

Arizona Administrative REGISTER

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From the Publisher

ABOUT THIS PUBLICATION

The paper copy of the *Administrative Register* (A.A.R.) is the official publication for rules and rulemaking activity in the state of Arizona.

Rulemaking is defined in Arizona Revised Statutes known as the Arizona Administrative Procedure Act (APA), A.R.S. Title 41, Chapter 6, Articles 1 through 10.

The Office of the Secretary of State does not interpret or enforce rules published in the *Arizona Administrative Register* or *Code*. Questions should be directed to the state agency responsible for the promulgation of the rule as provided in its published filing.

The *Register* is cited by volume and page number. Volumes are published by calendar year with issues published weekly. Page numbering continues in each weekly issue.

In addition, the *Register* contains the full text of the Governor's Executive Orders and Proclamations of general applicability, summaries of Attorney General opinions, notices of rules terminated by the agency, and the Governor's appointments of state officials and members of state boards and commissions.

ABOUT RULES

Rules can be: made (all new text); amended (rules on file, changing text); repealed (removing text); or renumbered (moving rules to a different Section number). Rules activity published in the *Register* includes: proposed, final, emergency, expedited, and exempt rules as defined in the APA.

Rulemakings initiated under the APA as effective on and after January 1, 1995, include the full text of the rule in the *Register*. New rules in this publication (whether proposed or made) are denoted with underlining; repealed text is stricken.

WHERE IS A "CLEAN" COPY OF THE FINAL OR EXEMPT RULE PUBLISHED IN THE REGISTER?

The *Arizona Administrative Code* (A.A.C.) contains the codified text of rules. The A.A.C. contains rules promulgated and filed by state agencies that have been approved by the Attorney General or the Governor's Regulatory Review Council. The *Code* also contains rules exempt from the rulemaking process.

The printed *Code* is the official publication of a rule in the A.A.C. is prima facie evidence of the making, amendment, or repeal of that rule as provided by A.R.S. § 41-1012. Paper copies of rules are available by full Chapter or by subscription. The *Code* is posted online for free.

LEGAL CITATIONS AND FILING NUMBERS

On the cover: Each agency is assigned a Chapter in the *Arizona Administrative Code* under a specific Title. Titles represent broad subject areas. The Title number is listed first; with the acronym A.A.C., which stands for the *Arizona Administrative Code*; following the Chapter number and Agency name, then program name. For example, the Secretary of State has rules on rulemaking in Title 1, Chapter 1 of the *Arizona Administrative Code*. The citation for this chapter is 1 A.A.C. 1, Secretary of State, Rules and Rulemaking

Every document filed in the office is assigned a file number. This number, enclosed in brackets, is located at the top right of the published documents in the *Register*. The original filed document is available for 10 cents a copy.

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ADMINISTRATIVE CODE
A price list for the *Arizona Administrative Code* is available online. You may also request a paper price list by mail. To purchase a paper Chapter, contact us at (602) 364-3223.

PUBLICATION DEADLINES
Publication dates are published in the back of the *Register*. These dates include file submittal dates with a three-week turnaround from filing to published document.

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Participate in the Process

Look for the Agency Notice

Review (inspect) notices published in the *Arizona Administrative Register*. Many agencies maintain stakeholder lists and would be glad to inform you when they proposed changes to rules. Check an agency's website and its newsletters for news about notices and meetings.

Feel like a change should be made to a rule and an agency has not proposed changes? You can petition an agency to make, amend, or repeal a rule. The agency must respond to the petition. (See A.R.S. § 41-1033)

Attend a public hearing/meeting

Attend a public meeting that is being conducted by the agency on a Notice of Proposed Rulemaking. Public meetings may be listed in the Preamble of a Notice of Proposed Rulemaking or they may be published separately in the *Register*. Be prepared to speak, attend the meeting, and make an oral comment.

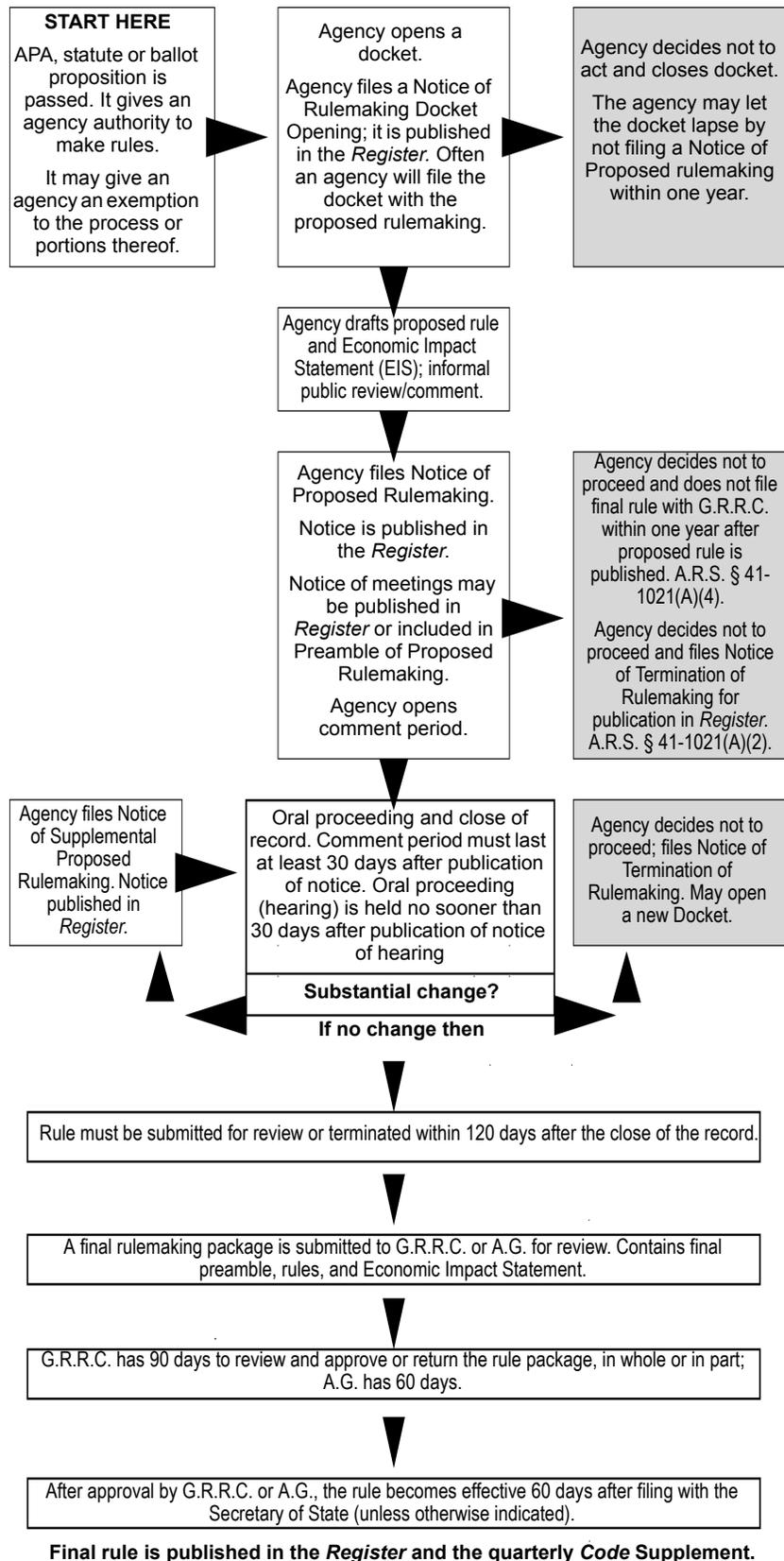
An agency may not have a public meeting scheduled on the Notice of Proposed Rulemaking. If not, you may request that the agency schedule a proceeding. This request must be put in writing within 30 days after the published Notice of Proposed Rulemaking.

Write the agency

Put your comments in writing to the agency. In order for the agency to consider your comments, the agency must receive them by the close of record. The comment must be received within the 30-day comment timeframe following the *Register* publication of the Notice of Proposed Rulemaking.

You can also submit to the Governor's Regulatory Review Council written comments that are relevant to the Council's power to review a given rule (A.R.S. § 41-1052). The Council reviews the rule at the end of the rulemaking process and before the rules are filed with the Secretary of State.

Arizona Regular Rulemaking Process



Definitions

Arizona Administrative Code (A.A.C.): Official rules codified and published by the Secretary of State's Office. Available online at www.azsos.gov.

Arizona Administrative Register (A.A.R.): The official publication that includes filed documents pertaining to Arizona rulemaking. Available online at www.azsos.gov.

Administrative Procedure Act (APA): A.R.S. Title 41, Chapter 6, Articles 1 through 10. Available online at www.azleg.gov.

Arizona Revised Statutes (A.R.S.): The statutes are made by the Arizona State Legislature during a legislative session. They are compiled by Legislative Council, with the official publication codified by Thomson West. Citations to statutes include Titles which represent broad subject areas. The Title number is followed by the Section number. For example, A.R.S. § 41-1001 is the definitions Section of Title 41 of the Arizona Administrative Procedures Act. The "§" symbol simply means "section." Available online at www.azleg.gov.

Chapter: A division in the codification of the *Code* designating a state agency or, for a large agency, a major program.

Close of Record: The close of the public record for a proposed rulemaking is the date an agency chooses as the last date it will accept public comments, either written or oral.

Code of Federal Regulations (CFR): The *Code of Federal Regulations* is a codification of the general and permanent rules published in the *Federal Register* by the executive departments and agencies of the federal government.

Docket: A public file for each rulemaking containing materials related to the proceedings of that rulemaking. The docket file is established and maintained by an agency from the time it begins to consider making a rule until the rulemaking is finished. The agency provides public notice of the docket by filing a Notice of Rulemaking Docket Opening with the Office for publication in the *Register*.

Economic, Small Business, and Consumer Impact Statement (EIS): The EIS identifies the impact of the rule on private and public employment, on small businesses, and on consumers. It includes an analysis of the probable costs and benefits of the rule. An agency includes a brief summary of the EIS in its preamble. The EIS is not published in the *Register* but is available from the agency promulgating the rule. The EIS is also filed with the rulemaking package.

Governor's Regulatory Review (G.R.R.C.): Reviews and approves rules to ensure that they are necessary and to avoid unnecessary duplication and adverse impact on the public. G.R.R.C. also assesses whether the rules are clear, concise, understandable, legal, consistent with legislative intent, and whether the benefits of a rule outweigh the cost.

Incorporated by Reference: An agency may incorporate by reference standards or other publications. These standards are available from the state agency with references on where to order the standard or review it online.

Federal Register (FR): The *Federal Register* is a legal newspaper published every business day by the National Archives and Records Administration (NARA). It contains federal agency regulations; proposed rules and notices; and executive orders, proclamations, and other presidential documents.

Session Laws or "Laws": When an agency references a law that has not yet been codified into the Arizona Revised Statutes, use the word "Laws" is followed by the year the law was passed by the Legislature, followed by the Chapter number using the abbreviation "Ch.," and the specific Section number using the Section symbol (§). For example, Laws 1995, Ch. 6, § 2. Session laws are available at www.azleg.gov.

United States Code (U.S.C.): The Code is a consolidation and codification by subject matter of the general and permanent laws of the United States. The Code does not include regulations issued by executive branch agencies, decisions of the federal courts, treaties, or laws enacted by state or local governments.

Acronyms

A.A.C. – *Arizona Administrative Code*

A.A.R. – *Arizona Administrative Register*

APA – *Administrative Procedure Act*

A.R.S. – *Arizona Revised Statutes*

CFR – *Code of Federal Regulations*

EIS – *Economic, Small Business, and Consumer Impact Statement*

FR – *Federal Register*

G.R.R.C. – *Governor's Regulatory Review Council*

U.S.C. – *United States Code*

About Preambles

The Preamble is the part of a rulemaking package that contains information about the rulemaking and provides agency justification and regulatory intent.

It includes reference to the specific statutes authorizing the agency to make the rule, an explanation of the rule, reasons for proposing the rule, and the preliminary Economic Impact Statement.

The information in the Preamble differs between rulemaking notices used and the stage of the rulemaking.



NOTICES OF PROPOSED RULEMAKING

This section of the *Arizona Administrative Register* contains Notices of Proposed Rulemakings.

A proposed rulemaking is filed by an agency upon completion and submittal of a Notice of Rulemaking Docket Opening. Often these two documents are filed at the same time and published in the same *Register* issue.

When an agency files a Notice of Proposed Rulemaking under the Administrative Procedure Act (APA), the notice is published in the *Register* within three weeks of filing. See the publication schedule in the back of each issue of the *Register* for more information.

Under the APA, an agency must allow at least 30 days to elapse after the publication of the Notice of Proposed Rulemaking in the *Register* before beginning any proceedings for making, amending, or repealing any rule. (A.R.S. §§ 41-1013 and 41-1022)

The Office of the Secretary of State is the filing office and publisher of these rules. Questions about the interpretation of the proposed rules should be addressed to the agency that promulgated the rules. Refer to item #4 below to contact the person charged with the rulemaking and item #10 for the close of record and information related to public hearings and oral comments.

NOTICE OF PROPOSED RULEMAKING

TITLE 2. ADMINISTRATION

CHAPTER 8. STATE RETIREMENT SYSTEM BOARD

[R16-98]

PREAMBLE

- | | |
|--|---------------------------------|
| <u>1. Article, Part or Section Affected (as applicable)</u> | <u>Rulemaking Action</u> |
| R2-8-126 | Amend |
- 2. Citations to the agency’s statutory rulemaking authority to include the authorizing statute (general) and the implementing statute (specific):**
 Authorizing statute: A.R.S. § 38-714(E)(4)
 Implementing statutes: A.R.S. §§ 38-711, 38-764, 38-769, 38-771, 38-771.01, and 38-774
- 3. Citations to all related notices published in the Register as specified in R1-1-409(A) that pertain to the record of the proposed rules:**
 Notice of Docket Opening: 21 A.A.R. 1834, September 11, 2015
 Notice of Proposed Rulemaking: 21 A.A.R. 2281, October 9, 2015
 Notice of Final Rulemaking: 22 A.A.R. 79, January 15, 2016
 Notice of Substantive Policy Statement: 22 A.A.R. 707, April 1, 2016
 Notice of Rulemaking Docket Opening: 22 A.A.R. 1064, May 6, 2016
- 4. The agency’s contact person who can answer questions about the rulemaking:**
 Name: Jessica A. Ross, Rule Writer
 Address: Arizona State Retirement System
 3300 N. Central Ave., Ste. 1400
 Phoenix, AZ 85012-0250
 Telephone: (602) 240-2039
 E-mail: JessicaR@azasrs.gov
- 5. An agency’s justification and reason why a rule should be made, amended, repealed, or renumbered, to include an explanation about the rulemaking:**
 R2-8-126 provides notice to members regarding what type of annuity the member may elect at retirement based on age and/or dollar amount. However, the ASRS will amend subsections (I) and (J) of this rule to better clarify those annuity options are applicable only to retirees with an original retirement date on or after the effective date of those provisions.
- 6. A reference to any study relevant to the rule that the agency reviewed and proposes either to rely on or not rely on in its evaluation of or justification for the rule, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material.**
 None



7. A showing of good cause why the rulemaking is necessary to promote a statewide interest if the rulemaking will diminish a previous grant of authority of a political subdivision of this state:

Not applicable

8. The preliminary summary of the economic, small business, and consumer impact:

The ASRS promulgates rules that allow the agency to provide for the proper administration of the state retirement trust fund. ASRS rules affect ASRS members and ASRS employers regarding how they contribute to, and receive benefits from, the ASRS. The ASRS effectively administrates how public-sector employers and employees participate in the ASRS. As such, the ASRS does not issue permits or licenses, or charge fees, and its rules have little to no economic impact on private-sector businesses, with the exception of some employer partner charter schools, which have voluntarily contracted to join the ASRS. Thus, there is little to no economic, small business, or consumer impact, other than the minimal cost to the ASRS to prepare the rule package. The rule will have minimal economic impact, if any, because it merely clarifies current annuity options without imposing any additional requirements on the public. Clarifying the applicability of R2-8-126(I) and (J) will increase understandability of the annuity options available to a member at retirement and will ensure ASRS members and their spouses have notice regarding those options; thus, reducing the regulatory burden and the economic impact.

9. The agency’s contact person who can answer questions about the economic, small business, and consumer impact statement:

Name: Jessica A. Ross, Rules Writer
Address: Arizona State Retirement System
3300 N. Central Ave., Ste. 1400
Phoenix, AZ 85012-0250
Telephone: (602) 240-2039
E-mail: JessicaR@azasrs.gov

10. The time, place, and nature of the proceedings for to make, amend, repeal, or renumber the rule, or if no proceeding is scheduled, where, when, and how persons may request and oral proceedings on the proposed rule:

An oral proceeding regarding the proposed rule will be held as follows:

Date: August 16, 2016
Time: 9:00 a.m.
Location: Arizona State Retirement System
10th Floor Board Room
3300 N. Central Ave.
Phoenix, AZ 85012-0250

11. All agencies shall list other matters prescribed by statute applicable to the specific agency or to any specific rule or class of rules. Additionally, an agency subject to Council review under A.R.S. §§ 41-1052 and 41-1055 shall respond to the following questions:

None

a. Whether the rule requires a permit, whether a general permit is used and if not, the reasons why a general permit is not used:

None of the rules requires a permit.

b. Whether a federal law is applicable to the subject of the rule, whether the rule is more stringent than federal law, and if so, citation to the statutory authority to exceed the requirements of federal law:

26 USC 401(a)(9), and corresponding Treasury Regulations: §§ 1.401(a)(9)-1 (Q&A-2(d)); 1.401(a)(9)-9 (Q&A-2); 1-401(a)(9)-6 (Q&A-2) specifically apply to this rulemaking. These federal regulations indicate that a member may participate in certain types of annuity options at certain ages, regardless whether the contingent annuitant is a current or former spouse. With the changes completed in this rulemaking, R2-8-126 will not be more stringent than these federal laws.

c. Whether a person submitted an analysis to the agency that compares the rule’s impact on the competitiveness of business in this state to the impact on business in other states:

No analysis was submitted.

12. A list of incorporated by reference material as specified in A.R.S. § 41-1028 and its location in the rules:

None

13. The full text of the rules follows:



TITLE 2. ADMINISTRATION

CHAPTER 8. STATE RETIREMENT SYSTEM BOARD

ARTICLE 1. RETIREMENT SYSTEM; DEFINED BENEFIT PLAN

Section
R2-8-126. Calculating Optional Forms of Benefits

ARTICLE 1. RETIREMENT SYSTEM; DEFINED BENEFIT PLAN

R2-8-126. Calculating Optional Forms of Benefits

- A. For the purposes of this Section, the following definitions apply, unless stated otherwise:
1. ~~“prior-prior service credit”~~ means a “service credit” listed in R2-8-501(24), credited service that is earned pursuant to A.R.S. § 38-739, or a service credit that is transferred or redeemed pursuant to A.R.S. §§ 38-730, 38-771, or 38-921 et seq.
 2. “Original retirement date” means:
 - a. The date a member retires from the ASRS for the first time; or
 - b. The date a member retires from the ASRS after returning to active membership for 60 consecutive months or more pursuant to A.R.S. § 38-766(C).
- B. An individual who is 104 years of age or older at the time of retirement is not eligible to ~~select~~ elect an option of life annuity with a term certain.
- C. An individual who is 93 years of age or older at the time of retirement is not eligible to ~~select~~ elect the options of life annuity with ten years certain or life annuity with 15 years certain.
- D. An individual who is 85 years of age or older at the time of retirement is not eligible to ~~select~~ elect the option of life annuity with 15 years certain.
- E. As authorized under A.R.S. § 38-764(F), if the life annuity of any ~~Plan~~ member is less than a monthly amount determined by the Board, the ASRS shall not pay the annuity. Instead, the ASRS shall make a lump sum payment in the amount determined by using appropriate actuarial assumptions.
- F. The ASRS shall calculate a member’s or beneficiary’s benefits, based on the attained age of the member or beneficiary, determined in years and full months, as of:
 1. ~~the effective~~ The date of the benefit payment member’s retirement; or
 2. The date of the member’s death, if the beneficiary is eligible to elect the survivor benefit as monthly income for life pursuant to A.R.S. § 38-762(C).
- G. ~~The~~ Before the ASRS applies the calculation for an optional form of retirement benefit provided in A.R.S. § 38-760, the ASRS shall add include any prior service credit benefit that is payable to a member applicable to the life annuity of the member before the ASRS applies any optional payment plan calculation provided for in A.R.S. § 38-760.
- H. A member who is ten ~~or more~~ years and one day, or more, older than the member’s non-spousal contingent annuitant is not eligible to participate in a 100% joint-and-survivor option. A member who is 24 ~~or more~~ years and one day, or more, older than the member’s non-spousal contingent annuitant is not eligible to participate in a 66 2/3% joint-and-survivor option.
- I. ~~Notwithstanding~~ For members whose original retirement date is on or after March 6, 2016, notwithstanding subsection (H), a member who is ten ~~or more~~ years and one day, or more, older than the member’s ex-spouse contingent annuitant is eligible to participate in a 100% joint-and-survivor option, if:
 1. The member ~~selected~~ elected the ex-spouse as the contingent annuitant prior to divorce from the ex-spouse; and
 2. The member submits a DRO to the ASRS which requires the ex-spouse to be the contingent annuitant on the member’s account.
- J. ~~Notwithstanding~~ For members whose original retirement date is on or after March 6, 2016, notwithstanding subsection (H), a member who is 24 ~~or more~~ years and one day, or more, older than the member’s ex-spouse contingent annuitant is eligible to participate in a 66 2/3% joint-and-survivor option, if:
 1. The member ~~selected~~ elected the ex-spouse as the contingent annuitant prior to divorce from the ex-spouse; and
 2. The member submits a DRO to the ASRS which requires the ex-spouse to be the contingent annuitant on the member’s account.
- K. Notwithstanding subsection (F), for purposes of determining whether a member is eligible to participate in a joint-and-survivor option, the ASRS shall calculate the difference in a member’s age and the contingent annuitant’s age based on the birthdates of the member and the contingent annuitant.



NOTICES OF FINAL RULEMAKING

This section of the Arizona Administrative Register contains Notices of Final Rulemaking. Final rules have been through the regular rulemaking process as defined in the Administrative Procedures Act. These rules were either approved by the Governor's Regulatory Review Council or the Attorney General's Office. Certificates of Approval are on file with the Office.

The final published notice includes a preamble and

text of the rules as filed by the agency. Economic Impact Statements are not published.

The Office of the Secretary of State is the filing office and publisher of these rules. Questions about the interpretation of the final rules should be addressed to the agency that promulgated them. Refer to Item #5 to contact the person charged with the rulemaking. The codified version of these rules will be published in the Arizona Administrative Code.

NOTICE OF FINAL RULEMAKING

TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

[R16-99]

PREAMBLE

- 1. Article, Part, and Section Affected (as applicable) Rulemaking Action
Article 13 New Article
R20-5-1301 New Section
R20-5-1302 New Section
R20-5-1303 New Section
R20-5-1304 New Section
R20-5-1305 New Section
R20-5-1306 New Section
R20-5-1307 New Section
R20-5-1308 New Section
R20-5-1309 New Section
R20-5-1310 New Section
R20-5-1311 New Section
R20-5-1312 New Section
2. Citations to agency's statutory rulemaking authority to include the authorizing statute and the implementing statute:
Authorizing statute: A.R.S. § 23-107(A)(1)
Implementing statute: A.R.S. § 23-1062.03
3. The effective date of the rule:
a. If the agency selected a date earlier than the 60 day effective date as specified in A.R.S. § 41-1032(A), include the earlier date and state the reason or reasons the agency selected the earlier effective date as provided in A.R.S. § 41-1032(A)(1) through (5):
Not applicable
b. If the agency selected a date later than the 60 day effective date as specified in A.R.S. § 41-1032(A), include the later date and state the reason or reasons the agency selected the later effective date as provided in A.R.S. § 41-1032(B):
October 1, 2016
The Industrial Commission requests the new rules become effective on October 1, 2016. An effective date later than the 60 day effective date specified in A.R.S. § 41-1032(A) is necessary to allow the Commission to complete the infrastructure needed to apply the new rules.
4. Citations to all related notices published in the Register as specified in R1-1-409(A) that pertain to the record of the proposed rule:
Notice of Rulemaking Docket Opening: 21 A.A.R. 2475, October 23, 2015
Notice of Proposed Rulemaking: 21 A.A.R. 2739, November 13, 2015
5. The agency's contact person who can answer questions about the rulemaking:
Name: Jacqueline Kurth, Manager, Medical Resource Office
Address: Industrial Commission of Arizona



800 W. Washington St., Suite 305
Phoenix, AZ 85007

Telephone: (602) 542-6731

Fax: (602) 542-4797

E-mail: Jacqueline.Kurth@azica.gov

6. An agency's justification and reason why a rule should be made, amended, repealed or renumbered, to include an explanation about the rulemaking:

Arizona Revised Statutes § 23-1062.03 requires the Industrial Commission of Arizona to develop and implement a process for the use of evidence-based medical treatment guidelines to treat injured workers within the context of Arizona's workers' compensation system. The Industrial Commission is making these rules to comply with that legislative directive. These rules, which implement a process for the use of treatment guidelines, are intended to improve the quality and outcomes of medical care, and to improve the efficiency and effectiveness of the process under which that medical care is provided to injured workers.

7. A reference to any study relevant to the rule that the agency reviewed and proposes either to rely on or not rely on in its evaluation of or justification for the rule, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:

Not applicable

8. A showing of good cause why the rulemaking is necessary to promote a statewide interest if the rulemaking will diminish a previous grant of authority of a political subdivision of this state:

Not applicable

9. A summary of the economic, small business and consumer impact:

In accordance with the statutory mandate, the Industrial Commission has adopted the Work Loss Data Institute's *Official Disability Guidelines - Treatment in Workers Compensation* (ODG) as the standard reference for evidence-based medicine used in treating injured workers within the context of Arizona's workers' compensation system. The use of the ODG treatment guidelines is expected to reduce workers' compensation costs. For example, the impact resulting from the adoption of a closed drug formulary alone, part of the ODG treatment guidelines, is estimated to reduce overall workers' compensation costs in Arizona by \$23 million during the six month period between July 1 and December 31, 2016. This component of the estimated impact used an assumed effective date for Article 13 of July 1, 2016. Even though the actual effective date is anticipated to be October 1, 2016, the estimated impact for six months is still considered valid to illustrate the impact of the use of treatment guidelines.

There will be some costs incurred by the participants in the workers' compensation system. Participants include medical providers, payers (insurance carriers and self-insured employers), attorneys, and the Industrial Commission of Arizona. All participants will use evidence-based medical treatment guidelines published by the Work Loss Data Institute and referred to as the ODG. To access the ODG guidelines, participants may purchase an annual subscription and the cost to purchase an annual subscription in 2016 ranges from \$249.00 to \$599.00 or participants may access the ODG using dedicated computer workstations established at the Industrial Commission at no cost to the user. The 2016 cost to the Commission for each station will be \$325.00. The Industrial Commission has not yet determined how many workstations will be made available because the demand for such access cannot be accurately predicted.

The administrative review process may result in a peer review that will be conducted by a third party vendor who must be URAC accredited. URAC was originally incorporated under the name Utilization Review Accreditation Commission. That name was shortened to the acronym URAC in 1996 when it began accrediting other types of organizations such as health plans, pharmacies, and provider organizations. At present, URAC accreditations, certifications, and designations address health care management, health care operations, health plans, pharmacy quality management, and providers. The administrative review process and peer review should reduce delays in providing employees with reasonably required medical treatment, improve the processing of their workers' compensation claims, and reduce litigation time and cost. The cost for the peer review will be paid by the payer and the 2016 cost for a peer review ranges from \$250.00 to \$550.00 per peer review. The precise cost will depend on the complexity of the proposed medical treatment and the number of medical records involved in the peer review.

The Industrial Commission has created a Medical Resource Office (MRO) to administer the Commission's role in the administrative review process. The MRO will require an additional two staff and a program manager for a total number of three new "full time equivalent" positions. To support an efficient preauthorization process, the Commission is developing an electronic system and the estimated total cost to complete the system is \$190,300.00.



10. A description of any changes between the proposed rulemaking, to include supplemental notices, and the final rulemaking:

No substantial substantive changes have been made to the rules. Non-substantive grammatical, formatting, and consistency changes have been made throughout the rules. To reduce the use of “statements” in Article 13, and because describing what is included does not require also describing what is not included, the second paragraph of Rule 1301(A) has been deleted. Rule 1301(B) specifies that the guidelines shall apply to the management of chronic pain and the use of opioids in all stages of pain management and it is not necessary to include both the words “apply to” and “and are mandatory in.” Accordingly, the words “and are mandatory in” have been deleted from Rule 1301(B).

As published in the Notice of Proposed Rulemaking, Rule 1310 contained two subsections “B.” The second subsection “B” has been relettered to “F.” The words “or its contractor” were inadvertently omitted from Rule 1311(H) and (K) (although properly included in Rules 1311(G), 1311(I)(2)). In the definition of “Peer Review” in Rule 1302, “11(I)” was inadvertently omitted from the citation to R20-5-1311(I) and has been added. References in Rule 1304, 1309 and 1310 to the “administrative review” process in Rule 1312 have been changed to reflect that the process is actually Rule 1311.

As a result of stakeholder comments, the definition of “chronic pain” has been clarified to avoid potential confusion. As published in the Notice of Proposed Rulemaking, Rule 1301(B) explained that: “For purposes of this process, chronic pain shall be defined by the guidelines.” Rule 1302 also included a definition of chronic pain: “means any pain that persists beyond the anticipated time of healing.” Because the guidelines contain a definition for chronic pain, it is not necessary to also include a definition in Rule 1302. Accordingly, the superfluous inclusion of a definition of chronic pain in Rule 1302 has been deleted. The incorrect reference to Rule 1301(F) in the definition of “Applicability” in Rule 1302 has been corrected to Rule 1301(B) and (C). The incorrect reference to Rule 1314(B) in the definition of “Fast Track ALJ Dispute Resolution Program” in Rule 1302 has been corrected to 1312(B).

11. Any agency’s summary of the public or stakeholder comments made about the rulemaking and the agency response to the comments:

The Commission received five written comments related to the proposed rulemaking from the following: Property Casualty Insurers (PCI), Arizona Association of Lawyers for Injured Workers (AALIW), Healthsystems, Copper-Point Mutual Insurance Company, and the Arizona Self-Insurers Association (ASIA). The Industrial Commission held an oral proceeding regarding the proposed rules on December 15, 2015. Representatives of three stakeholders spoke at the Oral Proceeding. Those three stakeholders were, CopperPoint Mutual Insurance, AALIW, and Coventry/CompPharma. The comments pertaining to each rule are addressed in order:

Rule 1301 Adoption and Applicability of the Article

Comment: Property Casualty Insurers (PCI) supports the adoption of the *Official Disability Guidelines* (ODG) as evidence-based guidelines for chronic pain and opioid treatment. PCI has stated that the adoption of the ODG should not be limited to the management of chronic pain and the use of opioids for all stages of pain management. PCI would like the Industrial Commission of Arizona (ICA) to utilize ODG for all medical care delivered under the Arizona Workers Compensation Act. Written comments from PCI 12/01/2015.

Response: A.R.S. § 23-1062.03 directs the Commission to develop and implement a process for the use of evidence-based medical treatment guidelines, where appropriate, to treat injured workers. In compliance with the statutory directive, the Commission has already adopted the ODG. Although the Commission has specified that the use of the ODG is limited to management of chronic pain and the use of opioids for all stages of pain management, the Commission recognizes that the application of the use of the ODG to treat injured workers may be expanded and Rule 1301(C) provides for this possibility.

Rule 1301(B) Adoption and Applicability of the Article

Comment: AALIW suggests the rule read, “Until further action of the Commission, the guidelines shall apply only to and are mandatory only in the management of chronic pain and the use of opioids for chronic pain management.” AALIW would like to change the language in the proposed rule so that the rule would apply the guidelines only to management of chronic pain and the use of opioids for chronic pain management as opposed to applying the use of opioids to all stages of pain management. Written comments from AALIW 12/11/2015 were the same comments made at Oral Proceeding 12/15/2015.

Response: The Commission’s adoption of the ODG and the initial scope of the use of the ODG results from consensus recommendations produced by the Advisory Committee for Evidence Based Medical Treatment Guidelines (Director’s Advisory Committee). This committee of community stakeholders included medical doctors, attorneys who represent injured workers, payers, attorneys who represent payers and Industrial Commission staff. The Commission has adopted the consensus recommendations. One of those recommendations was for the ODG to initially apply to the management of chronic pain and the use of opioids for all stages of pain management. The Commission continues to consider this appropriate.



Comment: Healthsystems commented that the rules should be mandatory for the management of treatment of chronic pain and the use of opioids for all stages of pain management, and presumably “all stages” includes the initial onset. This would imply that the entire ODG would be applicable to any injury where there is a pain management component. Managing pain often involves prescribing medications that are not opioids but generate requests for preauthorization and may not be appropriate for an injured worker’s treatment plan. For this reason, whether Appendix A, closed formulary, is included should be clarified. Written comments from Healthsystems 12/14/2015.

Arizona Self-Insured Association (ASIA) views limiting the rules to chronic pain as an important first step, and continue to support the expansion of the rules to all injuries so all claims, injured workers, and employers are treated equally under the rules. Written comments from ASIA 12/15/2015.

Response: The Commission’s adoption of the ODG and the initial scope of the use of the ODG results from consensus recommendations produced by the Director’s Advisory Committee. The consensus recommendations did not include the use of the word “only” and the Commission does not consider it necessary nor desirable to use the word “only” in Rule 1301(B) as doing so may create confusion between Rule 1301(B) and 1301(C). Likewise, the Commission’s adoption of the consensus recommendation was to apply the ODG to the use of opioids for all stages of pain management. Appendix A is part of the ODG treatment guidelines.

Rule 1301(C) Adoption and Applicability of the Article

Comment: AALIW would like the Commission to limit the applicability of the treatment guidelines for at least two years after implementation of these rules. “The Commission may modify or change the applicability of the guidelines as described in subsection B if the Commission determines that modification or changing the applicability of the guidelines 1) will improve medical treatment for injured workers, 2) will make treatment and claims processing more efficient and cost effective, and 3) where the guidelines provide adequate coverage of the body parts or conditions.” AALIW also commented that a sentence should be added to the end of Rule 1301(C) as follows: “Such action may only be taken after sufficient time has passed to evaluate the effect of the current applicability on the provision of appropriate medical care. Sufficient time shall be at least two (2) years after the implementation of these rules.”

Response: Neither the Director’s Advisory Committee’s consensus recommendations nor the Commission’s adoption of the consensus recommendations include any time period limitation. Rule 1301(C) requires the Commission provide the public with the opportunity to comment and hold a public hearing before the Commission may take action to modify or change the applicability of the guidelines.

1302 Definitions

Comment: AALIW believes the definition of “Chronic Pain” as “any pain that persists beyond the anticipated time of healing” is extremely vague and subject to a wide range of interpretation. To add solidity to the definition, AALIW suggests the following change be made to the definition of Chronic Pain: “intermittent in addition to continuous, namely that it has persisted for at least three months and has resulted in pain on at least half the days in the past six months.” Additionally, AALIW suggests adding “has persisted for at least three months after the original injury or any surgery” to make clearer that the issue addressed is chronic pain rather than acute pain.

Response: Both the Director’s Advisory Committee and the Commission, when it adopted the Committee’s recommendations, intended for the definition of chronic pain to be the definition as contained in the guidelines (as noted in Rule 1301(A)). To avoid any confusion with the unnecessary definition of chronic pain that was in Rule 1302, that definition has been deleted.

Rule 1303 et seq. Provider Request for Preauthorization

Comment: PCI comment: It is critical that the preauthorization process be utilized to ensure that there is proper medical basis for departing from the guidelines before the injured worker receives that treatment in order to avoid unnecessary chemical dependency or addiction. The legislative directive to the Commission found in A.R.S. § 23-1062.03 is broad enough to include a mandatory preauthorization process adopted by the Commission for the use of evidence-based medical treatment guidelines. The rules should include the following: “No preauthorization is required to ensure payment for reasonably required medical treatment or services supported by the adopted guidelines. Preauthorization is required for all medical treatment or services that are not supported by the adopted guidelines or are not addressed by the adopted guidelines.”

Response: Assuming the Commission has the authority to impose a mandatory preauthorization process, the Commission has elected not to do so at this time.

Rule 1304 Payer Denial of Request for Preauthorization

Comment: AALIW states that nothing in these new rules overcomes the requirements of A.R.S. § 23-1062.02(F), which requires that, when there is a conflict on the need for opioids, the payer is to provide drug rehabilitation and detoxification treatment. In the event of a dispute regarding the need for rehabilitation and detoxification, the payer



must continue to provide the opioids until a determination is made after a hearing by an administrative law judge.

Response: The rules do not override A.R.S. § 23-1062.02(F).

Rule 1304(B) Payer Denial of Request for Preauthorization

Comment: AALIW believes this rule is at odds with Rule 1309(B) in that it requires a payer to provide a great deal of information if they deny preauthorization for treatment that is supported by the guidelines, but Rule 1309(B) allows them to simply ignore the request.

Response: This comment mischaracterizes Rule 1309(B) as allowing a payer to “ignore” a request. The rule provides the payer with a time-frame for communicating its decision regarding a request for preauthorization and if a payer does not communicate its decision within the specified time-frame, provides the provider and injured employee with the ability to seek administrative review.

Rule 1309(D) Payer Decision of Request for Preauthorization

Comment: AALIW suggest changes to eliminate “final” IME as they believe the provider and the applicant should be privy to all of the doctor’s reports as they become available. The following is the suggested change to the rule: “If, no later than 10 business days after a request for preauthorization has been received, a payer provides notice to the provider that an IME has been requested under R20-5-114, then the payer’s decision on a request for preauthorization shall be issued no later than 10 business days after the IME report has been received by the payer. The payer shall provide a copy of the IME report to the provider immediately upon receipt of the IME report. The IME must be scheduled to occur within 45 days of the receipt of the request for preauthorization. The report shall be provided within 10 days of the examination.”

Response: The comment appears to be directed at obtaining preliminary written communications from IME doctors even in those circumstances where the preliminary “report” has no impact on the decision. This may occur, for example, when an IME doctor communicates to the payer that an IME clinical examination has been completed but the doctor is waiting for results from an MRI before rendering an opinion. In those circumstances where the IME doctor agrees with the attending physician and preauthorization is approved, requiring the payer to supply all the preliminary written communications would not appear to be an efficient and effective use of resources. Given that the preauthorization process is intended to be an efficient and effective process with minimal extraneous requirements, it does not appear appropriate to require a payer to supply this type of written communication as part of the preauthorization process. The rules do not have any impact on the parties’ ability to obtain such medical records during the course of discovery should a workers’ compensation claim involve litigation.

Rule 1309(H)(6)(c) Payer Decision of Request for Preauthorization

Comment: AALIW suggest adding “the applicant or their representative,” to the sentence that begins “The provider shall file this request . . .” so the beginning of the sentence would read: “The provider, the applicant or their representative, shall file this request . . .”

Response: The process described in Rule 1309(H)(6)(c) is intended to provide a process for a provider to request the payer review a decision that is issued without an IME and the intent was to limit the initiation of this particular process to the provider.

Rule 1309(I) Payer Decision of Request for Preauthorization

Comment: AALIW suggest adding “or their representative” to the following sentence: “A payer shall provide a copy of its written decision to deny treatment or services to the injured employee.” so it would read: “A payer shall provide a copy of its written decision to deny treatment or services to the injured employee or their representative.”

Response: It is a common practice for payers to communicate with attorneys, rather than directly with the injured employee, in those circumstances where an injured employee is represented by an attorney and the attorney has notified the payer of the representation and has requested that the payer communicate with the attorney. Because it is a common practice, payers are expected to continue to communicate with attorneys and it does not appear necessary to include such a requirement in Rule 1309(I).

Additional Response: Under existing rules, A.A.C. R20-5-102 and A.A.C. R20-5-158, an individual authorized by law to act on behalf of an injured employee who has provided written notice of this authorization to the Commission must be served on all awards, decisions, orders, notices, documents or other matters as required by law. While it does not appear necessary to include additional language in Rule 1309(I), the Commission agrees that adding “or authorized representative” to the end of this subsection would be a non-substantive change.

Rule 1310(C) Payer Reconsideration of Request for Preauthorization

Comment: AALIW suggest changing “Final IME” to “IME” and recommends an additional two sentences be added to the proposed rule as follows: “If, no later than 10 business days after a request for reconsideration has been received, a payer provides notice to the provider that an IME has been requested under R20-5-114, then the payer’s decision on a request for reconsideration shall be issued no later than 10 business days after the IME report has been



received by the payer. The payer shall provide a copy of the IME report to the provider immediately upon receipt of the IME report. The IME must be scheduled within 45 days of receipt of the request for preauthorization. The report shall be provided within 10 days of the examination.”

Response: The rule, as drafted, adequately describes the process.

Additional Response: If a preliminary IME report provides sufficient information for a payer to make a decision regarding preauthorization, then the payer should notify the medical provider and the injured employee of the preauthorization decision within 10 business days from the receipt of the preliminary report. However, it is not uncommon for IME physicians to request additional information, including diagnostic testing, prior to finalizing their IME reports which can result in different opinions and recommendations than those set forth in preliminary reports. Therefore, it is recommended that the preauthorization decision be communicated to the medical provider and the injured employee within 10 business days from the receipt of the final IME report unless the preliminary IME report provides the payer with sufficient information to make a decision regarding a preauthorization request.

Rule 1310(B) Payer Reconsideration of Request for Preauthorization

Comment: AALIW identified a possible typographical error in that the second subsection identified as “B” in Rule 1310 should be “F.” In 1310(E)(6)(a), AALIW suggest adding “the applicant or their representative” to the sentence that begins “The provider shall file this request” so the sentence would read: “The provider, the applicant or their representative, shall file this request. . . .”

Response: The second use of “B” is a typographical error and has been corrected. In those circumstances where an injured employee is represented by an attorney, that attorney may submit a request for administrative review on behalf of the injured employee.

Rule 1311(A) Administrative Review by Commission

Comment: AALIW recommends restricting application of the rule to chronic pain management and to not apply the rule to the use of opioids to all stages of pain management. AALIW suggest making the following changes to the rule: “Until further action of the Commission under R20-5-1301 (C), administrative review under this Article is limited to requests for medical treatment or services related to the management of chronic pain or the use of opioids for chronic pain management.”

Response: The intent is for the ODG treatment guidelines to apply to the use of opioids for all stages of pain management.

Rule 1311(I)(1) Administrative Review by Commission

Comment: AALIW recommends changes to the requirements for the individual conducting the peer review from performing patient care for a minimum of 8 hours per week in one of the five preceding years to at least three of the five preceding years. The recommended changes are as follows: “Hold an active, unrestricted license or certification to practice medicine or health profession during the 5 preceding years. For purposes of this subsection, “active practice” means performing patient care for a minimum of 8 hours per week in at least three of the five preceding years.”

Response: The suggested amendment imposes an unnecessary restriction on those physicians who may perform peer reviews. As drafted, the rule provides for an appropriate practice requirement.

General Comments:

The following general comments, A through E, were received from Healthsystems 12/14/2015;

Comment: A. Scope and Applicability of the ODG and Appendix A; Closed Formulary. Review of the draft is unclear as to the applicability of the ODG Appendix A, closed formulary. If the intent is to set a standard of care for all injury types where pain management is a component of care, then the ODG could be broadly applied to all claims and all injury types where the patient’s symptoms include acute or chronic pain.

Response: The Commission adopted the ODG which includes Appendix A, ODG Workers’ Compensation Drug Formulary for the management of chronic pain and the use of opiates for all stages of pain management.

Comment: B. How Pharmacy Benefit Managers Factor into the Process. Payers use pharmacy benefit managers (PBM) to identify medications which are appropriate for additional screening. Pharmacies are equipped to communicate in real time with payers through the payers’ PBMs. The entire transaction from pharmacist to payer for approval response takes a fraction of a second to complete. Some medications, including opioids and non-opioid drug classes cannot be immediately substantiated as casually related or appropriate by the available medical evidence. This may cause authorization to take longer, but most requests take only a few minutes or hours, not days, to get a payer decision.

Comment: C. This real time connectivity between the pharmacy and the PBM eliminates the need for paper forms being sent back and forth between these entities. Most pharmacies and PBMs are connected via electronic “switches” using nationally adopted standardized formats. Pharmacists should not be required to use the MRO-1 Preauthorization Form as paper forms are rarely used by pharmacists. Healthsystems recommends consolidating



the MRO-1 Form and the MRO-2 Form into a single form, where the payer can respond on the bottom of the request.

Response: The Medical Resource Office (MRO) is developing an electronic system for those who wish to request preauthorization. The MRO process is not intended to replace or displace forms that providers may use to communicate with vendors (such as PBMs), with other providers, or with payers.

Additional Response: Use of the MRO-1 Request for Preauthorization Form is to be used by medical providers (prescribers) and payers and is not intended for use by pharmacies and PBMs.

Comment: D. Commission education and support for the community. Healthsystems recommends the Commission provide educational support to providers, payers and the injured worker community. Training may include classroom, online webinars or web based resources as well as Frequently Asked Questions (FAQs).

Response: The Industrial Commission has made training available to the public on how to use the ODG treatment guidelines by offering multiple workshops at the Commission’s Annual Claims Seminar held in August 2015 and the Commission’s website, www.azica.gov, has links to ODG webinars, FAQs about ODG and MRO forms for participation in the treatment guidelines process. When the Rules are finalized, the Commission will offer training workshops online and at the Commission on how to use the treatment guidelines and the process for administrative review.

Comment: E. Applicability of the formulary. Healthsystems suggest clarification as to the applicability of the formulary within the rule. If Appendix A closed formulary of ODG is not adopted, then we suggest it be specifically excluded as per the other exclusions in Rule 1301. If Appendix A closed formulary is adopted, in part for opioids only, or in whole, we suggest the Commission also incorporate language which specifies that to avoid confusion by payers, medical providers and injured workers.

Response: The Commission has adopted Work Loss Data Institute’s *Official Disability Guidelines* (ODG) Treatment Guidelines which includes Appendix A, Workers’ Compensation Drug Formulary for management of chronic pain and the use of opioids for all stages of pain management.

Additional Response: Appendix A, ODG Workers’ Compensation Drug Formulary, has been adopted in whole by the Industrial Commission and will apply to all medications prescribed for the management of chronic pain and the use of opioids for all stages of pain management.

The following general comments, A through H, were received from CopperPoint Mutual Insurance Company on December 15, 2015 and were the same as the comments presented at the Oral Proceeding held on December 15, 2015:

Comment: A. National Council on Compensation Insurance (NCCI) report on Arizona medical cost. CopperPoint cites the following statistics from NCCI Medical Data Report for the state of Arizona September 2015: medical benefits represent 76% of total benefit cost which compares unfavorably to 64% for the Region (CO, NV, NM and UT) and 59% when looking at Countrywide. NCCI reports distribution of Arizona drug dollars at 13% while both the Region and Countrywide are reported to be 11%.

Comment: B. Adoption of Article 13. CopperPoint fully supports adoption of these rules.

Comment: C. Proposed Rule. CopperPoint comments that the proposed rule is a culmination of several years’ work by highly respected individuals within the Arizona workers’ compensation community. Hours of research were undertaken to investigate solutions to a real, shared problem – chronic pain and the use of opioid medications across all injuries. Litigation for these types of cases can be protracted and lengthy, resulting in treatment being delayed and debated for well over a year. The ultimate decision is not medically based but the course of care is determined by an administrative law judge.

Comment: D. Official Disability Guidelines (ODG). CopperPoint concurs that the ODG published by the Work Loss Data Institute are the most comprehensive, user friendly and most appropriate for Arizona. They point out that nationally other workers’ compensation jurisdictions have successfully been using evidence-based guidelines for years.

Comment: E. Preauthorization Request Form (MRO-1). CopperPoint suggests making the use of the MRO-1 Form mandatory to expedite recognition of a Provider Request for Preauthorization by a Payer, which would allow for appropriate processing for a timely response of the covered request by the payer. Experience from other jurisdictions indicates a vast majority of preauthorization requests are approved.

Comment: F. Administrative Review Process by Commission. Different opinions will be adequately resolved via the Administrative Review Process at the Commission through utilization of an independent peer review process. The requesting physician will have an opportunity to explain a requested deviation from the ODG to a similarly credentialed peer physician reviewer.

Comment: G. Fast Track Hearing Process. CopperPoint believes this process provides an opportunity to expedite a litigate dispute thereby eliminating the delay in treatment for the injured worker.



Comment: H. Expansion of the use of evidence-based medicine. CopperPoint urges the Commission to expand evidence-based medicine to all conditions 6 months after implementation of the Rule. Further delay in the expansion of evidence-based medicine will not adequately resolve the issues intended by implementation of this enhancement to our system.

Response: With respect to item E, neither the use of the preauthorization process or the “forms” within the electronic process are mandatory. With respect to item H, neither the Director’s Advisory Committee’s consensus recommendations nor the Commission’s adoption of the consensus recommendations include any specific time period for the Commission to consider expanding the scope of the use of the treatment guidelines and the Commission is not able to predict when, or if, the scope will be expanded. The remaining comments seem to support the rulemaking and the Commission appreciates this support.

The following general comments, A through C, were received from ASIA 12/15/2015:

Comment: A. Strongly supports the Industrial Commission effort to implement evidence-based medicine treatment standards for Arizona’s Workers’ Compensation System.

Comment: B. Believes the original intent of A.R.S. § 23-1062.03 was to implement evidence-based guidelines for a broader range of workers’ compensation injuries. By segregating the rules to apply to only one type of condition, the proposed rules create a disparity of treatment with injured workers who have sustained other conditions that may also benefit from the preauthorization and peer review processes.

Comment: C. Supports the remaining language outlining the process for evidence-based medicine

Response: A.R.S. § 23-1062.03 directs the Commission to develop and implement a process for the use of evidence-based medical treatment guidelines, where appropriate, to treat injured workers. In compliance with the statutory directive, the Commission has already adopted the ODG. Although the Commission has specified that the use of the ODG is limited to management of chronic pain and the use of opioids for all stages of pain management, the Commission recognizes that the application of the use of the ODG to treat injured workers may be expanded and Rule 1301(C) provides for this possibility.

The following general comments, A through D, were received from Coventry Health Care and CompPharma at the Oral Proceeding held 12/15/2015:

Comment: A. Supports across the board the adoption of treatment guidelines and recommendations by the Commission.

Comment: B. Requests clarification regarding preauthorization. There is no language that says preauthorization is required if treatment is not located within the treatment guidelines. They recommend a slight addendum to the language.

Comment: C. Asserts that the current definition of chronic pain leaves it open to interpretation regarding whose definition is accepted: Provider? Prescriber? Payer? Injured Worker? Having a more concrete definition will ease everybody’s burden as we put this into practice.

Comment: D. Suggests it is not clear what part of *Official Disability Guidelines* (ODG) will be adopted. Specifically, they would like to understand if Appendix A in the ODG, Drug Formulary, which includes multiple classes of medications, including narcotics and opioids, is adopted. They would like to ensure that for all of the Pharmacy Benefit Managers (PBMs) that covered lives continue to either get delivery of medications or people get into appropriate weaning practices. They would like to educate people in terms of how the process is going to work from all sides. As currently written guidelines versus practicality, they believe it is open-ended and would make it difficult to put things in a workflow process so that they (Coventry/CompPharma) know if they are adhering to guidelines. But generally speaking, they are very supportive of treatment guidelines.

Response: With respect to item B, the Arizona workers’ compensation act does not require preauthorization and, assuming the Commission has the authority to impose mandatory preauthorization, the Commission has elected not to do so at this time. With respect to item C, the term “Chronic Pain” is defined by the ODG. With respect to item D, the Commission has adopted Work Loss Data Institute’s *Official Disability Guidelines* (ODG) Treatment Guidelines which includes Appendix A, Workers’ Compensation Drug Formulary for management of chronic pain and the use of opioids for all stages of pain management. The Commission appreciates the support for the rulemaking.

12. All agencies shall list other matters prescribed by statute applicable to the specific agency or to any specific rule or class of rules. Additionally, an agency subject to Council review under A.R.S. §§ 41-1052 and 41-1055 shall respond to the following questions:

a. Whether the rule requires a permit, whether a general permit is used and if not, the reasons why a general permit is not used:

The rule does not require a permit.

b. Whether a federal law is applicable to the subject of the rule, whether the rule is more stringent than the federal law and if so, citation to the statutory authority to exceed the requirements of federal law:

Not applicable

c. Whether a person submitted an analysis to the agency that compares the rule’s impact of the competitiveness



of business in this state to the impact on business in other states:

No analysis was submitted.

13. A list of any incorporated by reference material as specified in A.R.S. § 41-1028 and its location in the rule:

None

14. Whether the rule was previously made, amended, repealed as an emergency rule. If so, cite the notice published in the Register as specified in R1-1-409(A). Also the agency shall state where the text changed between the emergency and the final rulemaking packages:

Not applicable

15. The full text of the rules follows:

TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. THE INDUSTRIAL COMMISSION OF ARIZONA

ARTICLE 13. TREATMENT GUIDELINES

Section

- R20-5-1301. Adoption and Applicability of the Article
- R20-5-1302. Definitions
- R20-5-1303. Provider Request for Preauthorization
- R20-5-1304. Payer Denial of Request for Preauthorization
- R20-5-1305. Payer Denial of Payment for Provided Treatment or Services
- R20-5-1306. Payer Reversal of Decision to Deny Treatment or Services
- R20-5-1307. Payer Decision, In Whole or In Part
- R20-5-1308. Failure to Comply with Required Time Limits
- R20-5-1309. Payer Decision on Request for Preauthorization
- R20-5-1310. Payer Reconsideration on Request for Preauthorization
- R20-5-1311. Administrative Review by Commission
- R20-5-1312. Hearing Process

ARTICLE 13. TREATMENT GUIDELINES

R20-5-1301. Adoption and Applicability of the Article

- A. The Industrial Commission of Arizona (Commission) has adopted the Work Loss Data Institute’s Official Disability Guidelines – Treatment in Workers Compensation (ODG) as the standard reference for evidence-based medicine used in treating injured workers within the context of Arizona’s workers’ compensation system. By adopting and referencing the most recent edition (at the time of treatment), and continuously updated Official Disability Guidelines, the Commission can ensure the latest available medical evidence is used in making medical treatment decisions for injured workers.**
- B. Until further action of the Commission, the guidelines shall apply to the management of chronic pain and the use of opioids for all stages of pain management. For purposes of this process, chronic pain shall be defined by the guidelines.**
- C. The Commission may modify or change the applicability of the guidelines as described in subsection (B) if the Commission determines that modification or changing the applicability of the guidelines will: 1) improve medical treatment for injured workers, 2) make treatment and claims processing more efficient and cost effective, and 3) the guidelines adequately cover the body parts or conditions. Before taking action to modify or change the applicability of the guidelines, the Commission shall provide an opportunity for public comment and hold a public hearing. A decision of the Commission under this subsection shall be made by a majority vote of a quorum of Commission members present at a public meeting.**
- D. Action taken by the Commission to modify or change the applicability of the guidelines under subsection (C) shall be published in the minutes of the Commission meeting when such action was taken. The minutes of this action shall be published on the Commission’s website and shall be available from the Commission upon request.**
- E. The guidelines shall apply prospectively. Recommendations provided in the guidelines shall apply to medical treatment or services occurring on or after the effective date of this Article.**
- F. This Article applies to all claims filed with the Commission.**
- G. This Article only applies to medical treatment and services for body parts and conditions that have been accepted as compensable.**
- H. The guidelines are to be used as a tool to support clinical decision making and quality health care delivery to injured employees. The guidelines set forth care that is generally considered reasonable and are presumed correct if the guidelines provide recommendations related to the requested treatment or service. This is a rebuttable presumption and reasonable medical care may include deviations from the guidelines. To support a request to deviate from the guidelines, the provider must produce documentation and justification that demonstrates by a preponderance of credible medical evidence a medical basis for departing from the guidelines. Credible medical evidence may include clinical expertise and judgment.**
- I. The Commission shall provide administrative review and oversight of this Article.**

**R20-5-1302. Definitions**

In this Article, unless the context otherwise requires:

“Act” means the Arizona Workers’ Compensation Act, A.R.S. Title 23, Ch. 6, Articles 1 through 11.

“Active Practice” means performing patient care for a minimum of eight hours per week in one of the five preceding years.

“Administrative Law Judge” or “ALJ” means a hearing officer appointed under A.R.S. § 23-108.02.

“Administrative Review” means a process that includes a peer review for preauthorization of a request for medical treatment or services that has been denied or partially denied by a payer. The administrative review process will be managed by the Medical Resource Office (MRO) at the Industrial Commission of Arizona.

“American Board of Medical Specialties” means the organization that develops a uniform system for specialty boards to administer examinations for certification of physicians within specific medicine specialties.

“American Osteopathic Association” means the organization that develops a uniform system for specialty boards to administer examinations for certification of osteopathic physicians within specific osteopathic medicine specialties.

“Applicability” means the medical conditions that are covered under this Article and authorized by the Commission under R20-5-1301(B) and (C).

“Claim” means the workers’ compensation claim filed by the injured employee under the Act.

“Contractor” means an independent peer review organization accredited by URAC.

“Fast Track ALJ Dispute Resolution Program” or “fast track process” means the voluntary dispute resolution process set forth in R20-5-1312(B).

“International Classification of Diseases Code” or “ICD Code” means a set of medical diagnostic codes that creates a universal language for reporting diseases and injury.

“International Classification of Diseases” or “ICD” means an official list of categories of diseases, physical and mental, that is issued and maintained by the World Health Organization.

“IME” means an independent medical examination scheduled under R20-5-114.

“Injured Employee” means a person defined in A.R.S. § 23-901 whose claim has been accepted for workers’ compensation benefits.

“Medical File Review Opinions” means a formal examination of patient data and medical records for the purpose of determining the need for medical treatment, services or both.

“Payer” means an insurance carrier defined under A.R.S. § 23-901, a self-insured employer defined in R20-5-102, a third-party administrator, and the Special Fund of the Industrial Commission of Arizona.

“Peer Review” means an independent medical review conducted by an individual meeting the requirements of R20-5-1311(I).

“Preauthorization” means a request from a provider to a payer requesting approval to provide medical treatment or services to an injured employee.

“Provider” means a physician as defined in R20-5-102.

“Reconsideration” means a written request to the payer or identified review organization by an injured employee or medical provider to reconsider a previous payer decision to deny medical treatment or services and that identifies the specific justification to support the request.

“Third-Party Administrator” or “TPA” means an organization that processes insurance or employee benefit claims for a separate entity.

“Treatment Guidelines” or “guidelines” means medical treatment guidelines that are used as a tool to support clinical decision making and quality health care delivery to injured employees.

“URAC” refers to URAC, a non-profit organization formerly known as the Utilization Review Accreditation Commission.

R20-5-1303. Provider Request for Preauthorization

A. No preauthorization is required under the Act to ensure payment for reasonably required medical treatment or services. While preauthorization is not required under the Act, a provider may seek preauthorization as provided in this subsection.

B. A provider shall submit a request for preauthorization in writing, which shall include the following information:

1. Patient information (including date of injury, date of birth, and payer claim number);
2. Diagnosis and ICD code;
3. Date of request;
4. Type of request - Initial, Routine, Urgent, or Life Threatening;
5. A statement of the treatment or services requested. Where appropriate, information about quantity, strength, duration and frequency of the treatment or services should be included. Use of the applicable codes should also be included and will facilitate the process; and
6. Documentation, if not already provided, that supports the medical necessity and appropriateness of the treatment or services requested, such as office notes and diagnostic reports.



C. A provider may submit the request by mail, electronically or by fax.

R20-5-1304. Payer Denial of Request for Preauthorization

A. A payer shall not deny a request for preauthorization solely because the guidelines do not address the requested treatment or services.

B. A payer shall not deny a request for preauthorization that is supported by the guidelines, unless the payer can rebut the presumption of reasonableness and correctness with a medical or psychological opinion establishing by a preponderance of the evidence that there is a contraindication or significant medical or psychological reason not to authorize the requested treatment or services. Upon request by the provider or injured employee, a denial of preauthorization in this situation shall be processed as an immediate referral to the Commission for administrative review as provided in R20-5-1311 unless the payer obtains an IME in support of its denial. If the payer obtains an IME which serves as the basis for the denial, then review of the payer's decision shall be processed as a request for investigation under A.R.S. § 23-1061(J) if filed by the injured employee.

R20-5-1305. Payer Denial of Payment for Provided Treatment or Services

A. A payer shall not deny payment for provided treatment or services solely because the guidelines do not address the requested treatment or services.

B. A payer shall not deny payment for provided treatment or services supported by the guidelines, unless the payer can rebut the presumption of reasonableness and correctness with a medical or psychological opinion establishing by a preponderance of the evidence that there is a medical contraindication or significant medical or psychological reason not to pay for the treatment or services.

C. A dispute related to a payer's failure to pay for provided treatment or services may be processed as a request for investigation under A.R.S. § 23-1061(J) if filed by an injured employee.

R20-5-1306. Payer Reversal of Decision to Deny Treatment or Services

A payer may reverse its decision to deny treatment or services at any time throughout the process described in this Article. In this situation, the payer's subsequent authorization or agreement to pay for the treatment or services at issue shall end this process.

R20-5-1307. Payer Decision, In Whole or In Part

A payer may issue a decision approving or denying a request for preauthorization in whole, or in part.

R20-5-1308. Failure to Comply with Required Time Limits

A payer's failure to comply with the required time limits of this process may be considered unreasonable delay under R20-5-163.

R20-5-1309. Payer Decision on Request for Preauthorization

A. Except as provided in subsection (D), a payer shall communicate to the provider its decision on a request for preauthorization no later than 10 business days after the request is received. This decision shall comply with the requirements set forth in subsection (H). For purposes of this Section, the 10 business days begin to run the day after the payer receives the request.

B. If a payer fails to communicate to a provider its decision on request for preauthorization within 10 business days, then the payer's failure to take action is deemed a "no response" and the provider or injured employee may submit a request for administrative review directly to the Commission as provided in R20-5-1311.

C. If a payer receives a request for preauthorization that fails to meet the requirements of R20-5-1303, the payer may, in its discretion:

1. Act on the incomplete request for preauthorization; or
2. No later than 10 business days after the request is received, notify the provider that the request for preauthorization is incomplete.

D. If, no later than 10 business days after a request for preauthorization has been received, a payer provides notice to the provider that an IME has been requested under R20-5-114, then the payer's decision on a request for preauthorization shall be issued no later than 10 business days after the final IME report has been received by the payer. The payer shall provide a copy of the final IME report to the provider upon receipt of the IME report.

E. Unless the payer decision was supported by an IME or otherwise falls within subsection R20-5-1304(B), an injured employee or provider may seek reconsideration of a payer decision by submitting a written request to the payer (or review organization identified by the payer) that states the specific reasons and justifications to support the request. If not previously provided, the injured employee or provider shall include supporting medical documentation with their written request.

F. An injured employee may seek review of a payer decision that is supported by an IME by requesting an investigation under A.R.S. § 23-1061(J).

G. Unless the decision was supported by an IME, an injured employee or provider may seek review of a payer decision issued under R20-5-1304(B) by requesting administrative review by the Commission as provided in R20-5-1311.

H. A payer shall include the following information in its written decision to approve or deny, in whole or in part, the request for preauthorization to provide treatment or services:

1. The date on which the request for preauthorization was received;
2. Patient information, including date of injury, date of birth, payer claim number and Commission claim number;
3. The date on which an IME was completed, if applicable;
4. A statement of what has been authorized, including if applicable, a partial authorization;



5. A statement of explanation if the request for preauthorization is denied, in whole or in part, which should include the medical reason supporting the payer's decision;
6. A statement of the process under which a provider or injured employee may request reconsideration or review of the payer's denial, in whole or in part, of a request for preauthorization, which shall include the following information:
 - a. For a decision that is issued without obtaining an IME that is not subject to R20-5-1304(B):
"If you wish to request reconsideration of the decision regarding your request for preauthorization to provide treatment or services, you must send a written request for reconsideration to:
Name of Payer or Review Organization Identified by Payer
Commission Address
Phone
Fax
E-mail
You must include the specific reason and justification to support your request. Please include additional supporting medical documentation if not previously provided."
 - b. For a decision that is supported by an IME:
"If you wish review of the decision regarding your request for preauthorization to provide treatment or services, then the injured employee is required to file a request for investigation under A.R.S. § 23-1061(J)."
 - c. For a decision that is issued without obtaining an IME that is subject to R20-5-1304(B):
"If you disagree with this decision and wish to request review by the Industrial Commission of Arizona, then you may submit a request for administrative review under R20-5-1311 to:
Industrial Commission of Arizona
Attn: Medical Resource Office
Commission Address
Commission Telephone Number

The provider shall file this request promptly and include the following information: patient information, including name, address, payer claim number, Commission claim number, and date of injury; diagnosis or ICD code; employer, insurance carrier or TPA information; provider information; information pertaining to request for treatment, including the justification for treatment; applicable treatment guideline or guidelines; denial of treatment by payer; copies of relevant medical information or records; and whether the request for medical treatment or services involves a request for urgent care or a life-threatening condition."

- I. A payer shall provide a copy of its written decision to deny treatment or services to the injured employee.

R20-5-1310. Payer Reconsideration on Request for Preauthorization

- A. Except as provided in subsection (C), a payer shall communicate to the provider its decision on a request for reconsideration no later than 10 business days after the request is received. This decision shall comply with the requirements set forth in subsection (E). For purposes of this subsection, the 10 business days begin to run the day after the payer receives the request for reconsideration.
- B. If a payer fails to respond to a request for reconsideration within 10 business days, the provider or injured employee may submit a request for administrative review directly to the Commission as provided in R20-5-1311.
- C. If, no later than 10 business days after a request for reconsideration has been received, a payer provides notice to the provider that an IME has been requested under R20-5-114, then the payer's decision on a request for reconsideration shall be issued no later than 10 business days after the final IME report has been received by the payer. The payer shall provide a copy of the final IME report to the provider upon receipt of the report.
- D. Commission Review of Payer Reconsideration Decision:
 1. An injured employee or provider may seek review of a payer reconsideration decision by requesting an administrative review by the Commission as provided in R20-5-1311 unless the payer decision was supported by an IME.
 2. An injured employee may seek review of a payer reconsideration decision that is supported by an IME by requesting an investigation under A.R.S. § 23-1061(J).
- E. A payer shall include the following information in its written decision to approve or deny, in whole or in part, a request for reconsideration of a denial of preauthorization:
 1. The date on which the request for reconsideration was received;
 2. Patient information, including date of injury, date of birth, payer claim number and Commission claim number;
 3. The date on which an IME was completed, if applicable;
 4. A statement of what has been authorized including, if applicable, a partial authorization;
 5. A statement of explanation if the request for treatment is denied, in whole or in part; and
 6. A statement of the process under which a provider or injured employee may request Commission review of the payer's denial, in whole or in part, of a request for preauthorization, which shall include the following information:
 - a. For a reconsideration decision that is issued without obtaining an IME:
"If you disagree with this reconsideration decision and wish to request review by the Commission, then you may submit a request for administrative review under R20-5-1311 to:
Industrial Commission of Arizona



Attn: Medical Resource Office
Commission Address
Commission Telephone Number.

The provider shall file this request promptly and include the following information: patient information, including name, address, payer claim number, Commission claim number, and date of injury; diagnosis or ICD code; employer, insurance carrier or TPA information; provider information; information pertaining to request for treatment, including the justification for treatment; applicable treatment guideline and denial of treatment by payer; copies of relevant medical information or records; copies of relevant documentation related to the payer reconsideration decision; and whether the request for medical treatment or services involves a request for urgent care or a life-threatening condition.”

- b. For reconsideration of a decision that is supported by an IME:
“If you disagree with this reconsideration decision and wish review by the Commission, then the injured employee is required to file a request for investigation under A.R.S. § 23-1061(J).”

F. A payer shall provide a copy of its written reconsideration decision to deny treatment or services to the injured employee.

R20-5-1311. Administrative Review by Commission

A. Until further action of the Commission under R20-5-1301(C), administrative review under this Article is limited to requests for medical treatment or services related to the management of chronic pain and the use of opioids for all stages of pain management.

B. A request for administrative review shall be in writing and submitted by mail, electronically or by fax. The request shall include the following information:

1. Identifying information of the injured employee and claim, including the injured employee’s name, address, commission claim number, and date of injury;
2. Diagnosis and ICD code;
3. Identifying information of the employer, insurance carrier or TPA;
4. Identifying information of the provider;
5. Information pertaining to request for treatment, such as the justification for treatment, applicable treatment guideline and, if applicable, the payer’s denial of treatment;
6. Copies of relevant medical information or records;
7. Copies of documentation related to the payer’s decision or non-response; and
8. Whether the request for medical treatment or services involves a request for urgent care or a life-threatening condition.

C. Upon receipt of a request for administrative review, the Commission shall determine whether the administrative review is available under this Article.

1. If administrative review is not available, then no later than three business days after receiving a request for administrative review, the Commission shall send notice to the injured employee and payer that administrative review is not available.
2. If administrative review is available, then no later than three business days after receiving the request, the Commission shall send notice to the payer that a request for administrative review has been received and provide information on how to participate in the process.

D. The administrative review conducted under this Section shall apply the guidelines as described in this Article and include a peer review performed by an individual meeting the requirements of subsection (I). The peer review shall consist of a records review and, when possible as described in subsection (I)(5), a conversation between the provider and individual conducting the peer review.

E. The Commission may enter into an agreement with one or more contractors, who shall be URAC accredited, to provide the review described in subsection (D).

F. The payer shall pay for the costs of the peer review conducted by the contractor.

G. To assist in its review, the Commission or its contractor may request or receive additional information and documentation from the provider, injured employee or payer, who shall cooperate and provide the Commission or its contractor with any necessary medical information, including information pertaining to the payer’s decision.

H. Before the Commission or its contractor issues a determination denying the request for treatment or services, a good faith effort shall be made to conduct a peer review with the provider requesting authorization to perform the treatment or services.

I. The individual conducting the peer review shall:

1. Hold an active, unrestricted license or certification to practice medicine or a health profession and be involved in the active practice of medicine or a health profession during the five preceding years. For purposes of this subsection, “active practice” means performing patient care for a minimum of eight hours per week in one of the five preceding years;
2. Be licensed in Arizona, unless the Commission or its contractor is unable to find such an individual, in which case the peer review may be conducted by an individual who is licensed in another state of the United States and who meets the other requirements of this subsection;



3. For a review of a request from an allopathic or osteopathic physician, nurse practitioner, physician assistant, or other mid-level provider, hold a current certification from the American Board of Medical Specialties or the American Osteopathic Association in the area or areas appropriate to the condition, procedure or treatment under review;
 4. Be in the same profession and the same specialty or subspecialty as typically performs or prescribes the medical procedure or treatment requested; and
 5. Make a good faith effort to contact the provider requesting the preauthorization. This good faith effort shall include making telephone contact during the provider's normal business hours and offering to schedule the peer review at a time convenient for the provider.
- J.** A provider may bill the payer for time spent participating in a peer review under this Section.
- K.** The Commission or its contractor shall issue a written determination of its administrative review that contains the name and title of the person that performed the administrative review, and includes the following information:
1. Whether the request for treatment or services is authorized or denied, in whole or in part;
 2. The information reviewed;
 3. The principle reason for the decision; and
 4. The clinical basis and rationale for the decision.
- L.** An interested party dissatisfied with the administrative review determination may request that the dispute be referred to the Commission's Administrative Law Judge Division for hearing. This request for hearing shall:
1. Be in writing;
 2. Filed no later than 10 business days after the administrative review determination is issued; and
 3. State whether the party requests to participate in the Fast Track ALJ Dispute Resolution Program by stipulation, or declines to participate in the Fast Track ALJ Dispute Resolution Program.
- M.** If a timely request for hearing is filed, the administrative review determination is deemed null and void and shall serve no evidentiary purpose.
- N.** The information provided by the parties under this Section and the determination issued by the Commission shall become a part of the Commission claims file for the injured employee.

R20-5-1312. Hearing Process

- A.** A referral of a request for hearing under R20-5-1311(L) shall be processed as provided for in the Act unless all parties agree to participate in the fast track process.
- B.** The following applies only to the Fast Track ALJ Dispute Resolution Program:
1. Parties must agree to participate in the Fast Track ALJ Dispute Resolution Program with the understanding that a short form decision will be issued.
 2. Review by the presiding ALJ shall be limited to the treatment or service dispute considered at the administrative review under R20-5-1311.
 3. The presiding ALJ shall issue a notice of hearing within 10 business days of the receipt of the fully executed agreement to participate and certificate of readiness.
 4. The hearing shall be held within 30 calendar days from the day that the notice of hearing is issued to the extent practicable.
 5. Discovery is limited to five interrogatories and no depositions are permitted.
 6. The presiding ALJ shall take all lay witness testimony at the time of the hearing and will not hold any further hearings.
 7. The presiding ALJ shall consider documentary medical evidence only; no medical testimony shall be taken.
 8. Medical file review opinions shall be deemed to constitute substantial evidence to support the requested treatment or service.
 9. All documentary evidence shall be submitted no later than 10 business days before the scheduled hearing.
 10. The hearing shall be recorded, but not transcribed, unless one or more of the parties files a request for review under A.R.S. § 23-942 and A.R.S. § 23-943.
 11. The presiding ALJ shall issue a short form decision within five business days after the matter is deemed submitted.



NOTICES OF PROPOSED EXEMPT RULEMAKING

This section of the Arizona Administrative Register contains Notices of Proposed Exempt Rulemaking. An agency may be exempt from rulemaking standards outlined in the Arizona Administrative Procedures Act (APA).

An agency's exemption is listed in the Preamble of the rulemaking as specified under: A.R.S. §§ 41-1005 or 41-1057; or a specific statute; or if a rule is promulgated by the Corporation Commission, it is exempt from Attorney General review under a court decision as determined by the Commission.

If an agency determines it is exempt under the law or court decision, the law may still require publication of the Proposed Exempt Rulemaking in this section to solicit and review public comments on the rulemaking.

Some agencies, even though completely exempt, may still elect to follow certain provisions of the APA, such as circulating its exempt rulemaking for comment. If an agency chooses this option, our office encourages filing the notice with our office for publication in the Register.

Please note, if a statute dictates that an agency is completely exempt from the rulemaking process, the agency is authorized to file a Notice of Exempt Rulemaking.

In all cases, an agency must still follow the procedures as established by our office in order to have its rulemaking package published.

The Office of the Secretary of State is the filing office and publisher of these rules. Questions about the interpretation of the proposed exempt rule should be directed to the agency proposing them. Refer to Item #5 of the Preamble to contact the person charged with the rulemaking.

NOTICE OF PROPOSED EXEMPT RULEMAKING

TITLE 2. ADMINISTRATION

CHAPTER 20. CITIZENS CLEAN ELECTIONS COMMISSION

[R16-107]

PREAMBLE

- 1. Article, Part or Section Affected (as applicable) Rulemaking Action
2. Citations to the agency's statutory rulemaking authority to include the authorizing statute (general) and the implementing statute (specific) and the statute or session law authorizing the exemption:
3. The effective date of the rule and the agency's reason it selected the effective date:
4. A list of all notices published in the Register as specified in R9-1-409(A) that pertain to the record of the exempt rulemaking:
5. The agency's contact person who can answer questions about the rulemaking:
6. An agency's justification and reason why a rule should be made, amended, repealed, or renumbered to include an explanation about the rulemaking:



change. Additionally, this change removes references to A.R.S. § 16-917 which will become outdated and reorganizes the rule for benefit of simplicity by moving issues related to separate regulated entities to separate rules. The Commission's rulemakings are exempt from Title 41, Ch. 6, Article 3, pursuant to A.R.S. § 16-956.

7. **A reference to any study relevant to the rule that the agency reviewed and either relied on or did not rely on in its evaluation of or justification for the rule, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:**
Not applicable
8. **A showing of good cause why the rule is necessary to promote a statewide interest if the rulemaking will diminish a previous grant of authority of a political subdivision of this state:**
Not applicable
9. **The summary of the economic, small business, and consumer impact, if applicable:**
Not applicable
10. **A description of any changes between the proposed rulemaking, including any supplemental proposed rulemaking, and the final rulemaking package, (if applicable):**
The proposed amendment would serve to provide clarity during the 2016 election cycle due to legislative enactments related to independent expenditures. The legality of those enactments under the Arizona Constitution remains open to question. However, in the interest of consistency, the Commission proposes to adopt this rule change. Additionally, this change removes references to A.R.S. 16-917 which will become outdated and reorganizes the rule for benefit of simplicity by moving issues related to separate regulated entities to separate rules. The Commission's rulemakings are exempt from Title 41, Ch. 6, Article 3, pursuant to A.R.S. § 16-956.
11. **An agency's summary of the public or stakeholder comments made about the rulemaking and the agency response to the comments, if applicable:**
The Commission solicits public comment throughout the rulemaking process.
12. **Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules. When applicable, matters shall include, but not be limited to:**
 - a. **Whether the rule requires a permit, whether a general permit is used and if not, the reasons why a general permit is not used:**
Not applicable
 - b. **Whether a federal law is applicable to the subject of the rule, whether the rule is more stringent than the federal law and if so, citation to the statutory authority to exceed the requirements of the federal law:**
Not applicable
 - c. **Whether a person submitted an analysis to the agency that compares the rule's impact of the competitiveness of business in this state to the impact on business in other states:**
Not applicable
13. **A list of any incorporated by reference material and its location in the rules:**
Not applicable
14. **Whether this rule previously made, amended, repealed or renumbered as an emergency rule. If so, the agency shall state where the text changed between the emergency and the exempt rulemaking packages:**
The rule was not previously made, amended, repealed, or renumbered as an emergency rule.
15. **The full text of the rules follows:**

TITLE 2. ADMINISTRATION

CHAPTER 20. CITIZENS CLEAN ELECTIONS COMMISSION

ARTICLE 1. GENERAL PROVISIONS

Section
R2-20-109. Independent Expenditure Reporting Requirements

ARTICLE 1. GENERAL PROVISIONS

R2-20-109. Independent Expenditure Reporting Requirements

A. No change

B. All participating candidates shall file campaign finance reports that include all receipts and disbursements for their current campaign account as follows:



1. Expenditures for consulting, advising, or other such services to a candidate shall include a detailed description of what is included in the service, including an allocation of services to a particular election. When appropriate, the Commission may treat such expenditures as though made during the general election period.
2. If a participating candidate makes an expenditure on behalf of the campaign using personal funds, the candidate's campaign shall reimburse the candidate within seven calendar days of the expenditure. After the 7 day period has passed, the expenditure shall be deemed an in-kind contribution subject to all applicable limits.
3. A candidate may authorize an agent to purchase goods or services on behalf of such candidate, provided that:
 - a. Expenditures shall be reported as of the date that the agent promises, agrees, contracts or otherwise incurs an obligation to pay for the goods or services;
 - b. The candidate shall have sufficient funds in the candidate's campaign account to pay for the amount of such expenditure at the time it is made and all other outstanding obligations of the candidate's campaign committee; and
 - c. Within seven calendar days of the date upon which the amount of the expenditure is known, the candidate shall pay such amount from the candidate's campaign account to the agent who purchases the goods or services.
4. A joint expenditure is made when two or more candidates agree to share the cost of goods or services. Candidates may make a joint expenditure on behalf of one or more other campaigns, but must be authorized in advance by the other candidates involved in the expenditure, and must be reimbursed within seven days. Participating candidates may participate in joint expenditures for the cost of goods and services with one or more candidates, subject to the following:
 - a. Joint expenditures must be authorized in advance by all candidates sharing in the expenditure and allocated fairly among candidates. An allocated share of a joint expenditure paid by one candidate pursuant to such an agreement must be reimbursed within seven days.
 - b. Any violator of part (a) shall be liable for a penalty pursuant to R2-20-222, in addition to penalties prescribed by any other law.
 - c. If a fairly allocated share of any joint expenditure is not reimbursed to a candidate, the unreimbursed amount of the joint expenditure fairly allocated to that candidate shall be deemed a contribution to that candidate by the campaign committee of the candidate obligated to reimburse the share.
 - d. If a fairly allocated share of any joint expenditure is not reimbursed to a participating candidate, the candidate obligated to reimburse the share shall reimburse the fund for the unreimbursed amount of the joint expenditure fairly allocated to the obligated candidate, in addition to any penalty specified by law.
5. For the purposes of the Act and Commission rules, a candidate or campaign shall be deemed to have made an expenditure as of the date upon which the candidate or campaign promises, agrees, contracts or otherwise incurs an obligation to pay for goods or services.

C. Timing of reporting expenditures.

1. Except as set forth in subsection (B)(2) above, a participating candidate shall report a contract, promise or agreement to make an expenditure resulting in an extension of credit as an expenditure, in an amount equal to the full future payment obligation, as of the date the contract, promise or agreement is made.
2. In the alternative to reporting in accordance with subsection (B)(1) above, a participating candidate may report a contract, promise or agreement to make an expenditure resulting in an extension of credit as follows:
 - a. For a month to month or other such periodic contract or agreement that is terminable by a candidate at will and without any termination penalty or payment, the candidate may report an expenditure, in an amount equal to each future periodic payment, as of the date upon which the candidate's right to terminate the contract or agreement and avoid such future periodic payment elapses.
 - b. For a contract, promise or agreement to provide goods or services during the general election period that is contingent upon a candidate advancing to the general election period, the candidate may report an expenditure, in an amount equal to the general election period payment obligation, as of the date upon which such contingency is satisfied.
 - c. For a contract, promise or agreement to pay rent, utility charges or salaries payable to individuals employed by a candidate's campaign committee as staff, the candidate may report an expenditure, in an amount equal to each periodic payment, as of the date that is the sooner of (i) the date upon which payment is made; or (ii) the date upon which payment is due.

D. Transportation expenses.

1. Except as otherwise provided in this subsection (D), the costs of transportation relating to the election of a participating statewide or legislative office candidate shall not be considered a direct campaign expense and shall not be reported by the candidate as expenditures or as in-kind contributions.
2. If a participating candidate travels for campaign purposes in a privately owned automobile, the candidate may:
 - a. Use campaign funds to reimburse the owner of the automobile at a rate not to exceed the state mileage reimbursement rate in which event the reimbursement shall be considered a direct campaign expense and shall be reported as an expenditure and reported in the reporting period in which the expenditure was incurred. If a candidate chooses to use campaign funds to reimburse, the candidate shall keep an itinerary of the trip, including



name and type of events(s) attended, miles traveled and the rate at which the reimbursement was made. This subsection applies to candidate owned automobiles in addition to any other automobile.

- b. Use campaign funds to pay for direct fuel purchases for the candidate's automobile only and shall be reported. If a candidate chooses to use campaign funds for direct fuel purchases, the candidate shall keep an itinerary of the trip, including name and type of events(s) attended, miles traveled and the rate at which the reimbursement could have been made.

3. Use of airplanes:

- a. If a participating candidate travels for campaign purposes in a privately owned airplane, within 7 days from the date of travel, the candidate shall use campaign funds to reimburse the owner of the airplane at a rate of \$150 per hour of flying time, in which event the reimbursement shall be considered a direct campaign expense and shall be reported as an expenditure. If the owner of the airplane is unwilling or unable to accept reimbursement, the participating candidate shall remit to the fund an amount equal to \$150 per hour of flying time.
- b. If a participating candidate travels for campaign purposes in a state-owned airplane, within 7 days from the date of travel, the candidate shall use campaign funds to reimburse the state for the portion allocable to the campaign in accordance with subsection 3a, above. The portion of the trip attributable to state business shall not be reimbursed. If payment to the State is not possible, the payment shall be remitted to the Clean Elections Fund.

- 4. If a participating candidate rents a vehicle or purchases a ticket or fare on a commercial carrier for campaign purposes, the actual costs of such rental (including fuel costs), ticket or fare shall be considered a direct campaign expense and shall be reported as an expenditure.

FB. Reports and Refunds of Excess Monies by Participating Candidates

- 1. In addition to the campaign finance reports filed pursuant to A.R.S. § 16-913, participating candidates shall file the following campaign finance reports and dispose of excess monies as follows:
 - a. Prior to filing the application for funding pursuant to A.R.S. § 16-950, participating candidates shall file a campaign finance report with the names of the persons who have made qualifying contributions to the candidate.
 - b. At the end of the qualifying period, a participating candidate shall file a campaign finance report consisting of all early contributions received, including personal monies and the expenditures of such monies:
 - i. The campaign finance report shall be filed with the Secretary of State no later than five days after the last day of the qualifying period and shall include all campaign activity through the last day of the qualifying period.
 - ii. If the campaign finance report shows any amount unspent monies, the participating candidate, within five days after filing the campaign finance report, shall remit all unspent contributions to the Fund, pursuant to A.R.S. § 16-945(B). Any unspent personal monies shall be returned to the candidate or the candidate's family member within five days.
- 2. Each participating candidate shall file a campaign finance report consisting of all expenditures made in connection with an election, all contributions received in the election cycle in which such election occurs, and all payments made to the Clean Elections Fund. If the campaign finance report shows any amount unspent, the participating candidate, within five days after filing the campaign finance report, shall send a check from the candidate's campaign account to the Commission in the amount of all unspent monies to be deposited the Fund:
 - a. The campaign finance report for the primary election shall be filed within five days after the primary election day and shall reflect all activity through the primary election day.
 - b. The campaign finance report for the general election shall be considered filed upon the filing of the post-general campaign finance report filed in accordance with A.R.S. § 16-913(B)(3).
- 3. In the event that a participating candidate purchases goods or services from a subcontractor or other vendor through an agent pursuant to subsection (A)(3), the candidate's campaign finance report shall include the same detail as required in A.R.S. § 16-948(C) for each such subcontractor or other vendor. Such detail is also required when petty cash funds are used for such expenditures.

FB. Independent Expenditure Reporting Requirements.

- 1. No change
- 2. Any person required to comply with A.R.S. § 16-917 shall provide a copy of the literature and advertisement to the Commission at the same time and in the same manner as prescribed by A.R.S. § 16-917(A) and (B). For purposes of this subsection (F), "literature and advertisement" includes electronic communications, including emails and social media messages or postings, sent to more than 1,000 people.
- 3. Any person who fails to file:
 - a. A timely campaign finance report pursuant to A.R.S. § 16-941(D), A.R.S. § 16-958, shall be subject to a civil penalty as prescribed in A.R.S. § 16-942(B), except as provided in A.R.S. § 16-922(1).
 - b. A timely campaign finance report pursuant A.R.S. § 16-913, shall be subject to a civil penalty as prescribed in A.R.S. § 16-942(B), except as provided in A.R.S. § 16-922(2).
- 3. Any person making an independent expenditure on behalf of a candidate, participating or non-participating, and not timely filing a campaign finance report as required by A.R.S. § 16-941(D), A.R.S. § 16-958, or A.R.S. § 16-913



shall be subject to a civil penalty as described in A.R.S. § 16-942(B). An expenditure advocating against one or more candidates shall be considered an expenditure on behalf of any opposing candidate or candidates. This subsection and A.R.S. § 16-942(B) applies to any political committee that accepts contributions or makes expenditures on behalf of any candidate, participating or nonparticipating, regardless of any other contributions taken or expenditures made. Penalties imposed pursuant to this subsection shall not exceed twice the amount of expenditures not reported. Any expenditure advocating against one or more candidates shall be considered an expenditure on behalf of any opposing candidate(s). Penalties shall be assessed as follows:

- a. No change
- b. No change
- c. The penalties in (a) and (b) shall be doubled if the amount not reported for a particular election cycle exceeds ten (10%) percent of the applicable one of the adjusted primary election spending limit or adjusted general election spending limit.
- d. No change
- e. Penalties imposed pursuant to this subsection shall not exceed twice the amount of expenditures not reported.
- 4. No change
- 5. No change
 - a. No change
 - b. No change
- 6. No change
- 7. No change
 - a. No change
 - b. No change
 - i. No change
 - ii. No change
 - iii. No change
- 8. No change
- 9. No change
- 10. No change
- 11. Any entity that has been granted an exemption as of September 11, 2014 is deemed compliant with the requirements of subpart (5) of this subsection (F) for the election cycle ending in 2014.
- 12. No change
 - a. No change
 - i. No change
 - ii. No change
 - iii. No change
 - (1) No change
 - (2) No change
 - iv. No change
 - v. No change
 - (1) No change
 - (2) No change
 - b. No change

G. Non-participating Candidate Reporting Requirements and Contribution Limits. Any person may file a complaint with the Commission alleging that any non-participating candidate or that candidate's campaign committee has failed to comply with or violated A.R.S. § 16-941(B). Complaints shall be processed as prescribed in Article 2 of these rules. In addition to those penalties outlined in R2-20-222(B), a non-participating candidate or candidate's campaign committee violating A.R.S. § 16-941(B) shall be subject to penalties prescribed in A.R.S. § 16-941(B) and A.R.S. § 16-942(B) and (C) as applicable:

- 1. Penalties under A.R.S. § 16-942(B); for a violation by or on behalf of any non-participating candidate or that candidate's campaign committee of any reporting requirement imposed by chapter 6 of title 16, Arizona Revised Statutes, in association with any violation of A.R.S. § 16-941(B):
 - a. For an election involving a candidate for statewide office, the civil penalty shall be \$300 per day.
 - b. For an election involving a legislative candidate, the civil penalty shall be \$100 per day.
 - c. The penalties in (a) and (b) shall be doubled if the amount not reported for a particular election cycle exceeds ten percent (10%) of the applicable one of the adjusted primary election spending limit or adjusted general election spending limit.
 - d. The dollar amounts in items (a) and (b), and the spending limits in item (c) are subject to adjustment of A.R.S. § 16-959.
- 2. Penalties under A.R.S. § 16-942(C): Where a campaign finance report filed by a non-participating candidate or that candidate's campaign committee indicates a violation of A.R.S. § 16-941(B) that involves an amount in excess of ten percent (10%) of the sum of the adjusted primary election spending limit and the adjusted general election



spending limits specified by A.R.S. § 16-961(G) and (H) as adjusted pursuant to A.R.S. § 16-959, that violation shall result in disqualification of a candidate or forfeiture of office.

3. Penalties under A.R.S. § 16-941(B): Regardless of whether or not there is a violation of a reporting requirement, a person who violates A.R.S. § 16-941(B) is subject to a civil penalty of three times the amount of money that has been received, expended, or promised in violation of A.R.S. § 16-941(B) or three times the value in money for an equivalent of money or other things of value that have been received, expended, or promised in violation of A.R.S. § 16-941(B).



NOTICES OF EMERGENCY RULEMAKING

This section of the Arizona Administrative Register contains Notices of Emergency Rulemaking.

The Office of the Secretary of State is the filing office and publisher of these rules.

Questions about the interpretation of the emergency rules should be addressed to the agency proposing them.

Refer to Item #5 to contact the person charged with the rulemaking.

NOTICE OF EMERGENCY RULEMAKING

TITLE 3. AGRICULTURE

CHAPTER 2. DEPARTMENT OF AGRICULTURE ANIMAL SERVICES DIVISION

[R16-102]

PREAMBLE

- 1. Article, Part, or Section Affected (as applicable) Rulemaking Action
R3-2-405 Amend
R3-2-601 Amend
R3-2-602 Amend
R3-2-603 Amend
R3-2-605 Amend
R3-2-606 Amend
R3-2-608 Amend
R3-2-609 Amend
R3-2-610 Amend
R3-2-611 Amend
R3-2-617 Repeal
R3-2-618 Repeal
2. Citations to the agency's statutory rulemaking authority to include the authorizing statute (general) and the implementing statute (specific):
Authorizing statute: A.R.S. §§ 3-107(A)(1), 3-1203(B)(1) and 3-1205(A)
Implementing statute: A.R.S. § 3-1205
3. The effective date of the rule:
June 22, 2016
a. If the agency selected a date earlier than the 60 day effective date as specified in A.R.S. § 41-1032(A), include the earlier date and state the reason or reasons the agency selected the earlier effective date as provided in A.R.S. § 41-1032(A)(1) through (5):
Refer to A.R.S. § 41-1026(D)
b. If the agency selected a date later than the 60 day effective date as specified in A.R.S. § 41-1032(A), include the later date and state the reason or reasons the agency selected the later effective date as provided in A.R.S. § 41-1032(B):
Not applicable
4. Citations to all related emergency notices published in the Register as specified in R1-1-409(A) that pertain to the record of this notice of emergency rulemaking:
None
5. The agency's contact person who can answer questions about the rulemaking:
Name: Leatta McLaughlin
Address: Department of Agriculture
1688 W. Adams
Phoenix, AZ 85007
Telephone: (602) 542-7186
Fax: (602) 542-4290



6. An agency's justification and reason why a rule should be made, amended, repealed or renumbered, to include an explanation about the rulemaking:

According to a report released on July 31, 2015 by the United States Department of Agriculture Animal and Plant Health Inspection Service Veterinary Service there have been confirmed cases of High Pathogenic Avian Influenza (HPAI) in 21 states. A total of 211 commercial and 21 backyard operations have been infected with HPAI. About 7.5 million turkeys and 42.1 million chickens have been depopulated due to HPAI outbreaks. On July 7, 2015 the Secretary of the United States Department of Agriculture transferred approximately \$305 million to the Animal and Plant Health Inspection Service for HPAI activities. In January 2016, the presence of HPAI was confirmed in a commercial turkey flock in Indiana.

HPAI outbreaks threaten the poultry industry in the state of Arizona. Recently game bird eggs were transported into Arizona from a farm in Iowa that later became infected with HPAI. While no infected poultry were detected in Arizona, this incident demonstrates how easily the disease could be brought into the state. If HPAI were to spread to poultry operations in the state of Arizona, it could result in millions of dollars lost in egg and chicken production and the depopulation of thousands or millions of birds. The indirect effect on related businesses could result in millions more in losses to the state economy. As a result, the rules governing the importation of poultry and hatching eggs into our state must be strengthened to reduce the threat posed by HPAI to the poultry industry and the state of Arizona.

7. A reference to any study relevant to the rule that the agency reviewed and either relied on or did not rely on in its evaluation of or justification for the rule, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:

The Department did not rely on any study in its evaluation of or justification for the rule. The Department did a limited review of the study 2014 Economic Contribution of the Poultry Industry to gather information on the economic impact of the poultry industry in Arizona. The study, underlying data, and analysis are available from the US Poultry and Egg Association.

8. A showing of good cause why the rulemaking is necessary to promote a statewide interest if the rulemaking will diminish a previous grant of authority of a political subdivision of this state:

Not applicable

9. A summary of the economic, small business, and consumer impact:

Refer to A.R.S. § 41-1055(D)(1)

10. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules. When applicable, matters shall include but are not limited to:

The Department received permission to conduct rulemaking from the Governor's Office in compliance with Executive Order 2015-01. Pursuant to A.R.S. § 3-104(F), the ADA Advisory Council approved this rulemaking. The Director of the Arizona Department of Agriculture is statutorily obligated to protect the poultry industry from contagious and infectious diseases. A.R.S. § 3-1203(A). This rulemaking is necessary to implement the Director's statutory obligations and to protect the public health and safety.

a. Whether the rule requires a permit, whether a general permit is used and if not, the reasons why a general permit is not used:

Not applicable. R3-2-607 allows a person to obtain a permit number from the Department. To obtain a Department permit number covers a class of activities that are substantially similar in nature. Obtaining a Department permit number requires less information than traditional permits and does not require a public hearing. A more general permitting system would not be technically feasible or meet the statutory requirements of protecting the livestock and poultry industry from disease.

b. Whether a federal law is applicable to the subject of the rule, whether the rule is more stringent than federal law and if so, citation to the statutory authority to exceed the requirements of federal law:

There is no federal law applicable to the subject of this rule. There is federal guidance applicable to movement of poultry out of federal quarantine zones, but state law governs importation into Arizona.

c. Whether a person submitted an analysis to the agency that compares the rule's impact of the competitiveness of business in this state to the impact on business in other states:

No

11. A list of any incorporated by reference material as specified in A.R.S. § 41-1028 and its location in the rule:

None

12. An agency explanation about the situation justifying the rulemaking as an emergency rule:

As stated above total of 210 commercial and 21 backyard operations have been infected with HPAI. About 7.5 million turkeys and 42.1 million chickens have been depopulated due to HPAI outbreaks. If Arizona were to experience a large HPAI outbreak the damage to affected business and the state economy could be substantial. The Department believes the spread of this contagious disease to be an emergency situation threatening the state and its welfare. This situation was not created due to the agency's delay or inaction nor can it be averted by timely compli-



ance with notice and public participation in the rulemaking. As indicated above infected animals can easily enter the state. Delaying this rulemaking could result in the introduction of the disease into Arizona during the notice and comment period. A.R.S. § 41-1026(A)(1) allows for emergency rulemakings necessary to protect public health, safety, or welfare. This rulemaking is needed to protect the state welfare from the cost of an HPAI outbreak.

13. The date the Attorney General approved the rule:
June 21, 2016

14. The full text of the rule follows:

TITLE 3. AGRICULTURE

**CHAPTER 2. DEPARTMENT OF AGRICULTURE
ANIMAL SERVICES DIVISION**

ARTICLE 4. ANIMAL DISEASE PREVENTION AND CONTROL

Section
R3-2-405. Depopulation of Animals Infected with a Foreign Disease

ARTICLE 6. HEALTH REQUIREMENTS GOVERNING ADMISSION OF ANIMALS

Section
R3-2-601. Definitions
R3-2-602. Importation Requirements
R3-2-603. Importation of Diseased Animals
R3-2-605. Quarantine for Animals Entering Illegally
R3-2-606. Health Certificate
R3-2-608. Consignment of Animals
R3-2-609. Diversion; Prohibitions
R3-2-610. Tests; Official Confirmation
R3-2-611. Transporter Duties
R3-2-617. ~~Poultry Repealed~~
R3-2-618. ~~Psittacine Birds Repealed~~

ARTICLE 4. ANIMAL DISEASE PREVENTION AND CONTROL

R3-2-405. Depopulation of Animals Infected with a Foreign Disease
When ~~any a foreign~~ animal disease identified in R3-2-402(1) and (2) is diagnosed, the State Veterinarian ~~shall~~ MAY order the owner to immediately depopulate and dispose of all infected and exposed animals and poultry on the premises if necessary to prevent the spread of the disease among animals and poultry.

ARTICLE 6. HEALTH REQUIREMENTS GOVERNING ADMISSION OF ANIMALS

R3-2-601. Definitions
The following terms apply to this Article:
“Animal” means livestock, feral swine, ~~rattie~~, bison, water buffalo, oxen, llama, and any exotic mammal not regulated as restricted live wildlife by the Arizona Game and Fish Department.
“Certified copy” means a copy of an official health certificate that includes an additional original signature from the authorizing veterinarian.
“HPAI” means highly pathogenic avian influenza.
“Macaque” means any monkey of the genus *Macaca* in the family *Ceropithecidae*.
“Official eartag” means an identification tag providing unique identification for individual animals. An official eartag that contains or displays an AIN with an 840 prefix must bear the US shield. The design, size, shape, color, and other characteristics of the official eartag will depend on the needs of the users, subject to the approval of the USDA. The official eartag must be tamper-resistant and have a high retention rate in the animals. Official eartags must adhere to one of the following number systems:
National Uniform Eartagging System,
Animal identification number (AIN),



Premises-based number system. The premises-based number system combines an official premises identification number (PIN) with a producer's livestock production numbering system to provide a unique identification number. The PIN and the production number must both appear on the official tag, or

Any other numbering system approved by the Administrator of APHIS for the identification of animals in commerce.

"Poultry" means any bird, whether live or dead, including but not limited to chickens, turkeys, ducks, geese, guineas, ratites, squabs, and any exotic birds not regulated as restricted live wildlife by the Arizona Game and Fish Department. The definition of "poultry" also includes hatching eggs, which are fertilized eggs produced by breeding poultry.

"Specifically approved stockyard" means a stockyard specifically approved by VS and the State Veterinarian for receiving from other states cattle and bison that are not brucellosis-reactor, brucellosis-suspect, or brucellosis-exposed.

R3-2-602. Importation Requirements

- A.** All animals or poultry transported or moved into the state of Arizona, unless otherwise specifically provided for in this Article, must be accompanied by:
1. An official health certificate from the state of origin or a permit number, or both; and
 2. The health documentation shall be attached to the waybill or in the possession of the driver of the vehicle or person in charge of the animals or poultry.
- B.** All poultry transported or moved into the state of Arizona must be accompanied by an official health certificate from the state of origin or a form 9-3 from the National Poultry Improvement Program.
- B.C.** When a single health certificate and permit number is issued for animals or poultry being moved in more than one vehicle, the driver of each vehicle shall retain the original or a certified copy of the health certificate and permit number.

R3-2-603. Importation of Diseased Animals

- A.** An animal affected with or recently exposed to any infectious, contagious, or communicable disease, or which originates in a state or federal quarantine area, shall not be transported or moved into the state of Arizona unless a permit for the entry is first obtained from the Arizona State Veterinarian's Office. All conditions for the movement of animals from a quarantined area established by the quarantining authority or APHIS shall be met.
- B.** Poultry shall not be transported or moved into the State of Arizona if it has been infected with or recently exposed to HPAI or it originates from one of the following:
1. A county where a wild bird tested positive for HPAI within the previous 60 days;
 2. A county, or a county contiguous to a county, with a state or federally established HPAI quarantine area;
 3. A county, or a county contiguous to a county, where all state or federal established HPAI quarantine areas have not been lifted for at least 30 days prior to shipment;
- B.C.** The owner or owner's agent shall obtain prior permission from the State Veterinarian to ship or move into Arizona any animal from a lot or herd from which an animal shows a suspicious or positive reaction to a test required for admission to Arizona.

R3-2-605. Quarantine for Animals Entering Illegally

- A.** Animals or poultry entering the state without a valid health certificate or permit number, or both if required, or in violation of any Section under 3 A.A.C. 2, shall be held in quarantine at the risk and expense of the owner until released by an authorized representative of the State Veterinarian. Animals under quarantine for noncompliance with this Article may be released only after the State Veterinarian is satisfied by testing, dipping, or observation over time, that the animals are not a threat to the livestock ~~industry~~ or poultry industries.
- B.** The State Veterinarian may request that an imported animal failing to meet entry requirements be returned to the state of origin, consigned directly to slaughter, confined to a designated feedlot, or consigned to a feedlot in another state within two weeks of the request. Any extension to this time-frame shall be approved in writing by the State Veterinarian.
- C.** If the owner or owner's agent fails to comply with a request to return an animal to the state of origin within the time-frame required in subsection (B), the Department shall require that the animal be immediately gathered at the owner's risk and expense to avoid exposure of Arizona animals. The owner shall pay the expenses no later than five days after receipt of the bill, or an auction of sufficient livestock to pay the just expenses shall be held within 10 days at a livestock auction market. If additional expenses occur due to lack of cooperation by the owner or the owner's agent, the Director shall order the further sale of livestock.
- D.** The State Veterinarian may request that imported poultry failing to meet entry requirements be returned to the state of origin, euthanized and disposed of at the owner's risk and expense, or held at a location specified by the State Veterinarian. If the owner or owner's agent fails to comply with a request by the time-frame stated in the request, the Department shall require that the poultry be immediately gathered at the owner's risk and expense to avoid exposure of Arizona poultry. The owner shall pay the expenses no later than five days after receipt of the bill. If additional expenses occur due to lack of cooperation by the owner or the owner's agent, the Director shall order the further sale of poultry.

R3-2-606. Health Certificate

- A.** A health certificate is valid for not more than 30 days after the date of issue, except where otherwise noted in this Article, and shall contain:
1. The name and address of the shipper and receiver;
 2. The origin of the animal;
 3. The animal's final destination;



- 4. Cattle.
 - a. The number of animals covered by the health certificate, an accurate description and, except for steers, spayed heifers, or "F" branded heifers consigned to a designated feedlot identified by brand, one of the following individual identifications:
 - i. The official eartag number that, for dairy cattle, identifies the herd of birth, or
 - ii. The registration tattoo number and the registration brand of a breed association recognized by VS.
 - b. The health status of the animals, including date and result of an inspection, dipping, test, or vaccination required by Arizona;
 - c. The method of transportation; and
 - d. For bulls subject to testing under R3-2-612(J), a statement that the bulls:
 - i. Tested negative for *Tritrichomonas foetus* within one month prior to shipment using a polymerase chain reaction test or three cultures collected at intervals of no less than seven days apart; and
 - ii. Have had no breeding activity during the interval between the collection of the samples and the date of shipment.
- 5. Swine.
 - a. Evidence that the swine have been inspected by the veterinarian issuing the health certificate within 10 days before the shipment,
 - b. A statement that:
 - i. The swine have never been fed garbage, and
 - ii. The swine have not been vaccinated for pseudorabies;
 - c. Except for feeder swine consigned to a restricted swine feedlot:
 - i. A list of the individual permanent identification for each exhibition swine, using an ear notch that conforms to the universal swine-ear notch system or for each commercial swine, using other individual identification, and the premises identification using a tattoo or producer-furnished tamper-proof eartag that conforms to the USDA National Premises Identification System;
 - ii. The validated brucellosis-free herd number and last test date for swine originating from a validated brucellosis-free herd;
 - iii. The pseudorabies status of the state of origin; and
 - iv. The pseudorabies qualified negative herd number, if applicable;
 - d. Except for feeder swine consigned to a restricted swine feedlot, swine moving directly to an exhibition, and swine from a farm of origin in a state recognized by APHIS as a pseudorabies Stage V state, a statement that the swine shall be quarantined on arrival at destination and kept separate and apart from all other swine until tested negative for pseudorabies no sooner than 15 days nor later than 30 days after entry into Arizona; and
 - e. Feeder swine consigned to a restricted swine feedlot shall be identified by premises of origin using a tattoo or producer-furnished tamper-proof eartag that conforms to the USDA National Premises Identification System;
- 6. Sheep and goats.
 - a. Individual identification prescribed in R3-2-614;
 - b. A statement that:
 - i. The sheep or goats are not infected with bluetongue, or exposed to scrapie, and do not originate from a scrapie-infected or source flock;
 - ii. Breeding rams have been individually examined and are free of gross lesions of ram epididymitis; and
 - c. A statement that the sheep or goat test negative for *Brucella ovis* if a test is required by R3-2-614(B); and
- 7. Equine.
 - a. An accurate identification for each equine covered by the health certificate including age, sex, breed, color, name, brand, tattoo, scars, and distinctive markings; and
 - b. A statement that the equine has a negative test for EIA, as required in R3-2-615, including:
 - i. The date and results of the test;
 - ii. The name of the testing laboratory; and
 - iii. The laboratory accession number.

B. A health certificate or a form 9-3 for poultry is valid for not more than 15 days after the date of issue.

~~**B-C.**~~ Additions, deletions, and unauthorized or uncertified changes inserted or applied to a health certificate renders the certificate void. Uncertified photocopies of health certificates are invalid.

~~**C-D.**~~ The veterinarian issuing a health certificate shall certify that the animals or poultry shown on the health certificate are free from evidence of any infectious, contagious, or communicable disease or known exposure.

~~**D-E.**~~ An accredited veterinarian shall inspect animals or poultry for entry into the state.

~~**E-F.**~~ The Director may limit the period for which a health certificate is valid to less than 15 days for poultry and less than 30 days for other animals if advised by the State Veterinarian of the occurrence of a disease that constitutes a threat to the livestock ~~industry~~ or poultry industries.

R3-2-608. Consignment of Animals

The owner, or owner's agent, of an animal or poultry transported or moved into Arizona, except an exhibition or show animal, shall consign the animal or poultry to or place it in the care of an Arizona resident or an entity authorized to do business



in Arizona.

R3-2-609. Diversion; Prohibitions

A person consigning, transporting, or receiving an animal or poultry into the state of Arizona shall not authorize, order, or carry out diversion of the animal or poultry to a destination or consignee other than as set forth on the health certificate and permit, if required, without first obtaining permission from the State Veterinarian.

R3-2-610. Tests; Official Confirmation

A state or federal animal diagnostic laboratory or APHIS-approved laboratory shall perform or confirm any animal or poultry testing required by a state or federal authority as a condition for entry into Arizona.

R3-2-611. Transporter Duties

- A. All owners and operators of railroads, trucks, airplanes, or other conveyances transporting animals or poultry into or through the state shall possess a valid health certificate under R3-2-606, and a permit number issued by the State Veterinarian, if required by R3-2-607. These documents shall be attached to the waybill, or be in the possession of the vehicle driver, or person in charge of the animals or poultry. When a single health certificate or permit number is issued for animals or poultry being moved in more than one vehicle, the driver of each vehicle shall possess the original or a certified copy of the health certificate containing the permit number, if required.
- B. The owner of a railroad car, truck, airplane, or other conveyance used to transport animals or poultry into or through the state shall maintain the conveyance in a clean and sanitary condition.
- C. The owners and operators of railroads, trucks, airplanes, or other conveyances who transport animals or poultry into the state in violation of this Section shall clean and disinfect the conveyance in which the animals or poultry were illegally brought into the state before using the conveyance for transporting more animals or poultry. The cleaning and disinfection shall be performed under the supervision of an authorized representative of the State Veterinarian or the USDA.
- D. The owners and operators of railroads, trucks, airplanes, or other conveyances shall follow the USDA requirements, Department and Arizona Commerce Commission rules, and Arizona statutes in the humane transport of animals or poultry into, within, or through the state.

R3-2-617. Poultry Repealed

~~The Department has no entry requirements on poultry provided the poultry appear healthy, do not originate from a poultry quarantine area, comply with all interstate requirements of APHIS, and are accompanied by a health certificate or Form 9-3 from the National Poultry Improvement Program.~~

R3-2-618. Psittacine Birds Repealed

- ~~A. The owner or the owner's agent of a psittacine bird entering Arizona shall obtain a health certificate issued by a veterinarian within 30 days of entry, certifying:
 - 1. The bird is not infected with the agent that causes avian chlamydiosis, and
 - 2. The bird was not exposed to birds known to be infected with avian chlamydiosis within the past 30 days.~~
- ~~B. The health certificate shall accompany the psittacine bird at the time of entry into Arizona.~~



GOVERNOR EXECUTIVE ORDERS

The Administrative Procedure Act (APA) requires the full-text publication of Governor Executive Orders.

With the exception of egregious errors, content (including spelling, grammar, and punctuation) of these orders has been reproduced as submitted.

In addition, the Register shall include each statement filed by the Governor in granting a commutation, pardon or reprieve, or stay or suspension of execution where a sentence of death is imposed.

EXECUTIVE ORDER 2016-03

Internal Review of Administrative Rules; Moratorium to Promote Job Creation and Customer-Service-Oriented Agencies

Editor's Note: This Executive Order is being reproduced in each issue of the Administrative Register until its expiration on December 31, 2016, as a notice to the public regarding state agencies' rulemaking activities.

[M16-29]

WHEREAS, Arizona is poised to lead the nation in job growth;

WHEREAS, burdensome regulations inhibit job growth and economic development;

WHEREAS, small businesses and startups are especially hurt by regulations;

WHEREAS, each agency of the State of Arizona should promote customer-service-oriented principles for the people that it serves;

WHEREAS, each State agency should undertake a critical and comprehensive review of its administrative rules and take action to reduce the regulatory burden, administrative delay, and legal uncertainty associated with government regulation;

WHEREAS, overly burdensome, antiquated, contradictory, redundant, and nonessential regulations should be repealed;

WHEREAS, Article 5, Section 4 of the Arizona Constitution and Title 41, Chapter 1, Article 1 of the Arizona Revised Statutes vests the executive power of the State of Arizona in the Governor;

NOW, THEREFORE, I, Douglas A. Ducey, by virtue of the authority vested in me by the Constitution and laws of the State of Arizona hereby declare the following:

- 1. A State agency subject to this Order, shall not conduct any rulemaking except as permitted by this Order.
2. A State agency subject to this Order, shall not conduct any rulemaking, whether informal or formal, without the prior written approval of the Office of the Governor. In seeking approval, a State agency shall address one or more of the following as justification for the rulemaking:
a. To fulfill an objective related to job creation, economic development, or economic expansion in this State.
b. To reduce or ameliorate a regulatory burden while achieving the same regulatory objective.
c. To prevent a significant threat to the public health, peace, or safety.
d. To avoid violating a court order or federal law that would result in sanctions by a court or the federal government against an agency for failure to conduct the rulemaking action.
e. To comply with a federal statutory or regulatory requirement if such compliance is related to a condition for the receipt of federal funds or participation in any federal program.
f. To comply with a state statutory requirement.
g. To fulfill an obligation related to fees or any other action necessary to implement the State budget that is certified by the Governor's Office of Strategic Planning and Budgeting.
h. To promulgate a rule or other item that is exempt from Title 41, Chapter 6, Arizona Revised Statutes, pursuant to section 41-1005, Arizona Revised Statutes.
i. To address matters pertaining to the control, mitigation, or eradication of waste, fraud, or abuse within an agency or wasteful, fraudulent, or abusive activities perpetrated against an agency.
j. To eliminates rules that are antiquated, redundant or otherwise no longer necessary for the operation of state government.
3. For the purposes of this Order, the term "State agencies," includes without limitation, all executive departments, agencies, offices, and all state boards and commissions, except for: (a) any State agency that is headed by a single elected State official, (b) the Corporation Commission and (c) any board or commission established by ballot measure during or after the November 1998 general election. Those State agencies, boards and commissions excluded



from this Order are strongly encouraged to voluntarily comply with this Order in the context of their own rulemaking processes.

4. This Order does not confer any legal rights upon any persons and shall not be used as a basis for legal challenges to rules, approvals, permits, licenses or other actions or to any inaction of a State agency. For the purposes of this Order, “person,” “rule,” and “rulemaking” have the same meanings prescribed in Arizona Revised Statutes Section 41-1001.
5. This Executive Order expires on December 31, 2016.

IN WITNESS WHEREOF, I have hereunto set my hand and caused to be affixed the Great Seal of the State of Arizona.

Douglas A. Ducey
GOVERNOR

DONE at the Capitol in Phoenix on this Eighth day of February in the Year Two Thousand and Fifteen and of the Independence of the United States of America the Two Hundred and Thirty-Fourth.

ATTEST:

Michele Reagan
Secretary of State



GOVERNOR PROCLAMATIONS

The Administrative Procedure Act (APA) requires the publication of Governor proclamations of general applicability, and ceremonial dedications issued by the Governor.

ARACHNOIDITIS AWARENESS MONTH

[M16-187]

WHEREAS, arachnoiditis is a debilitating, progressive, multi-symptom, neurological disease that simultaneously involves the central nervous system affecting a range up to 51 percent of pain patients with injurious events; and

WHEREAS, arachnoiditis attacks the function of the spinal cord, the afferent and efferent nerve pathways, and the pia-arachnoid sheath causing inflammation; and

WHEREAS, this progression of disease processes leads to a host of secondary symptoms indicative of severe injury to the central nervous system; and

WHEREAS, arachnoiditis knows no age limit, and if left unrecognized, untreated, or mistreated, leads to a variety of symptoms that may result in devastating consequences which can impair the person’s ability to function independently to meet their activities of daily living, employment, and lead to total disability; and

WHEREAS, prevention of this injury is paramount, and early diagnosis and intervention is crucial, and correct treatment by a qualified medical professional can lead to positive results before arachnoiditis progresses and treatment becomes increasingly difficult; and

NOW, THEREFORE, I, Douglas A. Ducey, Governor of the State of Arizona, do hereby proclaim July 2016 as

ARACHNOIDITIS AWARENESS MONTH

IN WITNESS WHEREOF, I have hereunto set my hand and caused to be affixed the Great Seal of the State of Arizona

Douglas A. Ducey
GOVERNOR

DONE at the Capitol in Phoenix on this twenty-sixth day of May in the year Two Thousand and Sixteen and of the Independence of the United States of America the Two Hundred and Fortieth.

ATTEST:
Michele Reagan
SECRETARY OF STATE

ARIZONA GEAR UP WEEK

[M16-178]

WHEREAS, Arizona is dedicated to helping every student graduate from high school prepared to succeed in college and the workforce; and

WHEREAS, the Gaining Early Awareness and Readiness for Undergraduate Programs (GEAR UP) is a federally-funded college access program designed to increase the number of high school graduates prepared for college and careers; and

WHEREAS, GEAR UP focuses on students from underserved communities who might be the first person in their family to enter and succeed in postsecondary education; and

WHEREAS, Arizona’s GEAR UP schools have high expectations for all students and provide varied and proven strategies for increasing high school graduation and college and career readiness in Arizona; and

WHEREAS, Arizona GEAR UP 2012 - 2019 will continue the successful GEAR UP cohort model implemented over the past decade and includes the Middle Grade Initiative which will significantly improve the college and career readiness of the state’s middle school students; and

WHEREAS, thousands of Arizona’s students have succeeded in achieving the dream of going to college as a result of 13 six-year GEAR UP grants awarded in Arizona since 1999 – three state grants and ten partnership grants.

NOW, THEREFORE, I, Douglas A. Ducey, Governor of the State of Arizona, do hereby proclaim September 19 – 23, 2016 as

ARIZONA GEAR UP WEEK



IN WITNESS WHEREOF, I have hereunto set my hand and caused to be affixed the Great Seal of the State of Arizona

Douglas A. Ducey
GOVERNOR

DONE at the Capitol in Phoenix on this sixteenth day of June in the year Two Thousand and Sixteen and of the Independence of the United States of America the Two Hundred and Fortieth.

ATTEST:
Michele Reagan
SECRETARY OF STATE

MUSCULAR DYSTROPHY AWARENESS MONTH

[M16-180]

WHEREAS, muscular dystrophy is not a single disease or disorder that effects everyone the same way but an umbrella term covering more than 52 different types of muscular and neuromuscular diseases ranging in severity; and

WHEREAS, all muscular dystrophies result in progressive muscle weakness, from mild muscle weakness to complete paralysis of all voluntary muscles, including those used for breathing and/or swallowing; and

WHEREAS, muscular dystrophy strikes people regardless of race, sex, age or ethnicity; and

WHEREAS, raising public awareness of these diseases will continue to facilitate the discovery of treatments and cures, as well as bring much needed funding for support and services for families in the State of Arizona affected by muscular dystrophy and neuromuscular diseases; and

WHEREAS, Muscular Dystrophy Awareness Month and “Light it Up Green for MD” Month is a special opportunity to educate the public about muscular dystrophy and issues in the muscular dystrophy community.

NOW, THEREFORE, I, Douglas A. Ducey, Governor of the State of Arizona, do hereby proclaim August 2016 as

MUSCULAR DYSTROPHY AWARENESS MONTH

IN WITNESS WHEREOF, I have hereunto set my hand and caused to be affixed the Great Seal of the State of Arizona

Douglas A. Ducey
GOVERNOR

DONE at the Capitol in Phoenix on this sixteenth day of June in the year Two Thousand and Sixteen and of the Independence of the United States of America the Two Hundred and Fortieth.

ATTEST:
Michele Reagan
SECRETARY OF STATE

REGISTER INDEXES

The *Register* is published by volume in a calendar year (See “Information” in the front of each issue for a more detailed explanation).

Abbreviations for rulemaking activity in this Index include:

PROPOSED RULEMAKING

PN = Proposed new Section
PM = Proposed amended Section
PR = Proposed repealed Section
P# = Proposed renumbered Section

SUPPLEMENTAL PROPOSED RULEMAKING

SPN = Supplemental proposed new Section
SPM = Supplemental proposed amended Section
SPR = Supplemental proposed repealed Section
SP# = Supplemental proposed renumbered Section

FINAL RULEMAKING

FN = Final new Section
FM = Final amended Section
FR = Final repealed Section
F# = Final renumbered Section

SUMMARY RULEMAKING**PROPOSED SUMMARY**

PSMN = Proposed Summary new Section
PSMM = Proposed Summary amended Section
PSMR = Proposed Summary repealed Section
PSM# = Proposed Summary renumbered Section

FINAL SUMMARY

FSMN = Final Summary new Section
FSMM = Final Summary amended Section
FSMR = Final Summary repealed Section
FSM# = Final Summary renumbered Section

EXPEDITED RULEMAKING**PROPOSED EXPEDITED**

PEN = Proposed Expedited new Section
PEM = Proposed Expedited amended Section
PER = Proposed Expedited repealed Section
PE# = Proposed Expedited renumbered Section

SUPPLEMENTAL EXPEDITED

SPEN = Supplemental Proposed Expedited new Section
SPEM = Supplemental Proposed Expedited amended Section
SPER = Supplemental Proposed Expedited repealed Section
SPE# = Supplemental Proposed Expedited renumbered Section

FINAL EXPEDITED

FEN = Final Expedited new Section
FEM = Final Expedited amended Section
FER = Final Expedited repealed Section
FE# = Final Expedited renumbered Section

EXEMPT RULEMAKING**EXEMPT PROPOSED**

PXN = Proposed Exempt new Section
PXM = Proposed Exempt amended Section
PXR = Proposed Exempt repealed Section
PX# = Proposed Exempt renumbered Section

EXEMPT SUPPLEMENTAL PROPOSED

SPXN = Supplemental Proposed Exempt new Section
SPXR = Supplemental Proposed Exempt repealed Section
SPXM = Supplemental Proposed Exempt amended Section
SPX# = Supplemental Proposed Exempt renumbered Section

FINAL EXEMPT RULMAKING

FXN = Final Exempt new Section
FXM = Final Exempt amended Section
FXR = Final Exempt repealed Section
FX# = Final Exempt renumbered Section

EMERGENCY RULEMAKING

EN = Emergency new Section
EM = Emergency amended Section
ER = Emergency repealed Section
E# = Emergency renumbered Section
EEXP = Emergency expired

RECODIFICATION OF RULES

RC = Recodified

REJECTION OF RULES

RJ = Rejected by the Attorney General

TERMINATION OF RULES

TN = Terminated proposed new Sections
TM = Terminated proposed amended Section
TR = Terminated proposed repealed Section
T# = Terminated proposed renumbered Section

RULE EXPIRATIONS

EXP = Rules have expired

See also “emergency expired” under emergency rulemaking

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C = Corrections to Published Rules

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R9-15-313.	FXR-851	R4-21-102.	FM-328	R4-39-302.	FM-921
R9-15-314.	FXR-851	R4-21-103.	FM-328	R4-39-303.	FM-921
R9-15-315.	FXR-851	R4-21-201.	FM-328	R4-39-304.	FM-921
R9-15-316.	FXR-851	R4-21-202.	FM-328	R4-39-305.	FM-921
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2016 RULES EFFECTIVE DATES CALENDAR

A.R.S. § 41-1032(A), as amended by Laws 2002, Ch. 334, § 8 (effective August 22, 2002), states that a rule generally becomes effective 60 days after the day it is filed with the Secretary of State's Office. The following table lists filing dates and effective dates for rules that follow this provision. Please also check the rulemaking Preamble for effective dates.

January		February		March		April		May		June	
Date Filed	Effective Date										
1/1	3/1	2/1	4/1	3/1	4/30	4/1	5/31	5/1	6/30	6/1	7/31
1/2	3/2	2/2	4/2	3/2	5/1	4/2	6/1	5/2	7/1	6/2	8/1
1/3	3/3	2/3	4/3	3/3	5/2	4/3	6/2	5/3	7/2	6/3	8/2
1/4	3/4	2/4	4/4	3/4	5/3	4/4	6/3	5/4	7/3	6/4	8/3
1/5	3/5	2/5	4/5	3/5	5/4	4/5	6/4	5/5	7/4	6/5	8/4
1/6	3/6	2/6	4/6	3/6	5/5	4/6	6/5	5/6	7/5	6/6	8/5
1/7	3/7	2/7	4/7	3/7	5/6	4/7	6/6	5/7	7/6	6/7	8/6
1/8	3/8	2/8	4/8	3/8	5/7	4/8	6/7	5/8	7/7	6/8	8/7
1/9	3/9	2/9	4/9	3/9	5/8	4/9	6/8	5/9	7/8	6/9	8/8
1/10	3/10	2/10	4/10	3/10	5/9	4/10	6/9	5/10	7/9	6/10	8/9
1/11	3/11	2/11	4/11	3/11	5/10	4/11	6/10	5/11	7/10	6/11	8/10
1/12	3/12	2/12	4/12	3/12	5/11	4/12	6/11	5/12	7/11	6/12	8/11
1/13	3/13	2/13	4/13	3/13	5/12	4/13	6/12	5/13	7/12	6/13	8/12
1/14	3/14	2/14	4/14	3/14	5/13	4/14	6/13	5/14	7/13	6/14	8/13
1/15	3/15	2/15	4/15	3/15	5/14	4/15	6/14	5/15	7/14	6/15	8/14
1/16	3/16	2/16	4/16	3/16	5/15	4/16	6/15	5/16	7/15	6/16	8/15
1/17	3/17	2/17	4/17	3/17	5/16	4/17	6/16	5/17	7/16	6/17	8/16
1/18	3/18	2/18	4/18	3/18	5/17	4/18	6/17	5/18	7/17	6/18	8/17
1/19	3/19	2/19	4/19	3/19	5/18	4/19	6/18	5/19	7/18	6/19	8/18
1/20	3/20	2/20	4/20	3/20	5/19	4/20	6/19	5/20	7/19	6/20	8/19
1/21	3/21	2/21	4/21	3/21	5/20	4/21	6/20	5/21	7/20	6/21	8/20
1/22	3/22	2/22	4/22	3/22	5/21	4/22	6/21	5/22	7/21	6/22	8/21
1/23	3/23	2/23	4/23	3/23	5/22	4/23	6/22	5/23	7/22	6/23	8/22
1/24	3/24	2/24	4/24	3/24	5/23	4/24	6/23	5/24	7/23	6/24	8/23
1/25	3/25	2/25	4/25	3/25	5/24	4/25	6/24	5/25	7/24	6/25	8/24
1/26	3/26	2/26	4/26	3/26	5/25	4/26	6/25	5/26	7/25	6/26	8/25
1/27	3/27	2/27	4/27	3/27	5/26	4/27	6/26	5/27	7/26	6/27	8/26
1/28	3/28	2/28	4/28	3/28	5/27	4/28	6/27	5/28	7/27	6/28	8/27
1/29	3/29	2/29	4/29	3/29	5/28	4/29	6/28	5/29	7/28	6/29	8/28
1/30	3/30			3/30	5/29	4/30	6/29	5/30	7/29	6/30	8/29
1/31	3/31			3/31	5/30			5/31	7/30		



July		August		September		October		November		December	
Date Filed	Effective Date										
7/1	8/30	8/1	9/30	9/1	10/31	10/1	11/30	11/1	12/31	12/1	1/30/13
7/2	8/31	8/2	10/1	9/2	11/1	10/2	12/1	11/2	1/1/13	12/2	1/31/13
7/3	9/1	8/3	10/2	9/3	11/2	10/3	12/2	11/3	1/2/13	12/3	2/1/13
7/4	9/2	8/4	10/3	9/4	11/3	10/4	12/3	11/4	1/3/13	12/4	2/2/13
7/5	9/3	8/5	10/4	9/5	11/4	10/5	12/4	11/5	1/4/13	12/5	2/3/13
7/6	9/4	8/6	10/5	9/6	11/5	10/6	12/5	11/6	1/5/13	12/6	2/4/13
7/7	9/5	8/7	10/6	9/7	11/6	10/7	12/6	11/7	1/6/13	12/7	2/5/13
7/8	9/6	8/8	10/7	9/8	11/7	10/8	12/7	11/8	1/7/13	12/8	2/6/13
7/9	9/7	8/9	10/8	9/9	11/8	10/9	12/8	11/9	1/8/13	12/9	2/7/13
7/10	9/8	8/10	10/9	9/10	11/9	10/10	12/9	11/10	1/9/13	12/10	2/8/13
7/11	9/9	8/11	10/10	9/11	11/10	10/11	12/10	11/11	1/10/13	12/11	2/9/13
7/12	9/10	8/12	10/11	9/12	11/11	10/12	12/11	11/12	1/11/13	12/12	2/10/13
7/13	9/11	8/13	10/12	9/13	11/12	10/13	12/12	11/13	1/12/13	12/13	2/11/13
7/14	9/12	8/14	10/13	9/14	11/13	10/14	12/13	11/14	1/13/13	12/14	2/12/13
7/15	9/13	8/15	10/14	9/15	11/14	10/15	12/14	11/15	1/14/13	12/15	2/13/13
7/16	9/14	8/16	10/15	9/16	11/15	10/16	12/15	11/16	1/15/13	12/16	2/14/13
7/17	9/15	8/17	10/16	9/17	11/16	10/17	12/16	11/17	1/16/13	12/17	2/15/13
7/18	9/16	8/18	10/17	9/18	11/17	10/18	12/17	11/18	1/17/13	12/18	2/16/13
7/19	9/17	8/19	10/18	9/19	11/18	10/19	12/18	11/19	1/18/13	12/19	2/17/13
7/20	9/18	8/20	10/19	9/20	11/19	10/20	12/19	11/20	1/19/13	12/20	2/18/13
7/21	9/19	8/21	10/20	9/21	11/20	10/21	12/20	11/21	1/20/13	12/21	2/19/13
7/22	9/20	8/22	10/21	9/22	11/21	10/22	12/21	11/22	1/21/13	12/22	2/20/13
7/23	9/21	8/23	10/22	9/23	11/22	10/23	12/22	11/23	1/22/13	12/23	2/21/13
7/24	9/22	8/24	10/23	9/24	11/23	10/24	12/23	11/24	1/23/13	12/24	2/22/13
7/25	9/23	8/25	10/24	9/25	11/24	10/25	12/24	11/25	1/24/13	12/25	2/23/13
7/26	9/24	8/26	10/25	9/26	11/25	10/26	12/25	11/26	1/25/13	12/26	2/24/13
7/27	9/25	8/27	10/26	9/27	11/26	10/27	12/26	11/27	1/26/13	12/27	2/25/13
7/28	9/26	8/28	10/27	9/28	11/27	10/28	12/27	11/28	1/27/13	12/28	2/26/13
7/29	9/27	8/29	10/28	9/29	11/28	10/29	12/28	11/29	1/28/13	12/29	2/27/13
7/30	9/28	8/30	10/29	9/30	11/29	10/30	12/29	11/30	1/29/13	12/30	2/28/13
7/31	9/29	8/31	10/30			10/31	12/30			12/31	3/1/13



REGISTER PUBLISHING DEADLINES

The Secretary of State's Office publishes the Register weekly. There is a three-week turnaround period between a deadline date and the publication date of the Register. The weekly deadline dates and issue dates are shown below. Council meetings and Register deadlines do not correlate. Also listed are the earliest dates on which an oral proceeding can be held on proposed rulemakings or proposed delegation agreements following publication of the notice in the Register.

Table with 3 columns: Deadline Date (paper only) Friday, 5:00 p.m., Register Publication Date, and Oral Proceeding may be scheduled on or after. Rows list dates from January 22, 2016 to August 5, 2016.



GOVERNOR’S REGULATORY REVIEW COUNCIL DEADLINES

The following deadlines apply to all Five-Year-Review Reports and any adopted rule submitted to the Governor’s Regulatory Review Council. Council meetings and Register deadlines do not correlate. We publish these deadlines as a courtesy.

All rules and Five-Year Review Reports are due in the Council office by noon of the deadline date. The Council’s office is located at 100 N. 15th Ave., Suite 402, Phoenix, AZ 85007. For more information, call (602) 542-2058 or visit www.grrc.state.az.us.

GOVERNOR’S REGULATORY REVIEW COUNCIL DEADLINES FOR 2016

DEADLINE TO BE PLACED ON COUNCIL AGENDA	FINAL MATERIALS DUE FROM AGENCIES	DATE OF COUNCIL STUDY SESSION	DATE OF COUNCIL MEETING
November 17, 2015	December 18, 2015	December 29, 2015	January 5, 2016
December 21, 2015	January 15, 2016	January 26, 2016	February 2, 2016
January 19, 2016 (Tuesday)	February 12, 2016	February 23, 2016	March 1, 2016
February 16, 2016 (Tuesday)	March 18, 2016	March 29, 2016	April 5, 2016
March 21, 2016	April 15, 2016	April 26, 2016	May 5, 2016
April 18, 2016	May 20, 2016	June 1, 2016 (Wednesday)	June 7, 2016
May 23, 2016	June 17, 2016	June 28, 2016	July 6, 2016 (Wednesday)
June 20, 2016	July 15, 2016	July 26, 2016	August 2, 2016
July 18, 2016	August 19, 2016	August 30, 2016	September 7, 2016 (Wednesday)
August 22, 2016	September 16, 2016	September 27, 2016	October 4, 2016
September 19, 2016	October 14, 2016	October 25, 2016	November 1, 2016
October 17, 2016	November 18, 2016	November 29, 2016	December 6, 2016
November 21, 2016	December 16, 2016	December 28, 2016 (Wednesday)	January 4, 2017 (Wednesday)

*Materials must be submitted by **noon** on dates listed as a deadline for placement on a particular agenda. Placement on a particular agenda is not guaranteed.