidiary may be allowed to, or shall upon request, provide a guaranty agreement from each member of the joint venture or the parent company. This guaranty agreement confirms the continuing agreement of each of the joint venture members or the parent company to guarantee the payment of all Idaho worker's compensation claims of employees of that joint venture or subsidiary self-insured employer. The guaranty agreement shall be in substantially the same form as the current sample Indemnity and Guaranty Agreement, and as applicable, the companion Consent of the Board of Directors, available on the Commission's website. ()

d. Maintain a Licensed Resident Adjuster. Maintain an Idaho licensed, resident claims adjuster located within the state of Idaho who shall have full authority to make decisions and to authorize the payment of all compensation on said claims on behalf of the employer including, but not limited to, the following: ()

i. Investigate and adjust all claims for compensation; ()

ii. Pay all compensation benefits due; ()

iii. Accept service of claims, applications for hearings, orders of the Commission, and all process which may be issued under the Worker's Compensation Law; ()

iv. Enter into compensation agreements and LSSs with Claimants; ()

v. Provide at the employer's expense necessary forms to any employee who wishes to file a Claim under the Worker's Compensation Law. ()

e. File Reports. Report to the Industrial Commission semi-annually, or more often as required by the Commission, total unpaid liability on all open claims. ()

i. The semi-annual report of total unpaid liability shall be filed with the Industrial Commission by the end of the months of January and July. ()

ii. The report shall provide the aggregate number of open claims, including indemnity with medical and Medical Only Claims, along with the amount of any compensation paid on open claims, as of the end of each June and December. ()

iii. The report shall be filed even if there are no open claims. In that event, the employer shall certify the fact that there are no open claims to be reported. ()

iv. The report shall be submitted on or in a format that is substantially the same as the current Form IC-211, “Self-Insured Employer Report of Total Unpaid Liability,” available on the Commission's website. The report may be produced as a computerized spreadsheet or database printout. ()

v. The report shall be signed and certified to be correct by a corporate officer. If an employer has designated more than one adjuster for worker's compensation claims in Idaho, a corporate officer of the employer shall prepare, certify, and file a consolidated report of all unpaid liability. ()

vi. A self-insured employer shall also make, within the time prescribed, such other reports and respond to such information requests as the Commission may require from time to time concerning matters under the Worker's Compensation Law. ()

f. Submit to Audits by Industrial Commission. Each year a self-insured employer shall provide the Industrial Commission with a copy of its annual financial statements, or other acceptable documentation. Each self-insured employer shall submit to audit by the Commission or its designee at any time and as often as it requires to verify the amount of premium such self-insured employer would be required to pay as premium to the State Insurance Fund, and to verify compliance with the provisions of these rules and the Idaho Worker's Compensation Law. For the purpose of determining such premium for uninsured contractors of a self-insured employer, the most recent proof of coverage information contained in the Industrial Commission's database shall be presumed to be correct for the purpose of determining such coverage. ()

g. Comply with Law and Rules. Comply with the statutes of the state of Idaho and the rules of the Industrial Commission to the end that payment of compensation shall be sure and certain and not unnecessarily delayed. The Commission may withdraw its approval of any employer to operate as a self-insurer if it shall appear to the Commission that workers secured by said self-insured employer are not adequately protected and served, or the employer is failing to comply with the provisions of these rules or the Worker's Compensation Law. ()

h. Idaho National Laboratory. An employer meeting the requirements of Section 72-301A, Idaho Code, does not have to comply with Paragraph 303.02.a. and 302.02.b., above. ()

303. RULE GOVERNING THE COLLECTION OF PREMIUM TAX ON WORKER'S COMPENSATION INSURANCE POLICIES.

This rule governs the collection of premium tax on worker's compensation insurance policies. This procedure applies to all worker's compensation policies. ()

01. Procedure for Submitting Premium Tax Forms. The form IC 4008, available on the Commission's website, shall be used to report numbers of policies and the total gross premiums written. The original shall be sent to the Commission; a copy shall also be attached to the reporting entity's annual premium tax statement that is filed with the Idaho Department of Insurance. This form is due to the Commission by July 31 for the reporting period of January 1 through June 30; it is due by March 3 for the reporting period of July 1 through December 31. ()

304. RULE GOVERNING PREMIUM TAX COMPUTATION FOR SELF-INSURED EMPLOYERS.

01. Payroll Reports. No later than March 3rd and July 31st, self-insured employers shall file a semi-annual premium tax report with the Fiscal Department of the Commission. Self-insured employers shall use the

Commission's current report form IC 4010, along with the accompanying computation form IC 4010a, available on the Commission's website. The premium tax payment due from a self-insured employer shall be based upon the manual premium calculated for each reporting period, as modified by an experience modification factor calculated by NCCI and submitted to the Commission in accordance with Subsection 304.02 of this rule. No other rating factor shall be allowed. If the self-insured employer elects to not provide such experience modification factor, the premium tax will be computed based upon the manual premium only. ()

02. Experience Modification. A self-insured employer that elects to use an experience modification factor in computing premium tax shall make an annual application to NCCI for an experience modification factor using the NCCI form ERM-6 and paying to NCCI any fees charged for providing that calculation. An NCCI experience modification factor may only be based on the employer's Idaho operations for which self-insured status is authorized. In order to have an experience modification factor considered for any reporting period, an employer must timely submit to the Commission's Fiscal Department: ()

- a. A copy of the completed form ERM-6 filed with NCCI; ()
- b. The resulting experience modification factor received from NCCI; and ()
- c. The completed IC 4010 Semi-Annual Premium Tax Form for Self-Insurers and IC 4010a Computation Form. ()

305. REQUIREMENTS FOR MAINTAINING IDAHO WORKER'S COMPENSATION CLAIMS FILES.

All insurance carriers, self-insured employers, and licensed adjusters servicing Idaho worker's compensation claims shall comply with the following requirements: ()

01. Idaho Office. ()

a. All insurance carriers, self-insured employers, and licensed adjusters servicing Idaho worker's compensation claims shall maintain an office within the state of Idaho. The offices shall be staffed by adequate personnel to conduct business. ()

b. The insurance carrier or self-insured employer shall authorize and require a member of its in-state staff or an Idaho licensed resident adjuster to service and make decisions regarding claims pursuant to Section 72-305, Idaho Code. ()

c. As staffing changes occur and, at least annually, the insurance carrier, self-insured employer, or licensed adjuster shall submit to the Commission Secretary the names of those authorized to make decisions regarding claims pursuant to Section 72-305, Idaho Code. Each authorized insurance carrier shall designate only one (1) Claims Administrator for each policy of worker's compensation insurance. ()

02. Claim Files. All Idaho worker's compensation claim files shall be maintained within the state of Idaho in either hard copy or immediately accessible electronic format. Claim files shall include, but are not limited to: ()

- a. FROI and Claim for Benefits; ()
- b. Copies of bills for medical care; ()
- c. Copy of lost-time computations, if applicable; ()
- d. Correspondence reflecting reasons for any delays in payments, the resolution of such delays, and acceptance or denial of compensability; ()
- e. Employer's return-to-work communications; and ()
- f. Medical reports. ()

03. Correspondence. All original correspondence involving adjusting decisions regarding Idaho worker's compensation claims shall be authorized from and maintained at in-state offices. ()

04. Date Stamp. Each of the documents listed in Subsections 305.02 and 305.03, above, shall be date-stamped with the name of the receiving office on the day received, and by each receiving agent or vendor acting on behalf of the claims office. ()

05. Notice and Claim. All First Reports of Injury, Claims for Benefits, notices of occupational illnesses, and fatalities shall be sent directly to the in-state adjuster for the insurance carrier or self-insured employer. The original copy of the FROI, Claim for Benefits, and notices of occupational illness and fatality shall be sent electronically to the Industrial Commission. ()

06. Compensation Payments - Generally. ()

a. All compensation, as defined by Section 72-102, Idaho Code, must be issued from the in-state office. ()

b. Except as ordered otherwise by the Commission, the insurance carrier or self-insured employer may make compensation payments by either: ()

i. Check or other readily negotiable instrument; ()

ii. When requested by the Claimant, electronic transfer payment to an account designated by the Claimant in accordance with the requirements of Subsection 305.07; or ()

iii. When requested by the Claimant, electronic transfer payments made through an access card; if that option is made available by the carrier or self-insured employer, in accordance with the requirements of Subsection 305.08. ()

c. If the Claimant is represented by an attorney who may have an attorney's lien for fees due on such compensation payments, the attorney must agree to payment by electronic transfer to Claimant's account or payment through an access card before such compensation may be paid other than by a check made payable to the Claimant and the attorney. ()

07. Electronic Transfer Payments. ()

a. A Claimant may request that the insurance carrier or self-insured employer make compensation payments by electronic transfer to a personal bank account by providing the insurance carrier or self-insured employer in writing: the name and routing transit number of the financial institution and the account number and type of account to which the Claimant wants to have the compensation electronically transferred. The insurance carrier or self-insured employer shall provide the Claimant with a written form to fill out the required information by this subsection within seven (7) days of receiving a request for electronic transfer of payments from the Claimant unless the Claimant has already completed an on-line electronic form provided by the carrier or employer. ()

b. The insurance carrier or self-insured employer may make compensation payments to the Claimant by electronic transfer to an account designated by the Claimant if the Claimant: ()

i. Requests in writing that payment be made by electronic transfer; ()

ii. Provides the information required by Paragraph 305.07.a. above; and ()

iii. Is reasonably expected to be entitled to receive compensation payments for a period of eight (8) weeks or more from the point that Subparagraphs 305.07.b.i. and 07.b.ii. are satisfied. ()

c. The insurance carrier or self-insured employer shall initiate payment by electronic transfer starting with the first benefit payment due on or after the twenty first day after the requirements of Paragraph 305.07.b., above

are met, but shall continue to make timely payments by check until the insurance carrier or self-insured employer initiates benefit payment delivery by electronic transfer. ()

d. If the Claimant has previously been receiving benefit payments by electronic transfer and wants to receive benefits by check, the insurance carrier or self-insured employer shall initiate benefit payment delivery by check starting with the first benefit payment due to the Claimant on or after the seventh day after receiving a written request for such payments. ()

08. Access Card Payments. ()

a. Access card means any card or other payment method that may be used by a Claimant to initiate electronic fund transfer from an insurance carrier's or a self-insured employer's bank account. The term “access card” does not include stored value cards or prepaid cards that store funds directly on the card and that are not linked to an insurance carrier's or a self-insured employer's bank account. ()

b. An insurance carrier or a self-insured employer may pay compensation through an access card to a Claimant if there is written mutual agreement signed by the insurance carrier or self-insured employer and the Claimant. The insurance carrier or self-insured employer shall maintain accurate records of the mutual agreement for, at a minimum, four hundred and one (401) weeks from the date of injury. The written agreement shall contain an acknowledgment that the Claimant received and agreed to the written disclosure required by Paragraph 305.08.d. ()

c. An insurance carrier or a self-insured employer providing compensation payments to a Claimant through an access card shall: ()

i. Permit the Claimant to withdraw the entire amount of the balance of an access card in one transaction; ()

ii. Not reduce compensation payments paid to a Claimant through an access card for the following fees, surcharges, and adjustments: ()

(1) Overdraft services under which a financial institution pays a transaction (including a check or other item) when the Claimant has insufficient or unavailable funds in the account; ()

(2) ATM withdrawal or point of sale purchase for more than the card holds and the transaction is denied; ()

(3) ATM balance inquiries; ()

(4) Withdrawing money from network ATMs; ()

(5) Withdrawing money from a teller; ()

(6) Customer service calls; ()

(7) Activating the card; ()

(8) Fees for card inactivity; ()

(9) Closing account; ()

(10) Access card replacement through standard mail; ()

(11) Withdrawing the entire payment in one transaction; ()

(12) Point of sale purchases, or ()

- (13) Any other fees or charges that are not authorized under Subparagraph 305.08.c.iii., and ()
- iii. Only permit a Claimant to be charged for the following: ()
 - (1) Fees for access card replacement through an expedited mail service; ()
 - (2) International transaction fees, and ()
 - (3) Out-of-network ATM fees. ()
- d. Insurance carriers or self-insured employers shall provide a written disclosure to the Claimant contemporaneously with the written mutual agreement required under Paragraph 305.08.b. that includes: ()
 - i. A summary of the Claimant's liability for unauthorized electronic fund transfers; ()
 - ii. The telephone number and address of the person or office to be notified when the Claimant believes that an unauthorized electronic fund transfer has been or may be made; ()
 - iii. The type of electronic fund transfers that the Claimant may make and any limitations on the frequency of transfers; ()
 - iv. Any fees imposed for electronic fund transfers or for the right to make transfers, including a statement that fees may be imposed by an ATM operator that is out-of-network; ()
 - v. Fees for expedited card replacement or international transaction fees will be removed from the balance maintained in the bank account linked to the access card; ()
 - vi. A summary of the Claimant's right to receipts and periodic statements; ()
 - vii. All bank locations and network ATMs in the United States where the Claimant may access his or her funds at no cost; ()
 - viii. A statement informing the Claimant that they have a right to receive payments directly into their personal bank account through direct deposit or by check. ()
- e. An insurance carrier or a self-insured employer shall provide the written disclosure and any notice of term or condition changes required under Paragraph 305.08.d. that: ()
 - i. Are printed in not less than twelve (12) point font; ()
 - ii. Include the full text to communicate all terms and conditions; ()
 - iii. Are written in a clear and coherent manner and wherever practical, words with common and everyday meaning shall be used to facilitate readability; and ()
 - iv. Are appropriately divided and captioned in a meaningful sequence such that each section contains an underlined, boldfaced, or otherwise conspicuous title or caption at the beginning of the section that indicates the nature of the subject matter included in or covered by the section. ()
- f. An access card issued to a Claimant under this Subsection 305.08 shall: ()
 - i. Not bear any information that could reasonably identify the Claimant as a participant in the worker's compensation system; and ()
 - ii. Include on the front or back of the access card a toll-free customer service number and website address. Customer service personnel shall be available by phone Monday through Friday during normal business hours (9 a.m. to 6 p.m. Mountain Time). ()

g. The insurance carrier or self-insured employer shall provide a written notice to the Claimant at least twenty one (21) days before the effective date of any change in a term or condition of the mutual agreement or disclosure, including terminating the access card program, increased fees, or liability for unauthorized electronic fund transfers. Any terms or conditions that violate the requirements of this Subsection 305.08 are null and void and may result in administrative action against the carrier or employer. An insurance carrier or employer shall provide a written notice of term or condition changes that: ()

i. Provides a comparison of the current terms and the changes; and ()

ii. References the Claimant's ability to request a change in method of payment to electronic fund transfer to his or her personal bank account in accordance with Subsection 305.07 or to payment by check. ()

h. An insurance carrier or a self-insured employer may close the access card account by issuing a check to the Claimant with the remaining balance of the access card if the account has been inactive for twelve (12) months or longer. ()

i. The insurance carrier or self-insured employer shall not remove money from the Claimant's account or access card except to remove permitted fees under Subparagraph 305.08.c.iii. or to close the account for inactivity of a period of twelve (12) months or more. An insurance carrier or a self-insured employer seeking to recoup overpayments shall follow the requirements of section 72-316, Idaho Code. ()

j. An insurance carrier or a self-insured employer is considered to have made a compensation payment the date the payment is available on the Claimant's access card. ()

09. Checks and Drafts. Checks must be signed and issued within the state of Idaho; drafts are prohibited. ()

a. The Commission may, upon receipt of a written Application for Waiver, grant a waiver from the provisions of Subsections 305.06 and 305.09 of this rule to permit an insurance carrier or a self-insured employer to sign and issue checks outside the state of Idaho. ()

b. An Application for Waiver must be accompanied by an affidavit signed by an officer or principal of the insurance carrier or self-insured employer, attesting to the fact that the insurance carrier or self-insured employer is prepared to comply with all statutes and rules pertaining to prompt payments of compensation. ()

c. All waivers shall be effective from the date the Commission issues the order granting the waiver. A waiver shall remain in effect until revoked by the Industrial Commission. At least annually, staff of the Industrial Commission may review the performance of any insurance carrier or self-insured employer for which a waiver under this rule has been granted to assure that the insurance carrier or self-insured employer is complying with all statutes and rules pertaining to prompt payments of compensation. ()

d. If at any time after the Commission has granted a waiver, the Commission receives information permitting the inference that the insurance carrier or self-insured employer has failed to provide timely benefits to any Claimant, the Commission may issue an order to show cause why the Commission should not revoke the waiver; and, after affording the insurance carrier or self-insured employer an opportunity to be heard, may revoke the waiver and order the insurance carrier or self-insured employer to comply with the requirements of Subsections 305.06 and 305.09 of this rule. ()

10. Copies of Checks. Copies of checks and/or electronically reproducible copies of the information contained on the checks must be maintained in the in-state files for Industrial Commission audit purposes. A copy of the first income benefit check shall be sent to the Industrial Commission electronically on the same day of issuance. ()

11. Prompt Claim Servicing. Prompt claim servicing includes, but is not limited to: ()

a. Making an initial decision to accept or deny a Claim for an injury or occupational disease within

thirty (30) days of the date the Claims Administrator receives knowledge of the same. The worker shall be given notice of that initial decision in accordance with Section 72-806, Idaho Code. Nothing in this rule shall be construed as amending the requirement to start payment of income benefits no later than four (4) weeks or twenty-eight (28) days from the date of disability under the provisions of Section 72-402, Idaho Code. ()

b. Payment of medical bills in accordance with the provisions of Section 803 of these rules. ()

c. Payment of income benefits on a weekly basis, unless otherwise approved by the Commission. ()

i. The first payment of income benefits under Section 72-408, Idaho Code, shall constitute application by the insurance carrier or self-insured employer for a waiver to pay Temporary Total Disability (TTD) benefits on a bi-weekly basis, Temporary Partial Disability (TPD) benefits on other than a weekly basis, Permanent Partial Disability (PPD) benefits based on permanent impairment and Permanent Total Disability (PTD) benefits every twenty-eight (28) days, rather than on a weekly basis. ()

ii. Such waiver application shall be granted upon receipt and remain in effect unless revoked by the Industrial Commission in accordance with Subparagraph 305.11.c.iii. ()

iii. If at any time after a waiver has been granted pursuant to this section the Commission receives information permitting the inference that the insurance carrier or self-insured employer has failed to service claims in accordance with Idaho law, or that such waiver has created an undue hardship on a Claimant, the Commission may issue an order to show cause why the Commission should not revoke that waiver, and after affording the insurance carrier or employer an opportunity to be heard, may revoke the waiver with respect to all or certain Claimants and order the insurance carrier or self-insured employer to comply with the requirements of Subsection 305.11.c. of this rule. ()

d. Payment of the first Permanent Partial Disability (PPD) benefit based on permanent impairment no later than fourteen (14) days after receipt of the Medical Report providing the impairment rating. The first payment shall include payment of benefits retroactive to the date of medical stability. ()

e. Temporary Partial Disability (TPD) payments shall be calculated using the employee's pay period, whether weekly, bi-weekly, or semi-monthly. For employees paid pursuant to any other schedule, TPD benefits shall be calculated semi-monthly. TPD payments owed for a particular pay period shall issue no later than seven (7) days following the date on which employee is ordinarily paid for that pay period. ()

12. Audits. The Industrial Commission will perform periodic audits to ensure compliance with the above requirements. ()

13. Non-Compliance. Non-compliance with the above requirements may result in the revocation of the authority of an insurance carrier to write worker's compensation insurance or self-insured employer to self-insure its worker's compensation insurance obligations in the state of Idaho, or such lesser sanctions as the Industrial Commission may impose. ()

306. RULE PROHIBITING USE OF SICK LEAVE OR OTHER ALTERNATIVE COMPENSATION.

01. Employee Not Required to Take Sick Leave in Lieu of Compensation. No employer obligated to pay worker's compensation benefits to an employee as provided by the Worker's Compensation Law may require an employee to accept "sick leave" or other comparable benefit in lieu of the worker's compensation benefits provided by law. Section 72-318(2), Idaho Code, specifically provides that no agreement by an employee to waive his rights to compensation under the Worker's Compensation Law shall be valid. ()

02. Election of Sick Leave or Alternative Compensation Prohibited. Further, an employee may not elect to accept "sick leave" or other comparable benefit from an employer in lieu of worker's compensation benefits to which the employee is entitled under the Worker's Compensation Law. ()

307. RULE GOVERNING REPORTING INDEMNITY AND MEDICAL PAYMENTS AND MAKING PAYMENT OF INDUSTRIAL SPECIAL INDEMNITY FUND ASSESSMENT.

Pursuant to Section 72-327, Idaho Code, the state insurance fund, every authorized insurance carrier, and self-insured employer in Idaho shall report annually to the Industrial Commission the total gross amount of medical only and Indemnity Benefits paid on Idaho worker's compensation claims during the applicable reporting period. This report is used to calculate the pro rata share of the annual assessment for the ISIF, under Section 72-327, Idaho Code. ()

01. Filing. The report of indemnity and medical payments shall be filed with the Industrial Commission simultaneously with the first Semi-Annual Premium Tax Report; which, pursuant to Section 72-523, Idaho Code, is due each year on March 3rd. ()

02. Form. The report of indemnity and medical payments shall be submitted in writing on, or in a format substantially the same as the current Form IC2-327, available on the Commission's website. ()

03. Report Required When No Indemnity Paid. If an entity required to report under this rule has no claims against which indemnity or medical payments have been made during the reporting period, a report shall be filed so indicating. ()

04. Penalty for Late Filing. A penalty shall be assessed by the Commission for filing the report of indemnity and medical payments later than March 3rd each year. ()

a. A penalty of two hundred dollars (\$200) for late filing of seven (7) days or less. ()

b. A penalty of one hundred dollars (\$100) per day for late filing of more than seven (7) days. ()

c. A penalty assessed by the Commission shall be payable to the Industrial Commission and be submitted with the April 1 payment of the ISIF assessment, following notice by the Commission of the penalty assessment. ()

05. Estimating Indemnity Payments for Entities That Fail to Report Timely. If an entity required to report indemnity payments under these rules fails to report within the time allowed in these rules, the Commission will estimate the indemnity payments for that entity by using the indemnity amount reported for the preceding reporting period and adding twenty percent (20%). ()

06. Adjustment for Overpayments or Underpayments. Overpayments or underpayments, including those resulting from estimating the indemnity payments of entities that fail to report timely, will be adjusted on the billing for the subsequent period. ()

308. – 400. (RESERVED)

401. RULE GOVERNING COMPUTATION OF AVERAGE WEEKLY WAGE.

01. Amounts Paid over Base Rate. Sums paid by an employer to an employee, over and above the base rate of compensation agreed upon by the employer and the employee in a contract of hire, which are contingent and dependent upon the employee's increased physical exertion and/or efficiency shall be included in computing the employee's average weekly wage pursuant to Section 72-419(4)(a), Idaho Code. Said sums shall not be considered premium pay. ()

02. Fringe Benefits. Also, in computing the average weekly wage, it shall be presumed that wages include, but are not limited to, cost of living increases, vacation pay, holiday pay, and sick leave. ()

03. Premium Pay. Further, in computing the average weekly wage, it shall be presumed that premium pay includes, but is not limited to, shift differential pay and overtime pay. ()

04. Examples Not Exclusive. The above-listed examples shall not be taken as exclusive in computing the average weekly wage. ()

402. RULE GOVERNING CONVERSION OF IMPAIRMENT RATINGS TO “WHOLE MAN” STANDARD.

01. Converting Single Rating of Body Part to Whole Person Rating. Impairment ratings shall be converted in accordance with the Industrial Commission Schedule, Section 72-428, Idaho Code, with the base of five hundred (500) weeks for the whole man. ()

02. Averaging Multiple Ratings. Where more than one (1) evaluating physician has given ratings, these shall be converted to the statutory percentage of the whole man, and averaged for the applicable rating. ()

03. Correcting Manifest Injustice. In the event that the Commission deems a manifest injustice would result from the above ruling, it may at its discretion take steps necessary to correct such injustice. ()

403. RULE GOVERNING COMPENSATION FOR DISABILITY DUE TO LOSS OF TEETH.

01. Compensation for Disability. A Claimant under the Worker's Compensation Law shall be entitled to compensation for permanent disability for the loss of each tooth other than wisdom teeth at the rate of one tenth of one percent (.1%) of the whole man. The loss of wisdom teeth shall not constitute any permanent disability. Compensation hereunder shall be in addition to payments for medical services including dental appliances and bridgework necessitated by the injury and any income benefits during the period of Claimant's recovery to which the Claimant be entitled. ()

02. Prima Facie Evidence. This rule and schedule shall be prima facie evidence of the percentage of permanent disability to be attributed to the loss of teeth. ()

404. SUBMISSION OF MEDICAL REPORTS *FROM PROVIDERS*.

This procedure applies to all open worker's compensation claims where medical services are provided *and which have not been denied by the Payor*. ()

01. Procedure. *In all cases in which a particular injury or occupational disease results in a worker's compensation Claim, the Provider shall submit written Medical Reports for each medical visit to the Payor. Payers and Providers may contract with one another to identify specific records that will be provided in support of billings. The Provider shall also submit the same written Medical Reports to the Claimant upon request. These reports shall be submitted within fourteen (14) days following each evaluation, examination, and/or treatment. The first copy of any such reports shall be provided to the Payor and the Claimant at no charge. If duplicate copies of reports already provided are requested by either the Payor or the Claimant, the Provider may charge the requesting party a reasonable charge to provide the additional reports. Whenever possible, billing information shall be coded using CPT. In the case of Hospitals, reports shall include a Uniform Billing Form 04. In the case of physicians and other Providers supplying outpatient services, this reporting requirement shall include a CMS 1500 form.* ()

a. *If an injury or occupational disease results in a Claim, the Employer/Surety or Provider shall submit written reports to the Commission upon request. Such request may either be in writing or telephonic. If a Claim is referred to the Rehabilitation Division, Medical Reports shall be furnished by the Payor or Provider directly to the office that requests such reports. The Payor or Provider shall consider this an on-going request until notice is received that the reports are no longer required.* ()

b. *If the injury or occupational disease results in a time-loss Claim, the Payor shall submit copies of medical records containing information regarding the beginning and ending of disability, releases to work whether light duty or regular duty, impairment ratings, physical restrictions to the Commission. Other Medical Reports shall be submitted to the Commission only upon request.* ()

c. *ISIF shall receive all copies of Medical Reports, without charge, from either the Claimant or the Payor, depending upon who seeks to join it as a party to a worker's compensation Claim.* ()

d. *If the Commission requests Medical Reports from the Payor or Provider, the information shall be provided within a reasonable time period without charge. If information is received for which the Commission has no need, the information may be discarded or destroyed.* ()

02. Report Form and Content. Upon approval of the Commission, Medical Reports may be submitted in electronic or other machine-readable form usable to all parties. ()

03. Timely Response Requirement. When the Commission requests a Medical Report from a Payor or Provider for use in monitoring a worker's compensation Claim, the Payor or Provider shall provide the requested information promptly. ()

04. Forfeiture of Payment. If a Provider fails to give records to the Payor or Claimant, the Payor or Claimant may petition the Commission for an order requiring the Provider to provide the requested information. The petition shall set forth the Petitioner's efforts to obtain the information, the responses to those efforts, and why the Petitioner believes that the Provider has the information. In response to the petition, the Commission may enter an order requiring the Provider to furnish the requested records or demonstrate that the records are not available. If a Provider fails to provide records when ordered by the Commission, the Commission may enter an Order of Forfeiture. In the event such an order is entered, the Provider will forfeit its right to payment from both the Payor and Claimant, until such time as the records are provided. ()

405. RULE GOVERNING REIMBURSEMENT FOR TRAVEL EXPENSES.

01. Mileage Rate. If Claimant has access to, and is able to operate, a vehicle for transportation covered by Sections 72-432(13) or 72-433(3), Idaho Code, employer shall reimburse Claimant at the mileage rate then allowed by the State Board of Examiners for State employees. Such rate shall be published annually by the Industrial Commission, together with the average state wage for the upcoming period. All such miles shall be reimbursed, with fractions of a mile greater than one-half (1/2) mile rounded to the next higher mile and fractions of a mile below one-half (1/2) mile disregarded. ()

02. Commercial Transportation. If Claimant has no vehicle, or has access to a vehicle and is reasonably unable to utilize the vehicle for transportation covered by Sections 72-432(13) or 72-433(3), Idaho Code, Claimant's employer shall reimburse Claimant the actual cost of commercial transportation as evidenced by actual receipts. Notwithstanding the above provision, no Claimant shall be eligible for reimbursement of the actual cost of commercial transportation where such Claimant is unable to operate a motor vehicle due to the revocation or suspension of driving privileges because Claimant was under the influence of alcohol and/or drugs. ()

03. Request for Reimbursement. It shall be Claimant's responsibility to submit a travel reimbursement request to the employer. Such request shall be made on a form substantially the same as Industrial Commission Form IC 432(1), posted on the Commission's website. The Claimant must attach to the form a copy of a bill or receipt showing that the visit occurred. The employer shall furnish the Claimant with copies of this form. ()

04. Frequency of Requests. Claimant shall not request transportation reimbursement more frequently than once every thirty (30) days. However, notwithstanding this provision, should a Claimant request transportation reimbursement more frequently than every thirty (30) days, employer need not issue more than one reimbursement check in any thirty-day (30) period. ()

406. -- 500. (RESERVED)

501. RULE GOVERNING PROTECTION AND DISCLOSURE OF REHABILITATION DIVISION RECORDS.

01. Request for Disclosure. Pursuant to Section 74-105(10), Idaho Code, a party requesting rehabilitation records shall do so in writing and identify which provision of 74-105(10), Idaho Code, authorizes their request. ()

02. Requests from Other Agencies. If records are in the possession of the Rehabilitation Division by reason of an agreement to comply with valid confidentiality regulations of any agency of the state of Idaho, or agency of the United States, then disclosure shall be requested from the source agency, and not from the Rehabilitation Division. ()

502. RULE GOVERNING REPORTS OF ATTORNEY COSTS AND FEES IN LITIGATED CASES.

When requested by the Commission, parties to a Litigated Case shall provide the Commission the information required by Section 72-528, Idaho Code. The form for Sureties is Form 1022 and the form for Claimant's attorneys is Form 1023; both are available on the Commission's website. ()

503. -- 600. (RESERVED)

601. SUBMISSION OF FROI AND SROI.

01. Purpose. Pursuant to Sections 72-602(1)-(2), Idaho Code, employers must submit a FROI and/or SROI in accordance with these rules. ()

02. EDI Reporting. The Commission requires electronic submission of FROIs and SROIs in accordance with the most current versions of the IAIABC EDI Claims Release 3.0, or release 3.1 after December 1, 2022, and the Commission's EDI Guides and Tables from any employer not otherwise exempt by these rules. Each FROI and SROI must comply with formatting requirements and must contain the information identified as mandatory or mandatory conditional, as applicable. ()

03. Trading Partner Agreements. Before commencing with electronic reporting, Trading Partners shall electronically submit a Trading Partner Agreement with the Commission, which the Commission must approve prior to submitting reports. This agreement must provide the effective date to send and receive electronic reports, the acceptable data to be sent and received, the method of transmission to be used, and other pertinent elements. This agreement will identify the insurance carrier, the Claims Administrator, the sender of the electronic files, and the electronic filing method. To ensure the accuracy of reported data, the Trading Partner must maintain their profile to reflect changes as they occur and the Commission may make periodic audits of Trading Partner files. In the event that a Trading Partner Agreement is entered into by a Claims Administrator, notice to the Trading Partner of a FROI shall be deemed to be notice to the underlying insurance carrier or self-insured employer. ()

04. Report Form and Content for Parties Exempt from EDI Requirements. ()

a. Individual injured workers, injured worker's legal counsel, and employers that are not insured are not required to comply with EDI requirements for FROIs and SROIs. ()

b. Parties exempt from EDI requirements must submit FROIs on a form 1A-1 and SROIs on a form IC-8, or in a format substantially similar. Both forms are available on the Commission's website. ()

05. Retaining Claims Files. Upon request of the Commission, insurance carriers, Claims Administrators, or employers shall provide to the Commission, in whole or in part according to the request, a copy of the claim file at no cost to the Commission. All insurance carriers, Claims Administrators, or employers shall retain complete copies of claims files for the life of the Claim and a minimum of five (5) years from the date of closure. ()

06. Filing Not an Admission. Filing a FROI is not an admission of liability and is not conclusive evidence of any fact stated therein. If a Claim is submitted electronically, no signatures are required. ()

07. Filing Considered Authorization. Filing of a Claim shall be considered an authorization for the release of medical records that are relevant to or bearing upon the particular injury or occupational disease for which the Claimant is seeking compensation. ()

08. Timely Response Requirement. When the Commission requests additional information in order to process the Claim, the Claimant or employer shall provide the requested information promptly. The Commission request may be either in writing or telephonic. ()

602. FINAL REPORTS.

01. Report Requirements. An electronic filing of the Final Report as prescribed by Commission EDI

requirements shall be filed for all indemnity claims or any claims resolved by lump sum settlement within thirty (30) days from the date the surety or self-insured employer closes the claim file. In the case of medical-only claims, no Final Report need be filed. For death claims and permanent total disability claims, Annual Reports shall be filed within the first quarter of each calendar year. A Final Report shall be filed within thirty (30) days from the date the surety or self-insured employer closes the death or permanent total disability claim file. In the event the Commission is unable to reconcile the Annual Report or Final Report, a request for additional information may be made, either in writing or telephonically, and the surety or self-insured employer shall submit the requested information within fifteen (15) working days of the request. If the surety or self-insured employer is unable to furnish the requested information, the surety or self-insured employer shall notify the Commission, in writing, of its inability to respond and the reasons therefor within fifteen (15) workings days of the request. ()

02. Format. The required format for Final Reports is contingent on the claim file date: ()

a. Final Reports for legacy claims filed on paper or via EDI Claims 1.0 prior to November 4, 2017, shall be submitted in a format substantially similar to IC Form 6, available on the Commission's website, or EDI Claims Release 3.1 after December 1, 2022. ()

b. Final Reports for legacy claims filed via EDI Claims 3.0 shall be submitted electronically via EDI Claims 3.0, or EDI Claims 3.1 after December 1, 2022. ()

03. Change in Status of Employer. In case of any default by the Employer or in the event the Employer shall fail to pay any final award or awards, by reason of insolvency or because a receiver has been appointed, the receiver or successor shall continue to report to the Commission, including the submission of Annual Reports, Final Reports and schedules of outstanding awards. ()

603. -- 800. (RESERVED)

801. RULE GOVERNING CHANGE OF STATUS NOTICE TO CLAIMANTS.

01. Notice of Change of Status. As required and defined by Section 72-806, Idaho Code, a worker shall receive written notice within fifteen (15) days of any change of status or condition, including, but not limited to, whenever there is an acceptance, commencement, denial, reduction, or cessation of medical or monetary compensation benefits to which the worker might presently or ultimately be entitled. Such notice is required when benefits are curtailed to recoup any overpayment of benefits in accordance with the provisions of Section 72-316, Idaho Code. ()

02. By Whom Given. Any notice to a worker required by Section 72-806, Idaho Code, shall be given by: the surety if the employer has secured Worker's Compensation Insurance; or the employer if the employer is self-insured; or the employer if the employer carries no Worker's Compensation Insurance. ()

03. Form of Notice. Any notice to a worker required by Section 72-806, Idaho Code, shall be mailed within ten (10) days by regular United States Mail to the last known address of the worker, as shown in the records of the party required to give notice as set forth above. The Notice shall be given in a format substantially similar to IC Form 8, available on the Commission's website. ()

04. Medical Reports. As required by Section 72-806, Idaho Code, if the change is based on a Medical Report, the party giving notice shall attach a copy of the report to the notice. ()

05. Copies of Notice. The party giving notice pursuant to Section 72-806, Idaho Code, shall send a copy of any such notice to the Industrial Commission, the employer, and the worker's attorney, if the worker is represented, at the same time notice is sent to the worker. The party giving notice may supply the copy to the Industrial Commission in accordance with the Commission's rule on electronic submission of documents. In the case of an overpayment recovery request made pursuant to I.C. 72-316, notice shall be contemporaneously submitted to the Commission in paper format. ()

802. RULE GOVERNING APPROVAL OF ATTORNEYS FEES

- 01. Purpose.** The Industrial Commission promulgates this rule to govern the approval of attorney fees. ()
- 02. Charges Presumed Reasonable:** ()
- a.** In a case in which no hearing on the merits has been held, twenty-five percent (25%) of Available Funds shall be presumed reasonable; or ()
- b.** In a case in which a hearing has been held and briefs submitted (or waived) under Judicial Rules of Practice and Procedure (JRP), Rules X and XI, thirty percent (30%) of Available Funds shall be presumed reasonable; or ()
- c.** In any case in which compensation is paid for total permanent disability, fifteen percent (15%) of such disability compensation after ten (10) years from date such total permanent disability payments commenced. ()
- 03. Statement of Charging Lien.** ()
- a.** All requests for approval of fees shall be deemed requests for approval of a Charging Lien. ()
- b.** An attorney representing a Claimant in a Worker's Compensation matter shall in any proposed LSS, or upon request of the Commission, file with the Commission, and serve the Claimant with a copy of the Fee Agreement, and an affidavit or memorandum containing: ()
- i.** The date upon which the attorney became involved in the matter; ()
- ii.** Any issues which were undisputed at the time the attorney became involved; ()
- iii.** The total dollar value of all compensation paid or admitted as owed by employer immediately prior to the attorney's involvement; ()
- iv.** Disputed issues that arose subsequent to the date the attorney was hired; ()
- v.** Counsel's itemization of compensation that constitutes Available Funds; ()
- vi.** Counsel's itemization of costs and calculation of fees; and ()
- vii.** Counsel's itemization of medical bills for which Claim was made in the underlying action, but which remain unpaid by employer/surety at the time of LSS, along with counsel's explanation of the treatment to be given such bills/claims following approval of the LSS. ()
- viii.** The statement of the attorney identifying with reasonable detail his or her fulfillment of each element of the Charging Lien. ()
- c.** Upon receipt and a determination of compliance with this Rule by the Commission by reference to its staff, the Commission may issue an Order Approving Fees without a hearing. ()
- 04. Procedure if Fees Are Determined Not to Be Reasonable.** ()
- a.** Upon receipt of the affidavit or memorandum, the Commission will designate staff members to determine reasonableness of the fee. The Commission staff will notify counsel in writing of the staff's informal determination, which shall state the reasons for the determination that the requested fee is not reasonable. Omission of any information required by Paragraph 802.02.b may constitute grounds for an informal determination that the fee requested is not reasonable. ()
- b.** If counsel disagrees with the Commission staff's informal determination, counsel may file, within fourteen (14) days of the date of the determination, a Request for Hearing for the purpose of presenting evidence and

argument on the matter. Upon receipt of the Request for Hearing, the Commission shall schedule a hearing on the matter. A Request for Hearing shall be treated as a motion under Rule III(e), JRP. ()

c. The Commission shall order an employer to release any Available Funds in excess of those subject to the requested Charging Lien and may order payment of fees subject to the Charging Lien which have been determined to be reasonable. ()

d. The proponent of a fee which is greater than the percentage of recovery stated in Subsection 802.02 shall have the burden of establishing by clear and convincing evidence entitlement to the greater fee. The attorney shall always bear the burden of proving by a preponderance of the evidence his or her assertion of a Charging Lien and reasonableness of his or her fee. ()

05. Disclosure Statement. Upon retention, the attorney shall provide to Claimant a copy of a disclosure statement. No fee may be taken from a Claimant by an attorney on a contingency fee basis unless the Claimant acknowledges receipt of the disclosure by signing it. Upon request by the Commission, an attorney shall provide a copy of the signed disclosure statement to the Commission. The terms of the disclosure may be contained in the Fee Agreement, so long as it contains the following text: ()

a. In worker's compensation matters, attorney's fees normally do not exceed twenty-five percent (25%) of the benefits your attorney obtains for you in a case in which no hearing on the merits has been completed. In a case in which a hearing on the merits has been completed, attorney's fees normally do not exceed thirty percent (30%) of the benefits your attorney obtains for you. ()

b. Depending upon the circumstances of your case, you and your attorney may agree to a higher or lower percentage which would be subject to Commission approval. Further, if you and your attorney have a dispute regarding attorney fees, either of you may petition the Industrial Commission, PO Box 83720, Boise, ID 83720-0041, to resolve the dispute. ()

803. MEDICAL FEES.

01. General Provisions for Medical Fees. The following provisions shall apply to Commission approval of claims for medical benefits. ()

a. Acceptable Charge. Payors shall pay Providers the acceptable charge for medical services. ()

b. Coding. The Commission will generally follow the coding guidelines published by CMS and by the American Medical Association, including the use of modifiers. ()

c. Disputes. Disputes between Providers and Payors are governed by Subsection 803.06 of this rule and JRP 19. ()

d. Outside of Idaho. Reimbursement for medical services provided outside the state of Idaho may be based upon the agreement of the parties. If there is no agreement, services shall be paid in accordance with the worker's compensation fee schedule in effect in the state in which services are rendered. If there is no fee schedule in effect in such state, or if the fee schedule in that state does not allow reimbursement for the services rendered, reimbursement shall be paid in accordance with these rules. ()

02. Acceptable Charges For Medical Services Provided By Physicians Under The Idaho Worker's Compensation Law. ()

a. The Commission adopts the RBRVS, published by CMS, as amended, as the standard to be used to determine acceptable charges by physicians. ()

b. Modifiers. Modifiers for physicians will be reimbursed as follows: ()

i. Modifier 50: Additional fifty percent (50%) for bilateral procedure. ()

- ii. Modifier 51: Fifty percent (50%) of secondary procedure. This modifier will be applied to each medical or surgical procedure rendered during the same session as the primary procedure. ()
 - iii. Modifier 80: Twenty-five percent (25%) of coded procedure. ()
 - iv. Modifier 81: Fifteen percent (15%) of coded procedure. This modifier applies to MD and non-MD assistants. ()
- c. Conversion Factors. The standard for determining the acceptable charge for a medical service, identified by a code assigned to that service in the latest edition of the Physician's CPT, published by the American Medical Association, as amended, is calculated by the application of the total facility or non-facility RVU for services as determined by place of service in the latest RBRVS in effect on the first day of January of the current calendar year, to the following corresponding conversion factors. The procedure with the largest RVU will be the primary procedure and will be listed first on the claim form. ()

MEDICAL FEE SCHEDULE			
SERVICE CATEGORY	CODE RANGE(S)	DESCRIPTION	CONVERSION FACTOR
Anesthesia	00000 - 09999	Anesthesia	\$60.33
Surgery - Group One	22000 - 22999	Spine	\$135.00
	23000 - 24999	Shoulder, Upper Arm, & Elbow	
	25000 - 27299	Forearm, Wrist, Hand, Pelvis & Hip	
	27300 - 27999	Leg, Knee, & Ankle	
	29800 - 29999	Endoscopy & Arthroscopy	
	61000 - 61999	Skull, Meninges & Brain	
	62000 - 62259	Repair, Neuroendoscopy & Shunts	
Surgery - Group Two	28000 - 28999	Foot & Toes	\$124.00
	64550 - 64999	Nerves & Nervous System	
Surgery - Group Three	10000 - 19999	Integumentary System	\$88.54
	20000 - 21999	Musculoskeletal System	
	29000 - 29799	Casts & Strapping	
	30000 - 39999	Respiratory & Cardiovascular	
	40000 - 49999	Digestive System	
	50000 - 59999	Urinary System	
	60000 - 60999	Endocrine System	
	62260 - 62999	Spine & Spinal Cord	
	64000 - 64549	Nerves & Nervous System	
	65000 - 69999	Eye & Ear	
Radiology	70000 - 79999	Radiology	\$88.54
Pathology & Laboratory	80000 - 89999	Pathology & Laboratory	To Be Determined
Medicine - Group One	90000 - 90749	Immunization, Injections, & Infusions	\$49.00
	94000 - 94999	Pulmonary / Pulse Oximetry	
	97000 - 97799	Physical Medicine & Rehabilitation	
	97800 - 98999	Acupuncture, Osteopathy, & Chiropractic	

MEDICAL FEE SCHEDULE			
SERVICE CATEGORY	CODE RANGE(S)	DESCRIPTION	CONVERSION FACTOR
Medicine - Group Two	90750 - 92999 93000 - 93999 95000 - 96020 96040 - 96999 99000 - 99607	Psychiatry & Medicine Cardiography, Catheterization, Vascular Studies Allergy / Neuromuscular Procedures Assessments & Special Procedures E / M & Miscellaneous Services	\$70.00

()

d. Anesthesiology. The Conversion Factor for the Anesthesiology CPT Codes shall be multiplied by the current Anesthesia Base Units assigned to that CPT Code by CMS, plus the allowable time units reported for the procedure. Time units are computed by dividing reported time by fifteen (15) minutes. Time units will not be used for CPT Code 01996. ()

e. Services Without CPT Code, RVU or Conversion Factor. The acceptable charge for medical services that do not have a current CPT code, a currently assigned RVU, or a conversion factor will be the reasonable charge for that service, based upon the usual and customary charge and other relevant evidence, as determined by the Commission. Where a service with a CPT Code, RVU, and conversion factor is, nonetheless, claimed to be exceptional or unusual, the Commission may, notwithstanding the conversion factor for that service set out in Paragraph 02.c, above, determine the acceptable charge for that service, based on all relevant evidence in accordance with the procedures set out in Subsection 06, below. ()

f. Medicine Dispensed by Physicians. Reimbursement to physicians for any medicine shall not exceed the acceptable charge calculated for that medicine as if provided by a Pharmacy under Subsection 04 of this rule without a dispensing or compounding fee. Reimbursement to physicians for repackaged medicine shall be the AWP for the medicine prior to repackaging, identified by the NDC reported by the original manufacturer. Reimbursement may be withheld until the original manufacturer's NDC is provided by the physician. ()

g. Adjustment of Conversion Factors. The conversion factors set out in this rule may be adjusted each fiscal year (FY) by the Commission to reflect changes in inflation or market conditions in accordance with Section 72-803, Idaho Code. ()

03. Acceptable Charges For Medical Services Provided By Hospitals And Ambulatory Surgery Centers Under The Idaho Worker's Compensation Law. The following standards shall be used to determine the acceptable charge for Hospitals and ASCs. ()

a. Critical Access Hospitals. The standard for determining the acceptable charge for inpatient and outpatient services provided by a Critical Access Hospital is ninety percent (90%) of the reasonable charge. Implantable hardware charges shall be reimbursed at the rate of the actual cost plus fifty percent (50%). ()

b. Hospital Inpatient Services. The standard for determining the acceptable charge for inpatient services provided by Hospitals, other than Critical Access Hospitals, is calculated by multiplying the base rate by the current MS-DRG weight for that service. The base rate for inpatient services is ten thousand two hundred dollars (\$10,200). Inpatient services that do not have a relative weight shall be paid at eighty-five percent (85%) of the reasonable charge; however, Implantable Hardware charges billed for services without an MS-DRG weight shall be reimbursed at the rate of actual cost plus fifty percent (50%). ()

c. Hospital Outpatient and ASC Services. The standard for determining the acceptable charge for outpatient services provided by Hospitals (other than Critical Access Hospitals) and for services provided by ASCs is calculated by multiplying the base rate by the Medicare Hospital Outpatient Prospective Payment System APC weight in effect on the first day of January of the current calendar year. The base rate for Hospital outpatient services is one hundred forty dollars and seventy-five cents (\$140.75). The base rate for ASC services is ninety-one dollars fifty cents (\$91.50). ()

i. Medical services for which there is no APC weight listed shall be reimbursed at seventy-five percent (75%) of the reasonable charge. ()

ii. Status code N items or items with no CPT or HCPCS code shall receive no payment except as provided in Subparagraph 803.03.c.ii.(1) or 803.03.c.ii.(2) of this rule. ()

(1) Implantable Hardware may be eligible for separate payment under Subparagraph 03.d.iii. of this rule. ()

(2) Outpatient laboratory tests provided with no other Hospital outpatient service on the same date, or outpatient laboratory tests provided on the same date of service as other Hospital outpatient services that are clinically unrelated may be paid separately if billed with modifier L1. Payment shall be made in the same manner that services with no APC weight are paid under Subparagraph 803.03.c.i. of this rule. ()

iii. When no medical services with a status code J1 appears on the same Claim, two (2) or more medical procedures with a status code T on the same Claim shall be reimbursed with the highest weighted code paid at one hundred percent (100%) of the APC calculated amount and all other status code T items paid at fifty percent (50%). When a medical service with a status code J1 appears on the same Claim, all medical services with a status code T shall be paid at fifty percent (50%). ()

iv. When no medical services with a status code J1 appears on the same Claim, status code Q items with an assigned APC weight will not be discounted. When a medical service with a status code J1 appears on the same Claim, status code Q items shall be paid at fifty percent (50%). ()

d. Additional Hospital Payments. When the charge for a medical service provided by a Hospital (other than a Critical Access Hospital) meets the following standards, additional payment shall be made for that service, as indicated. ()

i. Inpatient Threshold Exceeded. When the charge for a Hospital inpatient MS-DRG coded service exceeds the sum of thirty thousand dollars (\$30,000) plus the payment calculated under the provisions of Paragraph 03.b. of this rule, then the total payment for that service shall be the sum of the MS-DRG payment and the amount charged above that threshold multiplied by seventy-five percent (75%). Implantable charges shall be excluded from the calculation for an additional inpatient payment under this Subparagraph. ()

ii. Inpatient Implantable Hardware. Hospitals may seek additional reimbursement beyond the MS-DRG payment for invoiced Implantable Hardware where the aggregate invoice cost is greater than ten thousand dollars (\$10,000). Additional reimbursement shall be the invoice cost plus an amount which is equal to ten percent (10%) of the invoice cost, but which does not exceed three thousand dollars (\$3,000). Handling and freight charges shall be included in invoice cost. ()

iii. Outpatient Implantable Hardware. Hospitals and ASCs may seek additional reimbursement beyond the APC payment for invoiced Implantable Hardware where the aggregate invoice cost is greater than five hundred dollars (\$500). Additional reimbursement shall be the invoice cost plus an amount which is equal to ten percent (10%) of the invoice cost, but which does not exceed one thousand dollars (\$1,000). Handling and freight charges shall be included in invoice cost. ()

e. Adjustment of Hospital and ASC Base Rates. The Commission may periodically adjust the base rates set out in Paragraphs 803.03.b. and 803.03.c. of this rule to reflect changes in inflation or market conditions. ()

04. Acceptable Charges For Medicine Provided By Pharmacies. The following standards shall be used to determine the acceptable charge for medicine provided by pharmacies. ()

a. Brand/Trade Name Medicine. The standard for determining the acceptable charge for brand/trade name medicine shall be the AWP, plus a five dollar (\$5) dispensing fee. ()

b. Generic Medicine. The standard for determining the acceptable charge for generic medicine shall be the AWP, plus an eight dollar (\$8) dispensing fee. ()

c. Compound Medicine. The standard for determining the acceptable charge for compound medicine shall be the sum of the AWP for each drug included in the compound medicine, plus a five dollar (\$5) dispensing fee and a two dollar (\$2) compounding fee. All components of the compound medicine shall be identified by their original manufacturer's NDC when submitted for reimbursement. Payors may withhold reimbursement until the original manufacturer's NDC assigned to each component of the compound medicine is provided by the Pharmacy. Components of a compound medicine without an NDC may require medical necessity confirmation by the treating physician prior to reimbursement. ()

d. Prescribed Over-the Counter Medicine. The standard for determining the acceptable charge for prescribed over-the-counter medicine filled by a Pharmacy shall be the reasonable charge plus a two dollar (\$2) dispensing fee. ()

05. Acceptable Charges For Medical Services Provided By Other Providers Under The Idaho Worker's Compensation Law. The standard for determining the acceptable charge for Providers other than physicians, Hospitals or ASCs shall be the reasonable charge. ()

06. Billing And Payment Requirements For Medical Services And Procedures Preliminary To Dispute Resolution. This rule governs billing and payment requirements for medical services provided under the Worker's Compensation Law and the procedures for resolving disputes between Payors and Providers over those bills or payments. ()

a. Time Periods. None of the periods herein shall begin to run before the Notice of Injury/Claim for Benefits has been filed with the Employer as required by law. ()

b. Provider to Furnish Information. A Provider, when submitting a bill to a Payor, shall inform the Payor of the nature and extent of medical services furnished and for which the bill is submitted. This information shall include, but is not limited to, the patient's name, the employer's name, the date the medical service was provided, the diagnosis, if any, and the amount of the charge or charges. Failure to submit a bill complying with this Paragraph 06.b to the Payor within one hundred twenty (120) days of the date of service will result in the ineligibility of the Provider to utilize the dispute resolution procedures of the Commission set out in Paragraph 803.06.i. of this rule for that service. ()

i. A Provider's bill shall, whenever possible, describe the Medical Service provided, using the American Medical Association's appropriate CPT coding, including modifiers, the appropriate HCPCS code, the diagnostic and procedure code set version required by CMS and the original NDC for the year in which the service was performed. ()

ii. The bill shall also contain the name, address and telephone number of the individual the Payor may contact in the event the Payor seeks additional information regarding the Provider's bill. ()

iii. *If requested by the Payor, the bill shall be accompanied by a written report as defined by Subsection 010.31 and required by Section 404 of these rules. Where a bill is not accompanied by such Report, the periods expressed in Paragraphs 803.06.c. and 803.06.e. of this rule, shall not begin to run until the Payor receives the Report.* ()

c. Prompt Payment. Unless the Payor denies liability for the Claim or, pursuant to Paragraph 803.06.e. of this rule, sends a Preliminary Objection, a Request for Clarification, or both, as to any charge, the Payor shall pay the charge within thirty (30) calendar days of receipt of the bill or upon acceptance of liability, if made after bill is received from Provider. ()

d. Partial Payment. If the Payor acknowledges liability for the Claim and, pursuant to Paragraph 803.06.e. of this rule, sends a Preliminary Objection, a Request for Clarification, or both, as to only part of a Provider's bill, the Payor must pay the charge or charges, or portion thereof, as to which no Preliminary Objection or Request for Clarification has been made, within thirty (30) calendar days of receipt of the bill. ()

e. Preliminary Objections and Requests for Clarification. ()

i. Whenever a Payor objects to all or any part of a Provider's bill on the ground that such bill contains a charge or charges that do not comport with the applicable administrative rule, the Payor shall send a written Preliminary Objection to the Provider within thirty (30) calendar days of the Payor’s receipt of the bill explaining the basis for each of the Payor's objections. ()

ii. Where the Payor requires additional information, the Payor shall send a written Request for Clarification to the Provider within thirty (30) calendar days of the Payor’s receipt of the bill, and shall specifically describe the information sought. ()

iii. Each Preliminary Objection and Request for Clarification shall contain the name, address, and phone number of the individual located within the state of Idaho that the Provider may contact regarding the Preliminary Objection or Request for Clarification. ()

iv. Where a Payor does not send a Preliminary Objection to a charge set forth in a bill or a Request for Clarification within thirty (30) calendar days of receipt of the bill, or provide an in-state contact in accord with Subparagraph 06.e.iii., it shall be precluded from objecting to such charge as failing to comport with the applicable administrative rule. ()

f. Provider Reply to Preliminary Objection or Request for Clarification. ()

i. Where a Payor has timely sent a Preliminary Objection, Request for Clarification, or both, the Provider shall send to the Payor a written Reply, if any it has, within thirty (30) calendar days of the Provider's receipt of each Preliminary Objection or Request for Clarification. ()

ii. If a Provider fails to timely reply to a Preliminary Objection, the Provider shall be deemed to have acquiesced in the Payor's objection. ()

iii. If a Provider fails to timely reply to a Request for Clarification, the period in which the Payor shall pay or issue a Final Objection shall not begin to run until such clarification is received. ()

g. Payor Shall Pay or Issue Final Objection. The Payor shall pay the Provider's bill in whole or in part or send to the Provider a written Final Objection, if any it has, to all or part of the bill within thirty (30) calendar days of the Payor's receipt of the Reply. ()

h. Failure of Payor to Finally Object. Where the Payor does not timely send a Final Objection to any charge or portion thereof to which it continues to have an objection, it shall be precluded from further objecting to such charge as unacceptable. ()

i. Dispute Resolution Process. If, after completing the applicable steps set forth above, a Payor and Provider are unable to agree on the appropriate charge for any Medical Service, a Provider which has complied with the applicable requirements of this rule may move the Commission to resolve the dispute as provided in the Judicial Rule Re: Disputes Between Providers and Payors, as referenced in Paragraph 803.01.c. of this rule. If Provider's motion disputing CPT or MS-DRG coded items prevails, Payor shall pay the amount found by the Commission to be owed, plus an additional thirty percent (30%) of that amount to compensate Provider for costs and expenses associated with using the dispute resolution process. For motions filed by a Provider disputing items without CPT or MS-DRG codes, the additional thirty percent (30%) shall be due only if the Payor does not pay the amount found due within thirty (30) days of the administrative order. ()

804. – 999. (RESERVED)

IDAPA 21 – IDAHO DIVISION OF VETERANS SERVICES

DOCKET NO. 21-0000-2100F

NOTICE OF OMNIBUS RULEMAKING – ADOPTION OF PENDING FEE RULE

[LINK: LSO Rules Analysis Memo and Cost/Benefit Analysis \(CBA\)](#)

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2022 Idaho State Legislature for final approval. Pursuant to Section 67-5224(5)(c), Idaho Code, this pending rule will not become final and effective until it has been approved by concurrent resolution of the legislature because of the fee being imposed or increased through this rulemaking. The pending fee rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution unless the rule is rejected.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending fee rule. The action is authorized pursuant to Sections 65-202, 65-204, and 66-907, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending fee rule and a statement of any change between the text of the proposed rule and the text of the pending fee rule with an explanation of the reasons for the change.

This pending fee rule adopts and publishes the following rule chapters previously submitted to and reviewed by the Idaho Legislature under IDAPA 21, rules of the Idaho Division of Veterans Services:

IDAPA 21

- 21.01.01, *Rules Governing Admission, Residency, and Maintenance Charges in Idaho State Veterans Homes and Division of Veterans Services Administrative Procedure*; and
- 21.01.04, *Rules Governing the Idaho Veterans Cemetery*.

There are no changes to the pending fee rule and it is being adopted as originally proposed. The complete text of the proposed rulemaking was published in the October 20, 2021, Special Edition of the Idaho Administrative Bulletin, [Vol. 21-10SE, pages 3252-3279](#).

FEE SUMMARY: The following identifies the fee or charge imposed or increased through this rulemaking:

This rulemaking does not impose a new fee or charge, or increase an existing fee or charge, beyond what has been previously submitted for review in the prior rules. A specific description of the fees or charges being imposed pursuant to Section 65-202(8) and Section 66-907, Idaho Code, is listed below:

- IDAPA 21.01.01.915 – Maintenance Charges
- IDAPA 21.01.01.916.01 – Monthly Charges and Allowances, Nursing Care
- IDAPA 21.01.01.916.02 – Monthly Charges and Allowances, Residential and Domiciliary Care
- IDAPA 21.01.04.024 – Fees For Interment, Disinterment, and Reinterment, and Memorial.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars (\$10,000) during the fiscal year: This rulemaking is not anticipated to have any fiscal impact on the state general fund because the FY2022 budget has already been set by the Legislature, and approved by the Governor, anticipating the existence of the rules and fees being reauthorized by this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending fee rule, contact Kevin Wallior, Management Assistant, at 208-780-1308.

Dated this 22nd day of December, 2021.

Kevin R. Wallior
Idaho Division of Veterans Services
Boise, ID 83702
Fax: 208-780-1301

Management Assistant
351 Collins Road
Ph: 208-780-1380

THE FOLLOWING NOTICE PUBLISHED WITH THE OMNIBUS PROPOSED RULE

AUTHORITY: In compliance with Sections 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 65-202, 65-204, and 66-907, Idaho Code.

PUBLIC HEARING SCHEDULE: Oral comment concerning this rulemaking will be scheduled in accordance with Section 67-5222, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

This proposed rulemaking publishes the following rule chapters previously submitted to and reviewed by the Idaho Legislature under IDAPA 21, rules of the Idaho Division of Veterans Services:

IDAPA 21

- 21.01.01, *Rules Governing Admission, Residency, and Maintenance Charges in Idaho State Veterans Homes and Division of Veterans Services Administrative Procedure*; and
- 21.01.04, *Rules Governing the Idaho Veterans Cemetery*.

FEE SUMMARY: This rulemaking does not impose a fee or charge, or increase a fee or charge, beyond what was previously submitted to and reviewed by the Idaho Legislature in the prior rules.

The following is a specific description of the fees or charges:

- IDAPA 21.01.01.915 – Maintenance Charges
- IDAPA 21.01.01.916.01 – Monthly Charges and Allowances, Nursing Care
- IDAPA 21.01.01.916.02 – Monthly Charges and Allowances, Residential and Domiciliary Care
- IDAPA 21.01.04.024 – Fees For Interment, Disinterment, and Reinterment, and Memorial.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars (\$10,000) during the fiscal year: This rulemaking is not anticipated to have any fiscal impact on the state general fund because the FY2022 budget has already been set by the Legislature, and approved by the Governor, anticipating the existence of the rules and fees being reauthorized by this rulemaking.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not feasible because engaging in negotiated rulemaking for all previously existing rules will inhibit the agency from carrying out its ability to serve the citizens of Idaho and to protect their health, safety, and welfare.

Negotiated rulemaking conducted outside of this omnibus rulemaking under docket 21-0104-2101 published in the June 2021 Idaho Administrative Bulletin, [Vol. 21-6, page 58](#), and affects the following rule chapter included in this proposed rulemaking: IDAPA 21.01.04.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, incorporated material may be obtained or electronically accessed as provided in the text of the proposed rules attached hereto.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rules, contact Kevin Wallior, 208-780-1308 or kevin.wallior@veterans.idaho.gov.

Anyone may submit written comments regarding the proposed rulemaking. All written comments must be directed to the undersigned and must be delivered within twenty-one (21) days after publication of this Notice in the

Idaho Administrative Bulletin. Oral presentation of comments may be requested pursuant to Section 67-5222(2), Idaho Code, and must be delivered to the undersigned within fourteen (14) days of the date of publication of this Notice in the Idaho Administrative Bulletin.

DATED this October 20, 2021.

THE FOLLOWING IS THE TEXT OF OMNIBUS PENDING FEE DOCKET NO. 21-0000-2100F

IDAPA 21 – IDAHO DIVISION OF VETERANS SERVICES

21.01.01 – RULES GOVERNING ADMISSION, RESIDENCY, AND MAINTENANCE CHARGES IN IDAHO STATE VETERANS HOMES AND DIVISION OF VETERANS SERVICES ADMINISTRATIVE PROCEDURE

000. LEGAL AUTHORITY.

The Administrator of the Division of Veterans Services with the advice of the Veterans Affairs Commission is authorized by the Idaho Legislature to establish rules governing requirements for admission to Idaho State Veterans Homes and to establish rules governing charges for residency, pursuant to Sections 65-202, 65-204 and 66-907, Idaho Code. ()

001. TITLE AND SCOPE.

01. Title. These rules are titled IDAPA 21.01.01, “Rules Governing Admission, Residency, and Maintenance Charges in Idaho State Veterans Homes and Division of Veterans Services Administrative Procedure.” ()

02. Scope. These rules contain provisions for determining eligibility for admission and for establishing charges for residency in Idaho State Veterans Homes, together with rules of administrative procedure before the Idaho Veterans Affairs Commission. ()

002. POLICY.

Through the facilities and services available at Idaho State Veterans Homes, the Division of Veterans Services will provide necessary care for honorably discharged eligible veterans. No applicant will be denied admission on the basis of sex, race, color, age, political or religious opinion or affiliation, national origin, or lack of income, nor will any care or other benefit at a Home be provided in a manner, place, or quality different than that provided for other residents with comparable disabilities and circumstances. However, if residents are financially able to do so, they must contribute to the cost of their care, with allowances made for retention of funds for their personal needs. ()

003. INCORPORATION BY REFERENCE.

01. Incorporated Documents. These rules incorporate by reference: ()

a. 5 U.S.C. Section 2108(1) dated October 7, 2015. ()

b. 38 CFR Part 51, Subpart A, B, C, D, and E dated December 28, 2018. ()

02. Document Availability. Copies are available from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402-0001. ()

004. -- 009. (RESERVED)

010. DEFINITIONS.

For the purposes of the rules contained in this Chapter, the following terms are used as defined: ()

01. Applicant. A person who has expressed interest in applying for residency in an Idaho State Veterans Home. ()

02. Asset. Real or personal property that is owned in whole or in part by an applicant or resident, including stocks, bonds, goods, rights of action, evidences of debt, and cash or money that is not income. Insurance payments or monetary compensation for loss of or damage to an asset is an asset. Income not expended in the calendar month received is an asset beginning on the first day of the next calendar month. ()

03. Bona Fide Resident. A person who maintains a principal or primary home or place of abode in the state of Idaho coupled with the present intent to remain at that home or abode and return to it after any period of absence pursuant to Section 66-901, Idaho Code. ()

04. Commission. The Idaho Veterans Affairs Commission. ()

05. Division. Division of Veterans Services in the Idaho Department of Self Governing Agencies. ()

06. Division Administrator. The Administrator of the Division of Veterans Services in the Department of Self Governing Agencies, or his designee. The chief officer of the Division of Veterans Services. ()

07. Home Administrator. Administrator of an Idaho State Veterans Home. The chief officer of each respective Veterans Home. ()

08. Home. An Idaho State Veterans Home. ()

09. Idaho State Veterans Home. Pursuant to Section 66-901, Idaho Code, a Home for eligible veterans. ()

10. Income. Money received from any source including wages, tips, commissions, private pension and retirement payments, social security benefits, unemployment compensation, veterans assistance benefits, and gifts. ()

11. Legal Dependents. The mother, father, spouse, or minor children of an applicant or a resident who, by reason of insufficient financial resources, or non-minor children who because of disease, handicap or disability, must have financial support from the applicant or resident in order to maintain themselves. ()

12. Liquid Assets. Those assets which are cash or can be liquidated for cash within a reasonable period of time including, but not limited to, money market certificates, certificates of deposit, stocks and bonds, and some tax shelter investments. ()

13. Maintenance Charge. A charge made for care and residence at an Idaho State Veterans Home, based upon the current established rate. ()

14. Net Income. That income used to compute charges after allowable deductions have been made. ()

15. Resident. A person who is a resident of an Idaho State Veterans Home. ()

16. Spouse. The husband or wife, under a marriage recognized by Title 32, Idaho Code, of a veteran or the widow or widower of a veteran under a marriage recognized by Title 32, Idaho Code. ()

17. VA. United States Department of Veterans Affairs. ()

18. Veteran. Has the meaning established in Section 65-203, Idaho Code. The separation or discharge considered under this definition means the conditions of the most recent separation or discharge from military service. ()

011. -- 049. (RESERVED)

050. ADMINISTRATIVE POWERS.

The Home Administrator has full authority in the management of a Home, subject to review by the Division Administrator and Commission. A Home Administrator can, in the execution of his duties, delegate certain responsibilities to his staff. When requested by the Division Administrator, the Home Administrator will attend regular and special meetings of the Commission. ()

01. Representative Powers. The Division Administrator is authorized to represent the Commission in all official transactions between the Homes and other departments of Idaho state government. ()

02. Investigation Powers. Upon receipt of an application for residency and for the duration of residency of any resident, the Division is authorized to conduct an investigation to determine the total value of the property and assets of the applicant/resident to determine his ability to pay maintenance charges established in this Chapter pursuant to Section 66-907, Idaho Code. ()

03. Inspection Powers. Inspection of the rooms and facilities of a Home, as well as of the dress and appearance of all residents, can be conducted at any time by the Home Administrator. ()

04. Emergency Powers. In an emergency, the Home Administrator is authorized to use his judgment in matters not specifically covered by a statute, order, rule, or policy. ()

051. -- 074. (RESERVED)

075. ADMINISTRATIVE DUTIES.

The Home Administrator will enforce all orders and rules and implement all policies of the Division in the administration of a Home. ()

01. Management of Records. The Home Administrator must maintain accurate fiscal and resident records. ()

a. Nursing care records. Records relating to each nursing care resident of a Home will be kept in accordance with Idaho Department of Health and Welfare Rules, IDAPA 16.03.02, "Rules and Minimum Standards for Skilled Nursing and Intermediate Care Facilities in Idaho," and VA Rules 38 CFR Part 51; Subpart A, B, C, and D dated December 28, 2018. ()

b. Residential and domiciliary care records. Records relating to each residential care resident of a Home will be kept in accordance with VA Rules 38 CFR Part 51; Subpart A, B, C, and E dated December 28, 2018. ()

02. Response to Complaints. The Home Administrator will respond in writing to any written and signed complaint made by a resident pursuant to Section 300 of these rules. ()

076. -- 099. (RESERVED)

100. ELIGIBILITY REQUIREMENTS.

Applicants and residents must satisfy the following requirements: ()

01. Veterans or Eligible Spouse. ()

a. Nursing Care. Applicants for and residents of nursing care must be a veteran or the spouse of a veteran who is eligible for admission to a Home. The death of a veteran shall not disqualify a resident spouse if the veteran was eligible for admission to a Home at the time of death. ()

b. Residential Care and Domiciliary Care. Applicants for and residents of residential care and domiciliary care must be a veteran. A Home will not grant spouses admission for residential care or domiciliary care. ()

02. Idaho Residency. The applicant must be a bona fide resident of the state of Idaho at the time of admission to a Home. ()

03. Incompetent Applicants. Applicants and residents who are incompetent must provide copies of a legally sufficient guardianship or power of attorney. ()

04. Necessity of Services. Applicants and residents must meet the requirements for the level of care for which they apply or are receiving. At the request of the Home, residents must provide recertification of their need for services from a VA physician or a physician currently licensed by the Idaho Board of Medicine to practice medicine or surgery in the state of Idaho. ()

a. Nursing Care. To be eligible to receive nursing care in a Home, applicants must be referred by a VA physician or a physician currently licensed by the Idaho Board of Medicine to practice medicine or surgery in the state of Idaho. ()

b. Residential and Domiciliary Care. Each applicant must submit to a physical examination performed by a licensed physician and meet the physical limitation requirements for residential care and domiciliary care. Applicants and residents must be unable to earn a living and have no adequate means of support due to wounds, old age, or physical or mental disabilities. However, each residential care and domiciliary care resident must ambulate independently or with the aid of a wheelchair, walker, or similar device and be capable of performing at the time of admission, and for the duration of his residency, all of the following with minimal assistance: ()

- i. Making his bed daily; ()
- ii. Maintaining his room in a neat and orderly manner at all times; ()
- iii. Keeping all clothing clean through proper laundering; ()
- iv. Observing cleanliness in person, dress and living habits and dressing himself; ()
- v. Bathing or showering frequently; ()
- vi. Shaving daily or keeping his mustache or beard neatly groomed; ()
- vii. Proceeding to and returning from the dining room and feeding himself; ()
- viii. Securing medical attention on an ambulatory basis and managing medications; ()
- ix. Maintaining voluntary control over body eliminations or control by use of an appropriate prosthesis; and ()
- x. Making rational decisions as to his desire to remain or leave the Home. ()

05. Placement Restriction. A Home shall not accept applicants or continue to extend care to residents for whom the facility does not have the capability or services to provide an appropriate level of care. ()

06. Financial Statement. Each applicant must file a signed, dated statement with the Home Administrator containing a report of income from all sources and a report of all liquid assets which will be used to determine the amount of the maintenance charge which is required in accordance with Section 66-907, Idaho Code, and these rules. ()

07. Social Security Benefits. If eligible for Social Security benefits, the applicants and residents and their spouses must apply for those benefits unless waived by the Home Administrator. ()

08. Medicare Coverage. If eligible for Medicare, the applicants and residents must elect to participate, unless participation is waived by the Home Administrator. ()

09. Income Limitation. ()

a. Nursing Care. None. ()

b. Residential and Domiciliary Care. An applicant whose total monthly net income, at the time of his application for residency, exceeds the current maximum annual rate of VA pension for a single veteran pursuant to Public Law 95588 divided by twelve (12) cannot be admitted unless granted a waiver by the Home Administrator. This waiver must include a statement from a VA Medical Center physician indicating the veteran is in "need of continuing medical care." ()

10. VA Pension -- Nursing Care. Unless waived by the Home Administrator, a wartime veteran, as defined in 5 U.S.C. Section 2108, who is a nursing care applicant or resident must be eligible for, apply for, or be in receipt of a VA disability pension in accordance with Public Law 95588. Such waivers may be considered only when the applicant or resident has signed a statement that he is able to defray the necessary expenses of the medical care for which he is applying or receiving and arrangements are made to secure medical services not provided by the VA.

()

11. Agreements for Behavior and Care Needs. The Homes may require that applicants or residents enter into agreements concerning the applicant or resident's behavior or care needs while residing in the Home. The resident's failure to perform these agreements is a basis for discharge from the Home. ()

12. Limit on Admission of Spouses. Unless waived in writing by the Division Administrator, a Home shall not accept spouses for admission if the Home's residency is at ninety-five percent (95%) or more of capacity. Homes shall not admit a spouse if the number of spouses residing in the home will exceed twenty-five percent (25%) of the residents of the Home following admission of the applicant. ()

101. -- 149. (RESERVED)

150. APPLICATION PROCEDURE.

01. Submission of Application. An application may be submitted to the administrative offices of a Home on a form from the Division. ()

02. Application Processing. Completed applications will be processed no later than three (3) working days from receipt. ()

03. Waiting List. An applicant who is approved for admission for whom a vacancy does not exist will be placed on a waiting list and accepted on a first come, first served basis dependent on the Home's ability to provide a level of care consistent with the needs of the applicant. The Home Administrator may award "priority status" to prospective Home residents resulting in their names being placed near the top of the Home waiting list, provided they have completed all preadmission requirements and meet one (1) or more of the following criteria: ()

a. Veterans who served during any war or conflict officially engaged in by the government of the United States. ()

b. Previous residents of Homes who have been discharged for therapeutic treatment or to live in a lesser level of care or in an independent setting and whose discharge plan indicates a readmission priority. ()

c. Current Home residents who demonstrate a need for a level of care provided by a Home and who would benefit from maintaining a stable environment. ()

d. Receive special consideration as per the request of the medical director because of his desire to provide a very specific continuum of care. ()

04. Provision If Application Rejected. An applicant whose application has been rejected and who feels he meets the eligibility requirements can request a hearing in accordance with the procedures specified in Section 982, et seq., of these rules. ()

151. -- 199. (RESERVED)

200. CONDITIONS FOR ADMISSION.

01. Denial of Admission. Admission may be denied to an otherwise eligible applicant for any reason for which an admitted resident could be involuntarily discharged. ()

02. Assignment of Personal Property. Prior to admission to a Home, an eligible applicant must agree that while he is a resident of a Home he will assign the following, under the conditions specified: ()

a. Pursuant to Section 66-906, Idaho Code, all personal property owned, money held, or assets to which he is entitled at the time of his death -- unless disposed of by will or rightfully claimed within five (5) years of the death of the resident by an heir or person named in the resident's will -- must be assigned to the Division Administrator at the time of application for the sole use and benefit of a Home. ()

b. Upon discharge or voluntary departure from a Home, and after written notification is sent to the resident, all personal property owned or money deposited with the Home which is unclaimed by the former resident will be converted for the sole use and benefit of a Home as specified below: ()

i. Personal property unclaimed within thirty (30) days of departure or discharge will be made available to needy Home residents or disposed of at public auction or private sale and the proceeds deposited with the state; or ()

ii. Money deposited with the Home will be retained and deposited with the state; however, said money may be claimed by the former resident within five (5) years of departure or discharge. ()

201. WEAPONS.

Weapons including, but not limited to, firearms, ammunition, straight razors, and knives are not allowed. ()

202. ACKNOWLEDGMENT OF CONDITIONS LEADING TO DISCHARGE.

Upon admission to a Home, each resident will be advised in writing of the conditions under which immediate discharge will occur, as specified in Section 350 of these rules. Each resident must acknowledge receipt of this information by signature, and that acknowledgment will be a permanent part of each resident's file. ()

203. -- 299. (RESERVED)

300. CONDUCT OF RESIDENTS.

Each resident must comply with applicable rules in this Chapter and with any order or directive of the Home Administrator. All complaints made by the residents concerning food, quarters, ill treatment, neglect, abusive language, or other violations of any rule or standard applicable to the Home, or complaints against the operation of a Home may be made either verbally or in writing to the Home Administrator. ()

01. No Operation of Motor Vehicles by Nursing Care Residents. The operation or storage of privately owned motor vehicles by nursing care residents is prohibited on Home property. ()

02. Operation of Motor Vehicles by Domiciliary and Residential Care Residents. Each authorized domiciliary and residential care resident who drives a motor vehicle onto the grounds of a Home must adhere to the following: ()

a. Requirements: ()

i. Possess a valid driver's license; ()

ii. Have a current motor vehicle registration; ()

iii. Operator is insured against liability and property damage in accordance with Idaho law; and ()

iv. Park only in assigned spaces. ()

b. Prohibitions. Nonoperable motor vehicles and motor vehicle repairs are not permitted on the grounds of a Home. ()

03. Housekeeping. ()

a. Housekeeping services for nursing care residents shall be provided by the Home. ()

b. Each residential and domiciliary care resident must adhere to the following requirements (residential care residents may need minimal assistance): ()

i. Making his bed daily; ()

- ii. Maintaining his room in a neat and orderly manner at all times; and ()
- iii. Assuring that all clothing is appropriately marked, stored and kept clean through proper laundering. ()
- c. All residents are prohibited from: ()
 - i. Washing clothes or other articles which present a health or safety hazard in resident rooms or bathrooms; ()
 - ii. Using electrical devices, including televisions, radios, recorders, and shavers, until they have been certified by Home maintenance staff as being safe for use; ()
 - iii. Entering the kitchen, laundry, shop or mechanical spaces without permission; and ()
 - iv. Interfering or tampering with the heating, refrigeration or air conditioning systems, televisions, lighting, appliances, plumbing, or mechanical equipment at the Home without authorization. ()
- 04. Personal Conduct.** Each resident must adhere to the following: ()
 - a. Requirements: ()
 - i. Observing cleanliness in person, dress and in living habits; ()
 - ii. Bathing or showering frequently; ()
 - iii. Observing the smoking policies of a Home; and ()
 - iv. Residential and domiciliary care residents must retire to a recreation area or utilize an individual bed light if desiring to read between 10 p.m. and 6:30 a.m. during which time all room overhead lights are turned off. ()
 - b. Prohibitions: ()
 - i. Creating a disturbance or using intoxicating beverages or nonprescribed controlled substances in the buildings or on the grounds (unless prescribed by a physician); ()
 - ii. Marking or writing on the walls of a building, or damaging the grounds or any other property; ()
 - iii. Using profanity or exhibiting vulgar behavior in the Home or in any other public place; ()
 - iv. Becoming involved in quarrels, persistent dissension or criticism of others; ()
 - v. Lending money to, or borrowing money from, another resident or an employee of the Home; ()
 - vi. Smoking in an unauthorized area; ()
 - vii. Taking food (other than fresh fruit for consumption within a reasonable time period), condiments, dishes or utensils from the dining room; ()
 - viii. Cooking or using heating devices in residents' rooms or other unauthorized areas; and ()
 - ix. Storing flammable or combustible material including, but not limited to, gasoline, butane, solvents, and acetone on Home grounds. ()

301. -- 349. (RESERVED)

350. TRANSFER AND DISCHARGE OF RESIDENTS.

A resident can be transferred or discharged, for a period to be determined by the Home Administrator, for the bases set forth in Section 350 of these rules. The Home Administrator will provide notice of transfer or discharge and the opportunity to appeal a transfer or discharge in accordance with Section 980 of these rules. ()

01. Emergency Discharge or Transfer. Upon determination by the Home Administrator that an emergency exists, a resident may be immediately discharged or transferred. ()

02. General Discharge or Transfer. If the Home Administrator determines that one (1) or more of the following is present or has occurred, the resident may be discharged or transferred from the Home: ()

a. Possession of a lethal weapon of any kind by the resident on Division property; possession of wine, beer, or liquor by the resident on Division property; or possession of a controlled substance or medication by the resident, unless prescribed by the resident's physician; ()

b. Excessive or habitual intoxication; ()

c. Willfully destroys or wrongfully appropriates state or another person's property; ()

d. Failure to comply with the rules of this Chapter or a written directive of the Home Administrator or the Division Administrator; ()

e. Financial conditions set forth in Section 950 of these rules are present; ()

f. Engages in a pattern of behavior that infringes upon the rights of another person; ()

g. Unauthorized absences from the Home in excess of those permitted by Section 352 of these rules; ()

h. Endangers the safety, wellbeing, or health of the resident or other persons or disrupts the peace of the home; ()

i. The resident is required by law to register as a sex offender. Should it be determined by the Home that it must provide resources in excess of those provided to other residents to ensure the safety of the resident or other persons; ()

j. The resident does not meet the requirements and limitations set forth in Section 100 of these rules. ()

03. Discharge or Transfer During Absence. A resident who is absent from the Home may be discharged or transferred due to one (1) or more of the following: ()

a. The Home will not have the capability or services to provide an appropriate level of care to the resident upon the resident's return to the Home; ()

b. The resident has not returned to the Home from an absence prior to the expiration of the bed hold period established by a third party payer paying more than half of the resident's maintenance charges; ()

c. The resident ceases to pay the resident's maintenance charges or a bed hold charge applicable to an absence. ()

04. Voluntary Transfer or Discharge. A resident may be transferred or discharged at any time upon voluntary consent of the resident. ()

351. (RESERVED)

352. UNAUTHORIZED ABSENCES -- RESIDENTIAL AND DOMICILIARY CARE.

01. Unauthorized Absences Prohibited. For residential and domiciliary care residents, no more than three (3) unauthorized absences may be accumulated in a thirty (30) day period. If more than three (3) unauthorized absences are accumulated, the resident may be discharged for a period of thirty (30) days. ()

02. Yearly Maximum. The maximum number of unauthorized absences allowable in a one (1) year period is twelve (12). Any resident who exceeds twelve (12) unauthorized absences in one (1) year may be discharged for a period of up to one (1) year. ()

03. Readmission Requirements. Residents discharged for unauthorized absences must reapply for admission and are subject to the same restrictions and conditions as other applicants. ()

353. -- 850. (RESERVED)

851. AVAILABLE SERVICES.

The Division will make available the following services. ()

01. Residential and Domiciliary Care. The Division will make available the services listed below for residential and domiciliary care residents: ()

- a. Barber/Beauty Shop. ()
- b. Chaplain. ()
- c. Dietary. ()
- d. Laundry. ()
- e. Nursing (limited). ()
- f. Referral. ()
- g. Social Work. ()
- h. Therapeutic Recreation. ()
- i. Limited Transportation. ()

02. Nursing Care. In addition to the services listed in Subsection 851.01, the Division will make available the services listed below for nursing care residents: ()

- a. Dental Hygiene. ()
- b. Lab. ()
- c. Nursing (Skilled). ()
- d. Pharmaceutical. ()
- e. Physical Therapy. ()
- f. Physician. ()
- g. Speech Therapy. ()

h. X-Ray. ()

852. -- 879. (RESERVED)

880. FINANCIAL CONDITION OF APPLICANTS/RESIDENTS.

Each applicant/resident or his legal representative must submit a signed and dated financial statement to the Home Administrator on which his income and liquid assets from all sources are reported. The statement must also indicate whether the applicant/resident is responsible for the support of any legal dependent who should be considered in fixing the amount of monthly charges. If changes occur in the applicant's/resident's income or liquid assets, it is the applicant's/resident's responsibility to submit an accurate financial statement immediately. ()

01. Investigation of Financial Condition. The Division is authorized to investigate the financial condition of applicants/residents to determine their ability to pay maintenance charges. An applicant/resident may need to provide a power of attorney or a release of information to the Home Administrator in order to assist in investigating his financial condition and to aid in securing any benefits for which he may be eligible. ()

02. Retroactive Income. In the event an applicant/resident is awarded retroactive income from any source, he is responsible to report this award to the Home Administrator and to pay his maintenance charge retroactive to the effective date of income. ()

881. -- 914. (RESERVED)

915. MAINTENANCE CHARGES.

Upon becoming a resident of a Home, each resident is liable for the payment of a maintenance charge as well as expenses for supplies, medication, equipment, and services (other than basic services for the assigned level of care) that are not provided or paid for by VA, Medicaid, Medicare, or other insurance unless otherwise determined by the Home Administrator. Residents living in a Home for any part of a month must pay for each day, based on the actual number of days in the month, at that fraction of their total charge. Refusal or failure to pay the established maintenance charge or related expenses is cause for discharge from the Home. ()

01. Nursing Care Charges. Charges shall be computed, based on payment source to include VA, Medicaid, Medicare, or full cost of care. ()

02. Residential and Domiciliary Care Charges. Charges will be computed, based on the following factors: ()

- a. If the resident has an income, those items used to compute the charge will include: ()
 - i. Social Security benefits; ()
 - ii. Retirement benefits; ()
 - iii. Income from annuities; ()
 - iv. Insurance benefits; ()
 - v. Rental from property; ()
 - vi. Farm income; ()
 - vii. VA pensions or compensations; ()
 - viii. Tax refunds; and ()
 - ix. Income from any and all other sources. ()

b. If the resident is single, incompetent, and has liquid assets in excess of one thousand five hundred dollars (\$1,500), he will be assessed the current maximum charge until those assets are reduced to less than one thousand five hundred dollars (\$1,500). ()

c. If the resident is single, competent, and has liquid assets in excess of fifteen hundred dollars (\$1,500), he will be assessed the current maximum charge until those assets are reduced to less than fifteen hundred dollars (\$1,500). ()

d. Joint income will be used in computing charges for married persons. If the resident has dependents who rely upon him for financial support, the amount of liquid assets will not be drawn upon after they have declined to a level of five thousand dollars (\$5,000). ()

e. Residential Care. After allowable deductions, a resident will be assessed a fee of seventy-five percent (75%) of the remaining portion of his net monthly income up to the maximum charge. The maximum monthly maintenance charge shall be seventy-five percent (75%) of the current maximum annual rate of VA pension for a single veteran pursuant to Public Law 95 588 divided by twelve (12). ()

f. Domiciliary Care. After allowable deductions, a resident will be assessed a fee of sixty percent (60%) of the remaining portion of his net monthly income up to the maximum charge. The maximum monthly maintenance charge shall be sixty percent (60%) of the current maximum annual rate of VA pension for a single veteran pursuant to Public Law 95 588 divided by twelve (12). ()

03. Exclusions from Income or Payment for Residential and Domiciliary Care. The only exclusions in computing monthly charges will be: ()

a. Those funds which a resident receives from the sale of hobby/craft items constructed and sold as part of a Home occupational therapy program; or ()

b. Those unusual expenses specified below, which are incurred after the resident's admission to a Home and are approved by the Home Administrator, up to a maximum monthly allowance which is established pursuant to Section 916 of these rules: ()

i. Prosthetic, orthopedic, and paraplegic appliances; ()

ii. Sensory aids; ()

iii. Wheelchairs; ()

iv. Therapy services; ()

v. Hospital, medical, surgical expenses and bills for prescription drugs incurred and paid by the individual in the current month and documented by a paid receipt. ()

c. Reasonable medical insurance premiums, as paid, with documentation of payment. Other insurance premiums are excluded from consideration; or ()

d. An allowance established pursuant to Section 916 of these rules for retention by a resident for personal needs; ()

e. That amount necessary for a resident of a Home to contribute to the support of a legal dependent where proof of actual payment is documented. A monthly allowance will be established for a spouse or additional dependents pursuant to Section 916 of these rules. (These allowances take into consideration housing and utility costs.) ()

04. Income Eligibility Limits. ()

a. Nursing Care. None. ()

b. Residential and Domiciliary Care. A resident's total monthly net income, from all sources, may not exceed the current maximum annual rate of VA pension for a single veteran pursuant to Public Law 95-588 divided by twelve (12) unless waived by the Home Administrator in accordance with Subsection 100.08 of these rules. ()

c. While in residence at a Home, a domiciliary resident may seek outside employment and receive income so that his total monthly net income from all sources will exceed the current maximum annual rate of VA pension for a single veteran pursuant to Public Law 95-588 divided by twelve (12) for a one-month transitional period. At the end of this one-month transitional period, the resident will be discharged. ()

05. Continued Eligibility. ()

a. Nursing Care. A resident may continue to be eligible for residency in a Home, regardless of income changes, if the conditions defined in Subsection 100.09 of these rules continue to be met. ()

b. Residential and Domiciliary Care. If a resident's net monthly income exceeds the income eligibility limit after admission to the Home, the resident may appeal to the Home Administrator for a waiver of the income eligibility limit which may be granted for good cause. Consideration for good cause must include "need for continuing medical care" as documented by a VA Medical Center physician. ()

06. Payment Schedule. Maintenance charges are due the first of each month and must be paid in full by the resident or guardian on or before the tenth day of the month. Payments may be made either by cash or by check, and a receipt will be issued. ()

07. Security Deposit. A deposit of one hundred dollars (\$100) will be required by domiciliary and residential care residents upon admission to a Home, unless waived by the Home Administrator. This deposit will be held until the resident leaves. Any debts or liabilities on behalf of the resident will be offset against this deposit at that time. After payment of any debts or liabilities, the remaining balance of the deposit will be returned to the outgoing resident. ()

08. Leave of Absence or Hospitalization. Residents receiving Medicaid, Medicare, or VA per diem will be charged for leave of absence or hospitalization in accordance with Medicaid, Medicare, and VA requirements. The Home will not reduce charges for leave of absence or hospitalization of residents not qualifying for Medicaid, Medicare, or VA payment for such absence and each day will count as if the resident were present at a Home. Unless waived by the Home Administrator or prohibited by law, the Home will charge residents receiving Medicaid, Medicare, or VA per diem the current VA per diem rate for each absent day of a leave of absence or hospitalization in excess of the period eligible for payment by Medicaid, Medicare, or the VA. ()

09. Medicaid Eligibility. All nursing care residents, including re-admitted residents must either apply for or become eligible for Medicaid benefits, or must pay the maximum monthly charge as it may be established from time to time. Eligibility for Medicaid benefits is determined entirely by the Idaho Department of Health and Welfare and its agents. Residents who cannot, or choose not to, qualify for Medicaid are required to pay for services in full from other than Medicaid funds. Care and services for those residents who are Medicaid eligible will be billed to and paid by Medicaid. Residents eligible for Medicaid will be assessed a fee equal to the resident's liability as determined by Medicaid. ()

916. MONTHLY CHARGES AND ALLOWANCES.

01. Nursing Care. Pursuant to Section 66-907, Idaho Code, maximum monthly charges are established by the Division Administrator with the advice of the Commission. A schedule of charges will be available in the business office of each Home. Charges will be reviewed from time to time by the Division Administrator and the Commission. ()

a. Changes to Charges. Members of the public may comment on proposed changes at meetings of the Commission when changes are considered. ()

b. Notification and Posting. When changes are made to charges, residents or their families or sponsors will receive written notification and changes will be posted in the business office of each Home a minimum of thirty (30) days prior to the effective date of the change. ()

02. Residential and Domiciliary Care. Pursuant to Section 66-907, Idaho Code, maximum monthly charges and allowances are established by the Division Administrator with the advice of the Commission. A schedule of charges and allowances will be available in the business office of the Homes. Allowances will be reviewed from time to time by the Division Administrator and the Commission. ()

a. Changes to Charges and Allowances. Pursuant to Paragraphs 915.02.e. and 915.02.f. of these rules, monthly charges for residential and domiciliary care will be adjusted automatically when a change is made to the current maximum annual rate of VA pension for a single veteran pursuant to Public Law 95588 divided by twelve (12). Relative to monthly allowances, members of the public may comment on proposed changes at meetings of the Commission when changes are considered. ()

b. Notification and Posting of Changes to Allowances. When changes are made to allowances, residents or their families or sponsors will receive written notification, and changes will be posted in the business office of the Veterans Homes directly following notification pursuant to Public Law 95-588. ()

917. -- 949. (RESERVED)

950. FINANCIAL GROUNDS FOR REJECTION OR DISCHARGE.

The following circumstances may be considered as grounds for rejection of an application for residency or for revocation of residency and subsequent discharge. (When an application is rejected or a resident discharged, the applicant/resident will be given notification of intended application rejection or discharge, in accordance with the provisions in Section 982 of these rules.) ()

01. Disposal of Assets. If the Home Administrator determines that an applicant/resident has disposed of assets following or within sixty (60) months preceding initial application for residency, which would have the effect of reducing his maintenance charge, such action can lead to rejection of the application or discharge from a Home. ()

02. Failure to Pay Maintenance Charge. Refusal or failure to pay the established maintenance charge can be cause for discharge from a Home. If the resident is so discharged, or leaves a Home voluntarily, the resident will not be eligible for readmission to a Home until all indebtedness to the Home is paid in full, or acceptable arrangements have been made with the Home Administrator for repayment. ()

03. Failure to Pay for Services. ()

a. Residents who are excluded from receiving free services from a VA Medical Center may elect to purchase such services through a sharing agreement or contract between a Home and a VA Medical Center or an outside provider when such sharing agreement or contract exists. In those cases where sharing agreement or contract costs are borne by a Home, the resident must reimburse the Home for the costs of services provided. ()

b. Failure to reimburse a Home or a service provider within ten (10) days after receipt of a bill for services provided under a sharing agreement or contract may result in a resident's discharge from the Home. ()

951. -- 979. (RESERVED)

980. NOTICE OF RESIDENT TRANSFER OR DISCHARGE AND NOTICE OF DENIAL OF AN APPLICATION FOR RESIDENCY.

The Home Administrator or his designee must notify the applicant or resident of any action to be taken regarding rejection of an application or involuntary transfer or discharge from a Home. ()

01. Form of Notice. ()

- a.** The notice of denial of application may be made orally. ()
- b.** The notice of transfer or discharge must be in writing. ()
- 02. Content of Notice of Transfer or Discharge.** The notice must state the following: ()
- a.** The reason for the impending action and a reference to the pertinent rules under which the action is being brought or decision has been made; ()
- b.** The effective date of the action; ()
- c.** The location to which the resident is transferred or discharge, which is established for Nursing Care transfers and discharges only; ()
- d.** The applicant's or resident's right to request a hearing according to the provisions in Section 982 of these rules; and ()
- e.** The procedure for requesting a hearing, as provided in Subsection 982.03 of these rules. ()
- f.** The name, address, and telephone number of the State long term care ombudsman; ()
- g.** The name, address, and telephone number of the State Disability Rights agency responsible for the protection and advocacy for those residents with developmental disabilities or mental illness. ()
- 03. Notification Deadlines for Domiciliary Care.** The following notification deadlines are established for Domiciliary Care only: ()
- a.** Discharge notices must be sent to the resident three (3) days prior to the intended effective date of the action, except under the conditions noted in Subsections 350.01, 350.03 and 350.04 of these rules. ()
- b.** Notification of findings of ineligibility for residency will be mailed to the applicant within three (3) working days after receipt of the completed application citing the reasons for rejection. ()
- 04. Notification Deadlines for Residential Care.** The following notification deadlines are established for Residential Care only: ()
- a.** Discharge notices must be sent to the resident fifteen (15) days prior to the intended effective date of the action, except under the conditions noted in Subsections 350.01, 350.03 and 350.04 of these rules. ()
- b.** Notification of findings of ineligibility for residency will be mailed to the applicant within three (3) working days after receipt of the completed application citing the reasons for rejection. ()
- 05. Notification Deadlines for Nursing Care.** The following notification deadlines are established for Nursing Care only: ()
- a.** Notices of general discharge or transfer pursuant to Subsection 350.02 of these rules must be sent to the resident thirty (30) days prior to the intended effective date of the action. ()
- b.** Notices of emergency discharge or transfer pursuant to Subsection 350.01 of these rules must be sent to the resident as soon as practical. ()
- c.** Notices of discharge or transfer during absence pursuant to Subsection 350.03 of these rules must be sent to the resident within three (3) working days of the Home's determination to transfer. ()
- d.** Notice of discharge for unauthorized absences pursuant to Paragraph 350.02.g. of these rules must be sent to the resident within three (3) days of the last unauthorized absence establishing a basis for discharge. ()

e. The Home does not need to provide notice of voluntary transfer or discharge pursuant to Subsection 350.04 of these rules. ()

f. Notification of the denial of an application for residency will be mailed to the applicant within three (3) working days after receipt of the completed application citing the reasons for rejection. ()

981. APPEAL PROCEDURE.

Upon notification to a resident of transfer or discharge from a Home by the Home Administrator, the resident may request a hearing in accordance with the provisions in Section 982, "Provisions for Contested Cases," of these rules. Any additional violation of Home rules by a resident while on notice of transfer or discharge will be treated independent of any pending appeal. ()

982. PROVISIONS FOR CONTESTED CASES.

01. Inapplicability of Idaho Rules of Administrative Procedure of the Attorney General. All contested cases shall be governed by the provisions of these rules. The Commission and Division Administrator find that the provisions of IDAPA 04.11.01, et seq., "Idaho Rules of Administrative Procedure of the Attorney General," are inapplicable and inappropriate for contested cases before the Commission, because of the specific and unique requirements of federal and state law regarding notices, hearing processes, procedural requirements, time lines, and other provisions requiring the Division to adopt its own procedures pursuant to Section 67-5206(5)(b), Idaho Code, and hereby affirmatively promulgate and adopt alternative procedures and elect not to be governed by any of the provisions of IDAPA 04.11.01, et seq., "Idaho Rules of Administrative Procedure of the Attorney General." ()

02. Hearing Rights. Residents and applicants have the following rights to a hearing: ()

a. If a resident of a Home is notified of transfer or discharge, the resident will be afforded an opportunity for a hearing. A resident of a Home must attempt to resolve the bases stated on the notice of action through verbal discussions with the Home Administrator or his designee prior to submission of a written request for a hearing. A resident will not be afforded an opportunity for a hearing based upon a voluntary transfer or discharge under Subsection 350.04 of these rules. ()

b. If an application for residency in a Home is rejected, the applicant may request a hearing. ()

03. Requesting a Hearing for Nursing Care. A request for a hearing from a nursing care resident for residency in a Home must be submitted to the Idaho Department of Health and Welfare, Fair Hearing Office, P.O. Box 83720, Boise, Idaho 83720. Requests for appeal should be received by the Idaho Department of Health and Welfare before thirty (30) days have passed in order to stop the discharge before it occurs. ()

04. Requesting a Hearing for Residential and Domiciliary Care. ()

a. A request for a hearing from a resident for residential and domiciliary care residency in a Home must be submitted through the Home Administrator to the Division Administrator for possible resolution or the scheduling of a hearing. A resident's request must contain a description of what effort he has taken to satisfy the requirements of Paragraph 982.02.a. of these rules. ()

b. A request for a hearing must be in writing and signed by the applicant/resident. ()

c. A request for a hearing must be submitted within three (3) days of receipt of the written notice of action or denial. ()

d. Pending a hearing, benefits will be continued or held in abeyance as follows: ()

i. Benefits for domiciliary care, residential care, and nursing care residents will not be continued when the transfer or discharge is an emergency discharge under Subsection 350.01 of these rules or a discharge for unauthorized absences under Paragraph 350.02.g. of these rules. If the hearing request is made before the effective

date of action and within three (3) days of receipt of the notice, no action will be taken by the Home Administrator on a general discharge under Subsection 350.02 of these rules, except Paragraph 350.02.g., or a transfer under Subsection 350.03 of these rules pending receipt of the final order. ()

e. The Division Administrator will not accept a request for a hearing from a voluntary transfer or discharge pursuant to Subsection 350.04 of these rules. ()

983. PREHEARING PROVISIONS FOR RESIDENTIAL AND DOMICILIARY CARE.

The following general provisions are applicable to those phases of all appeals which occur before the hearing is conducted unless precluded by statute or rule. ()

01. Notice of Hearing. Upon the receipt of a timely request for a hearing, the hearing shall be arranged by the Division Administrator and a notice sent to all parties that includes: ()

a. A statement of the time, place and nature of the hearing; ()

b. A statement of the legal authority under which the hearing is to be held; ()

c. A reference to the particular sections of any statutes and rules involved; ()

d. A statement of the issues involved; ()

e. A statement that all documents to be relied upon by the hearing officer to make its order or notice of decision, or otherwise related to the issues involved in the hearing and relied upon by any party, are to be filed with the Division Administrator and that each party must serve its own documents unless otherwise stated by law; ()

f. A statement that all parties may be represented by counsel; and ()

g. A statement concerning advance requests for hearing transcripts pursuant to Subsection 983.08 of these rules. ()

h. The assignment of a hearing officer for the hearing. The Division Administrator may designate the Commission as a hearing officer. ()

02. Prehearing Conference. The Division Administrator or hearing officer may, upon written or other sufficient notice to all interested parties, hold a prehearing conference for the following purposes: ()

a. To formulate or simplify the issues; ()

b. To obtain admissions or stipulations of fact and of documents; ()

c. To arrange for exchange of proposed exhibits or prepared expert testimony; ()

d. To limit the number of witnesses; ()

e. To determine the procedure at the hearing; and ()

f. To determine any other matters which may expedite the orderly conduct and disposition of the proceeding. ()

03. Disposition of Case Without a Hearing. Unless precluded by law, disposition without a hearing may be made of any contested case by stipulation, agreed settlement, consent order, motions to dismiss, summary judgment, or default. ()

04. Withdrawal of Appeal. The initiating party at any time may withdraw from any contested case proceeding upon serving written notice of withdrawal to the Division Administrator. ()

05. Withdrawal of Attorney or Representative. Any attorney or other person representing a party in a contested case proceeding who wants to withdraw from such proceeding must immediately notify, in writing, the Division Administrator, and all involved parties. ()

06. Intervention. Persons, other than the original parties to the proceeding, who are directly and substantially affected by the proceeding, may intervene if they first secure an order from the Division Administrator granting leave to intervene. ()

a. Granting of Leave to Intervene. The granting of leave to intervene or to otherwise appear in any matter or proceeding shall not be construed to be a finding or determination that such party will or may be a party aggrieved by any ruling, order or decision of the agency for purposes of judicial review or appeal. ()

b. Form and Content of Petitions. Petitions for leave to intervene must be in writing and must clearly: ()

i. Identify the proceeding in which it is sought to intervene, setting forth the name and address of the intervenor; ()

ii. Make a clear and concise statement of the direct and substantial interest of the intervenor in such proceeding and the relationship of the intervenor to the other parties; ()

iii. State the manner in which such intervenor will be affected by such proceeding, outlining the matters and things relied upon by such intervenor as a basis for his request to intervene in such cause; ()

iv. If affirmative relief is sought, the petition must contain a clear and concise statement of relief sought and the basis thereof; and ()

v. A statement as to the nature and quantity of evidence the intervenor will present if such petition is granted. ()

c. Filing of Petitions. All petitions must be filed with the Division Administrator. Petitions to intervene and proof of service thereof on all other parties of record must be filed within seven (7) days after receiving notice of the proceeding, or if no notice is received, not less than fourteen (14) days prior to the date set for hearing and, if filed thereafter, must state a substantial reason for such delay; otherwise the petition will not be considered. ()

07. Hearing Record. The hearing officer or the Division Administrator will arrange for a record to be made of the hearing. The record must be a verbatim record and it will be recorded by a recording device, unless a party requests a stenographic recording by a certified court reporter, in writing, at least seven (7) days prior to the date of hearing. The record will be transcribed at the expense of the party requesting a transcription, and prepayment or guarantee of payment may be required. Once a transcription is requested, any party may obtain a copy at the party's own expense. The recorded proceedings will be provided to the Division Administrator for inclusion into the record. The Division will maintain an official record of each contested case for a period of not less than six (6) months after the expiration of the last date for judicial review, unless otherwise provided by law. The record will include all notices of proceedings, pleadings, motions, briefs, petitions and intermediate rulings, evidence received or considered, any oral or written statements allowed by the hearing officer or the Division Administrator, statement of matters officially noticed, offers of proof and objections and rulings thereon, the recording of the proceedings or any transcript of all or part of the proceedings, staff memoranda or data submitted to the hearing officer or the Division Administrator in connection with the proceeding, and any recommended order, preliminary order, final order or order on reconsideration. ()

08. Subpoenas. Where authorized by law, the hearing officer may compel the attendance of specific persons and the production of specific documents, materials, or objects at any hearing by subpoena issued by the Division Administrator. ()

09. Stipulations. The parties to a contested case proceeding may stipulate as to any fact at issue, either

by written stipulation or by oral statement shown upon the record. Any such stipulation is binding upon all parties so stipulating and may be considered by the hearing officer and the Division Administrator. The hearing officer and the Division Administrator may require proof by evidence of any facts stipulated to, notwithstanding the stipulation of the parties. ()

10. Rules of Civil Procedure. As contested case proceedings and hearings are informal, the Idaho Rules of Civil Procedure do not apply. The hearing officer shall provide the procedure at the hearing, as required by the provisions of Section 67-5242(3), Idaho Code. ()

11. Discovery. Prehearing discovery shall be strictly limited to obtaining the names of witnesses and copies of documents the opposing party intends to offer or present at the hearing. The hearing officer may order disclosure of this information if a party refuses to comply after receiving a written request. ()

12. Briefing Schedule. The hearing officer may require briefs and written memoranda to be filed by the parties, and may establish a reasonable briefing schedule. ()

13. Informal Disposition. Unless otherwise prohibited by statute or rule, the hearing officer may decline to initiate a contested case. Informal disposition may be made of any contested case by negotiation, stipulation, agreed settlement or consent order, which informal settlement is encouraged. The parties may stipulate as to the facts, reserving their right to appeal to a court of competent jurisdiction on issues of law. The hearing officer may request such additional information as may be necessary to decide whether to initiate or to decide a contested case. If the hearing officer declines to initiate or decide a contested case, a brief statement of the reasons for that decision will be furnished to all persons or parties involved. This disposition of a contested case by informal disposition is a final agency action pursuant to Section 67-5241, Idaho Code. ()

984. HEARING PROVISIONS FOR RESIDENTIAL AND DOMICILIARY CARE.

The following general provisions are applicable to those phases of all hearings, unless precluded by statute or rule. ()

01. Computation of Time. In computing any period of time relating to a hearing, the first day of the period is not to be included. The last day of the period is to be included unless it is a Saturday, Sunday or legal holiday, in which case the period runs until 5 p.m. of the next working day, unless otherwise provided by law. ()

02. Service of Documents. Documents concerning hearings must be served as follows: ()

a. All pleadings, briefs and subsequent papers must be served upon every party of record concurrently with the filing with the Division Administrator. ()

b. All notices and orders required to be served, other than the initial complaint or petition, must be served in person or by first-class mail. ()

c. The initial complaint or petition must be served in person or by certified mail. ()

c. The initial hearing request must be served in person or by certified mail. ()

d. Service by first-class or certified mail will be deemed complete when the document, properly addressed and stamped, is deposited in the United States mail. The postmark will be the determinant date for all time lines. ()

e. Proof of service must accompany all documents when they are filed with the Division Administrator. ()

03. Hearing Officer Authority. In the context of each proceeding and unless precluded by law, the hearing officer has the discretion, power and authority to: ()

a. Determine the order of presentation; ()

- b. Grant or deny petitions for reconsideration; ()
 - c. Determine the need, if any, for consolidation; ()
 - d. Rule on all evidentiary questions; ()
 - e. Rule on motions and objections and dispose of procedural requests; ()
 - f. Determine the need for prehearing conferences, recesses, adjournments, hearings on motions and postponements; ()
 - g. Administer oaths and affirmations; ()
 - h. Examine witnesses; ()
 - i. Issue subpoenas or request orders in the form of subpoenas as provided by law; ()
 - j. Prescribe general rules of hearing decorum and conduct; ()
 - k. Regulate the course of the proceeding; ()
 - l. Formulate a reasoned statement in support of the decision. Findings of fact should be set forth in statutory language and be accompanied by a concise and explicit statement of the underlying facts of record supporting the findings. ()
 - m. Perform any functions including those set forth in Sections 67-5241 through 67-5251, Idaho Code; and ()
 - n. All other functions specifically authorized by statute or rule. ()
 - o. The hearing officer shall not have the jurisdiction or authority to invalidate any federal or state statute, rule, or regulation. ()
- 04. Ex Parte Consultations.** Ex parte communications between the hearing officer and any party to a contested case proceeding are precluded pursuant to Section 67-5253, Idaho Code. ()
- 05. Representation by Counsel.** Any party in a contested case proceeding may be represented by counsel, at the party's own expense. ()
- 06. Open Hearings.** All hearings may be open to the public, unless precluded by law. When the Commission is acting as a hearing officer, hearings will be held during regular meetings of the Commission unless otherwise scheduled by the Commission and will be arranged by the Division Administrator. ()
- 07. Testimony Under Oath.** All testimony to be considered, with the exception of matters officially noticed or entered by stipulation, must be given under oath, as administered by the hearing officer or other authority authorized to administer oaths. ()
- 08. Appearance and Representation.** Any party to a proceeding may appear and be heard in person or may authorize an attorney to represent the party at the party's own expense. Unless otherwise prohibited by law and with the prior approval of the hearing officer, a party may be assisted, but not represented, by a friend or relative. When a party chooses to appear in person and does not speak or understand the English language, an interpreter shall be allowed to interpret under oath. The interpreter is not allowed to act as a representative of the party and shall act at the party's own expense. ()
- 09. Default.** If a party fails to appear at a scheduled hearing or at any stage of a contested case without good cause and reasonable notice to the hearing officer and to all other parties, the hearing officer may enter a notice

of proposed default order against the nonappearing party. A default order may be altered or set aside upon petition filed within seven (7) days of service of the order showing sufficient good cause stating the grounds relied on, and providing reasonable notice to all parties. ()

10. Order of Presentation and Burden of Proof. At any contested case hearing, the party having the burden of proof shall be the first to present testimony unless the hearing officer determines otherwise. Unless otherwise determined, in advance, by the hearing officer, the burden of proof shall be preponderance of the evidence. ()

11. Evidence. Pursuant to Section 67-5251, Idaho Code, the hearing shall be informal and technical rules of evidence do not apply, except that irrelevant, immaterial, incompetent, duly repetitious evidence, or evidence excludable on constitutional or statutory grounds protected by the rules of privilege recognized by law may be excluded. Hearsay evidence may be received if it is relevant to or corroborates competent evidence, but shall not be the sole basis for any finding of fact. Any part of the evidence may be received in written form if doing so will expedite the hearing without substantially prejudicing the interest of any party. Documentary evidence may be received in the form of copies or excerpts if the original is not readily available. ()

12. Testimony by Telephone or Other Electronic Means. With the prior approval of the hearing officer, witnesses may testify by telephone or other electronic means, provided the examination and responses are audible to all parties. ()

13. Official Notice. ()

a. Discretionary Notice. Notice may be taken of judicially cognizable facts by the hearing officer on its own motion or on motion of a party. In addition, notice may be taken of generally recognized technical or scientific facts within the hearing officer's specialized knowledge. Parties shall be notified either before or during the hearing, or by reference in preliminary reports or otherwise, of the material noticed including any staff memoranda or data, and the parties shall be afforded an opportunity to contest the material so noticed. The hearing officer's experience, technical competence, and specialized knowledge may be utilized in the evaluation of the evidence. ()

b. Mandatory Notice. For all hearings, the hearing officer must take official notice of the following materials on its own motion or on the motion of any party. Objections going to such notice must become a part of the record. For the purposes of the hearing, it is established as true without proof that the following are admissible, valid and enforceable: ()

- i. Rules of the Division and other state agencies; ()
- ii. Federal regulations; ()
- iii. The constitution and statutes of the United States and Idaho; ()
- iv. Public records; and ()
- v. Such other materials that a court of law must judicially notice. ()

14. Hearing Officer Decision. The hearing officer will issue a written order as provided in Section 67-5243, Idaho Code. ()

a. Recommended orders will contain a statement of the schedule for review of that order by the Division Administrator. ()

b. Preliminary orders will include notice of the right to seek a review of the order by the Division Administrator and a statement that the order will become final without a request for such review. A request for review shall be filed no later than fourteen (14) days following the issuance of the preliminary order, unless a request for reconsideration by the hearing officer is filed prior to the expiration of such fourteen (14) day period. If a petition for reconsideration is made, a request shall be filed within fourteen (14) days of the hearing officer's order disposing of the petition or the deemed denial of the petition pursuant to Section 67-5243, Idaho Code. ()

c. A party may file a motion for reconsideration with the hearing officer no later than fourteen (14) days following the issuance of the preliminary order or the recommended order. ()

15. Contents of the Record. Pursuant to Section 67-5249(2), Idaho Code, the record in a contested case proceeding will be kept by the Division Administrator, on behalf of the hearing officer, and must include the following: ()

- a. All notices, pleadings, motions and rulings; ()
- b. All evidence received or considered; ()
- c. A statement of all matters officially noticed; ()
- d. A record of testimony and offers of proof, objections and rulings thereon; ()
- e. A record of proposed findings and exceptions; ()
- f. Any decision, opinion, or report by the Commission; ()
- g. All staff memoranda or data submitted to the Commission in connection with consideration of the case; ()
- h. All briefs or memoranda submitted by any party; and ()
- i. Any recommended order, preliminary order, final order, or order on reconsideration. ()

16. Review by the Division Administrator and Issuance of the Final Order. Following the issuance of an order by the hearing officer, the Division Administrator will: ()

- a. Review recommended orders as provided in Section 67-5244, Idaho Code; ()
- b. Review preliminary orders upon the appeal of a party or upon the Division Administrator's own motion as provided in Section 67-5245, Idaho Code; and ()
- c. Issue a final order as provided in Section 67-5246, Idaho Code. ()

17. Judicial Review. In accordance with Section 67-5271, Idaho Code, a party which has exhausted all administrative remedies available within the Division may seek judicial review. Proceedings for judicial review shall be instituted in accordance with Sections 67-5270 and 67-5273, Idaho Code. ()

985. POST HEARING PROVISIONS FOR RESIDENTIAL AND DOMICILIARY CARE.

The following provisions are applicable to those phases of all contested case proceedings which occur after the hearing has been conducted: ()

01. Service of Decisions and Orders. Decisions and orders are deemed to have been served when copies thereof are mailed to all parties of record or their attorneys by the Division Administrator. ()

02. No Motions for Reconsideration. Unless otherwise provided by law or these rules, motions for reconsideration shall not be permitted. ()

03. Public Inspection. All final decisions and orders of the Commission must be maintained by the Division Administrator and made available for public inspection after service on the parties. ()

04. Effect of Petition for Judicial Review. The filing of a petition for judicial review shall not stay compliance with the decision and order or suspend the effectiveness of the decision and order, unless otherwise ordered or mandated by law. ()

986. -- 999. (RESERVED)

21.01.04 – RULES GOVERNING IDAHO STATE VETERANS CEMETERIES

000. LEGAL AUTHORITY.

The Idaho Legislature has given the Administrator of the Division of Veterans Services the authority to promulgate rules governing the Idaho State Veterans Cemetery pursuant to Section 65-202, Idaho Code. ()

001. SCOPE.

These rules contain provisions for eligibility for interment at Idaho State Veterans Cemeteries and the provisions for operation and maintenance of Idaho State Veterans Cemeteries. ()

002. INCORPORATION BY REFERENCE.

01. Incorporated Documents. These rules incorporate by reference the following: ()

a. The full text of 38 CFR 38.620, dated July 1, 2001. ()

b. 38 U.S.C.A. Section 2402, (2004 and Supp. 2004). ()

c. 38 CFR 39.5(d), dated July 1, 2008. ()

02. Document Availability. Copies are available from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402-0001. ()

003. -- 009. (RESERVED)

010. DEFINITIONS.

01. Administrator. The Administrator of the Idaho Division of Veterans Services or his designee. ()

02. Applicant. The individual requesting interment, disinterment or reinterment of a qualified person. ()

03. Armed Forces Member. A member or former member of the armed forces of the United States, the reserve component of the armed forces of the United States, the reserve officers training corps of the United States, or the armed forces of an ally of the United States who is eligible for burial in national cemeteries pursuant to 38 CFR 38.620 and 38 U.S.C. Section 2402. ()

04. Cemetery. Idaho State Veterans Cemeteries authorized pursuant to Section 65-108, Idaho Code. ()

05. Committal Service. A gathering of one (1) or more individuals prior to interment or reinterment. ()

06. Cremains. Cremated human remains. ()

07. Designated Interpretive Trail. A public recreational trail designated by a sign or marker. ()

08. Disinterment. The removal of human remains from their place of interment. ()

09. Division. The Idaho Division of Veterans Services. ()

10. Interment. The disposition of human remains by burial or the placement of cremains in a grave plot or in any location designated by the Administrator for use as a permanent location of cremains. ()

11. Qualified Person. A person who satisfies the requirements for eligibility for interment in national cemeteries found at 38 CFR 38.620 and 38 U.S.C. Section 2402 and is not prohibited from being interred by 38 CFR 39.10(b). ()

12. Reinterment. The interment of previously interred human remains. ()

13. Unremarried Spouse. An individual who is the surviving spouse of a deceased armed forces

member and who has not remarried. ()

14. USDVA. The United States Department of Veterans Affairs. ()

011. -- 019. (RESERVED)

020. ELIGIBILITY FOR INTERMENT.

01. Eligibility. A qualified person is eligible for interment at the cemetery. An individual who is a qualified person based upon a relationship to an armed forces member is eligible for interment at the cemetery if the armed forces member is pre-registered for interment at the cemetery or is interred at the cemetery. ()

02. Requirements. ()

a. Proof of qualification as an Armed Forces Member as evidenced by: ()

i. A valid discharge from the armed forces of the United States in the name of the individual indicating that the character of discharge was other than dishonorable; ()

ii. A copy of a Reserve Retirement Eligibility Benefits Letter in the name of the individual; ()

iii. A valid certificate of naturalization or a valid United States passport in the name of the individual and a valid discharge in the name of the individual from the armed forces of an ally of the United States in a war during which the individual served indicating that the character of discharge was other than dishonorable; ()

iv. Any other evidence satisfactory to the Administrator. ()

b. Proof of qualification for relatives of an Armed Forces Member as evidenced by the documentation necessary for an Armed Forces Member and the following: ()

i. For a parent of the individual, a valid birth or adoption record identifying such parent, and proof of the individual's birth date; or ()

ii. For the spouse of the individual, a valid record of marriage between the individual and the armed forces member, and a certification that the individual was an unremarried spouse at the time of death, if the armed forces member predeceased the individual; or ()

iii. Any other evidence satisfactory to the Administrator. ()

03. Burden of Proof. The burden of proof in establishing eligibility for interment or reinterment in the cemetery is on the applicant. ()

04. Application. Applications must be submitted on a form prescribed by the Administrator by a qualified person or their legal representative, the Administrator of their estate, or the personal representative or a relative of a deceased person. ()

021. (RESERVED)

022. INTERMENT AND REINTERMENT.

01. Remains. Remains shall be delivered to the cemetery in a casket or, if cremated, in a recoverable container. The container for cremains designated by the applicant for interment in a location other than a grave plot shall not exceed nine (9) inches in width, thirteen (13) inches in height, and nine (9) inches in depth. ()

02. Committal Services. The cemetery will provide a designated non-gravesite location for committal services. The cemetery will not provide facilities for viewing of remains. The arrangements for and any expenses associated with committal services are the responsibility of the applicant. ()

023. DISINTERMENT AND REINTERMENT.

01. Disinterment. The Administrator may approve an application for disinterment where the applicant for interment, the surviving unremarried spouse, if any, and the children of the interred person, or the legal representatives of any of the foregoing persons, complete and sign an application form prescribed by the Administrator and submit proof of applicable governmental approval of the disinterment, transporting, and reinterment of the remains. The Administrator shall approve an application for disinterment accompanied by the order of a court of competent jurisdiction. ()

02. Reinterment. ()

a. Who May Be Reinterred. The Administrator may approve an application for reinterment of remains in the cemetery where the remains are of a qualified person and the applicant for interment desires that the remains be interred with remains interred in the cemetery or with the remains of a qualified person pre-registered for interment in the cemetery. ()

b. Application and Proof of Eligibility. The applicant for reinterment shall complete an application form prescribed by the Administrator and submit proof of the eligibility of the qualified person and proof of applicable governmental approval of the disinterment, transporting, and reinterment of the remains. If the application seeks reinterment of the remains of a qualified person, the applicant shall identify the qualified person with whom the reinterred remains will be interred. ()

024. FEES FOR INTERMENT, DISINTERMENT, REINTERMENT, AND MEMORIAL.

The Administrator shall charge the following fees: ()

01. Interment. ()

a. A fee equal to the then current USDVA reimbursement for opening and closing an interment site containing a pre-placed crypt. The Administrator will accept, as full payment the amount of reimbursement by the USDVA to the Division for opening and closing an interment site containing a pre-placed crypt for a qualified veteran. ()

b. In addition to the fee charged under Paragraph 024.01.a. of this rule, the Administrator shall charge a fee of seven hundred dollars (\$700) for preparation of an interment site not containing a pre-placed crypt. ()

02. Disinterment. A fee equal to the then current USDVA reimbursement for opening and closing an interment site. The expenses of removal, transportation and reinterment of remains, and the expenses of removal, transportation and reinstallation of the grave marker, if any, shall be paid by the applicant for disinterment. ()

03. Reinterment. A fee equal to the then current USDVA reimbursement for opening and closing an interment site for reinterment. The expenses of reinterment of remains and reinstallation of the grave marker, if any, shall be paid by the applicant for reinterment. ()

04. Memorial Marker. A fee of two hundred dollars (\$200) to order, install, and provide perpetual care of a furnished flush granite marker to commemorate an eligible deceased Veteran whose remains have not been recovered or identified, were buried at sea, donated to science, or cremated and the remains scattered. ()

025. -- 029. (RESERVED)

030. CEMETERY USE.

01. Public Use. The cemetery will be open to public access from 8 a.m. to sunset daily. The Administrator may close the cemetery at 6 p.m. when a public fireworks display is planned. ()

02. Interment Schedule. Cemetery staff will schedule interments to ensure that cemetery staff complete their duties between the hours of 8 a.m. and 5 p.m. Cemetery staff will not schedule interments on

Saturdays, Sundays and legal holidays without the prior approval of the Administrator. ()

03. Public Behavior. The Administrator may adopt and enforce policies regarding public behavior in the cemetery, including but not limited to preservation of property, recreation, ceremonies and gatherings, animals, motor vehicles, alcohol, and photography. ()

031. -- 039. (RESERVED)

040. MEMORIALS AND DONATIONS.

01. Flowers and Grave Decorations. The Administrator will post the requirements for natural and artificial flowers and other grave decorations in the cemetery. Cemetery personnel may remove and discard grave decorations that fail to comply with the posted requirements or that are faded, wilted, tattered or worn. ()

02. Plaques, Statues, and Other Memorials. The Administrator may approve plaques, statues, and other memorials to commemorate events, units, individuals, groups, and organizations. Persons wishing to install such memorials at their own cost may submit an application on a form prescribed by the Administrator. Memorials approved by the Administrator are considered donations to the cemetery. ()

03. Grave Markers. Grave markers issued by the USDVA are approved as follows: ()

a. Graves – Upright granite markers. ()

b. Interments in an area reserved for the interment of cremains in the soil – Flush granite markers. ()

c. Interment of cremains in a structure reserved for the interment of cremains – Granite niche markers. ()

04. Donations and Gifts. The Administrator may accept gifts and donations to the Veterans Cemetery Maintenance Fund established pursuant to Section 65-107, Idaho Code. ()

041. – 999. (RESERVED)