RESERVE

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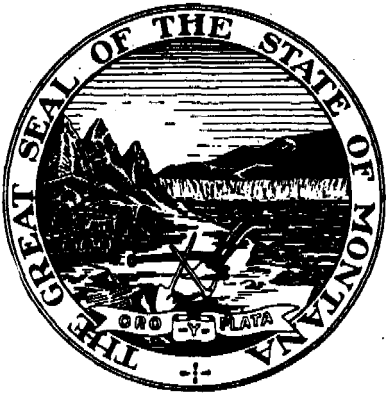

ISSUE NO. 9

The Montana Administrative Register (MAR), a twice-monthly publication, has three sections. The notice section contains state agencies' proposed new, amended or repealed rules, the rationale for the change, date and address of public hearing, and where written comments may be submitted. The rule section indicates that the proposed rule action is adopted and lists any changes made since the proposed stage. The interpretation section contains the attorney general's opinions and state declaratory rulings. Notices and tables are inserted at the back of each register.

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SPECIAL NOTICE AND TABLE SECTION

BEFORE THE BOARD OF HEALTH AND ENVIRONMENTAL SCIENCES
OF THE STATE OF MONTANA

In the matter of the repeal of rule 16.20.241 specifying laboratory fees for analyses of public water supply systems	NOTICE OF PUBLIC HEARING ON REPEAL OF RULE 16.20.241 (Laboratory Fees for Public Water Supply Systems)

To: All Interested Persons

1. On June 15, 1982, at 9:30 a.m. a public hearing will be held in Room C209 of the Cogswell Building, 1400 Broadway, Helena, Montana, to consider the repeal of rule 16.20.241 specifying laboratory fees for analyses of public water supply systems.

2. The rule proposed to be repealed can be found on page 16-910 of the Administrative Rules of Montana.

3. The rule is proposed to be repealed because the Board is proposing a new schedule of fees for analyses of drinking water in this notice.

4. Interested persons may present their data, views, or arguments, either orally or in writing, at the hearing. Written data, views, or arguments may also be submitted to Sandra R. Muckelston, Legal Division, Department of Health and Environmental Sciences, Cogswell Building - Room C216, Helena, MT., 59620, postmarked no later than June 14, 1982.

5. Sandra R. Muckelston, Helena, MT, has been designated to preside over and conduct the hearing.

6. The authority of the Board to repeal the rule is based on section 75-6-103, MCA, and the rule implements section 75-6-103, MCA.

In the matter of the adoption of a rule specifing fees for analyses of drinking water by the department of health and environmental sciences	NOTICE OF PUBLIC HEARING FOR ADOPTION OF A RULE ON FEES FOR ANALYSES OF DRINKING WATER

To: All Interested Persons

1. On June 15, 1982, at 9:30 a.m., public hearing will be held in Room C209 of the Cogswell Building, 1400 Broadway, Helena, Montana, to consider the adoption of a rule specifying fees for analyses of drinking water by the department of health and environmental sciences.

2. The proposed rule will replace rule 16.20.241 found at page 16-910 of the Administrative Rules of Montana.

3. The proposed rule provides as follows:

RULE I LABORATORY FEES -- DRINKING WATER Fees for analysis of drinking water by the department of health and environmental sciences are as follows:

(1) The fee for a standard microbiological (total coliform) analysis is $6.

(2) The fee for a complete inorganic chemical analysis, consisting of an analysis for arsenic, barium, cadmium, chromium, lead, mercury, nitrate, selenium, silver, fluoride, calcium, sodium, pH, and total alkalinity, is $98.

(3) The fee for a nitrate analysis is $10.

(4) The fee for a pesticide-herbicide analysis, consisting of an analysis for endrin, lindane, methoxychlor, toxaphene, 2,4-D, and 2,4,5-TP Silvex, is $232.

(5) The fee for a total trihalomethane analysis is $273.

(6) The fees per analysis to determine the concentration of individual constituents are as follows:

Analysis	Cost per Analysis
Acidity	$ 24.50
Alkalinity	10.50
Aluminum	8.50
Ammonia	10.05
Antimony	44.70
Arsenic	10.50
Barium	8.50
Beryllium	44.70
Biochemical Oxygen Demand (BOD)	55.10
Boron	17.50
Cadmium	3.90
Calcium	4.10
Chloride	11.40
Chromium	3.90
Chromium Hexavalent	74.40
Cobalt	44.70
Chemical Oxygen Demand (COD)	45.30
Color (2 tests - pH adjusted)	46.05
Copper	3.90
Cyanide	212.20
Fluoride	13.65
Iron	3.90
Lead	3.90
Lithium	44.70
Magnesium	4.10
Manganese	3.90
Mercury	7.95
Mercury Digestion	54.75
Metals Concentration (per sample)	2.30
Metals Digestion (except Mercury)	13.65
Molybdenum	44.70

Nickel	44.70
Nitrogen Kjeldahl	23.25
Oil and Grease	31.60
Ortho-Phosphorus	7.10
pH	1.40
Phenols	80.65
Total-Phosphorus	11.80
Potassium	4.10
Selenium	10.50
Silica	44.70
Silver	5.25
Sodium	4.10
Specific Conductance	1.90
Strontium	44.70
Sulfate	10.95
Sulfide	84.65
Tin	44.70
Total Suspended Solids	14.80
Turbidity	4.70
Vanadium	44.70
Zinc	3.90
Pesticides (Lindane, Endrin, Toxaphene, Methoxychlor) - first analysis per sample	75.20
each additional analysis per sample	11.40
Herbicides (2,4-D, Silvex) - first analysis per sample	109.00
each additional analysis per sample	13.65

(7) The fees specified in subsections (1) through (6) of this rule may be lowered by the department of health and environmental sciences when larger batches of samples warrant lower fees.

(8) When a laboratory analysis of drinking water is requested by a physician or dentist licensed pursuant to the laws of Montana or a health officer appointed pursuant to the laws of Montana, the analysis will be performed free of charge by the department of health and environmental sciences.

4. The Board is proposing this rule to establish one fee schedule for analyses of public and private water supplies. The Board is increasing the fees for the nitrate analysis and the complete inorganic chemical analysis in order to recover the costs of the analyses.

5. Interested persons may present their data, views, or arguments, either orally or in writing, at the hearing. Written data, views, or arguments may also be submitted to Sandra R. Muckelston, Legal Division, Department of Health and Environmental Sciences, Cogswell Building - Room C216, Helena, MT, 59620, postmarked no later than June 14, 1982.

6. Sandra R. Muckelston, Helena, MT, has been designated to preside over and conduct the hearing.

7. The authority of the Board to make the proposed rule is based on section 75-6-103, MCA and the rule implements section 75-6-103, MCA.

JOHN F. McGREGOR, M.D., Chairman

By
JOHN J. DRYNAN, M.D., Director
Department of Health and
Environmental Sciences

Certified to the Secretary of State May 3, 1982

BEFORE THE DEPARTMENT
OF PUBLIC SERVICE REGULATION
OF THE STATE OF MONTANA

IN THE MATTER of Proposed Adoption of Interpretive Rules Relative to the Nonregulated Status of "Car Pools."	))))	NOTICE OF PUBLIC HEARING ON PROPOSED ADOPTION OF INTERPRETIVE RULES RELATIVE TO THE NONREGULATED STATUS OF "CAR POOLS"

TO: All Interested Persons

1. June 24, 1982, in the large courtroom in the Federal Building at 316 North 26th Street, Billings, Montana at 7:30 p.m., a hearing will be held to consider the proposed adoption of interpretive rules specifying the position of the Commission concerning treatment of movements of passengers including "car pools" relative to the requirements of Title 69, Chapter 12, MCA, that operations "for hire on a commercial basis" are to be regulated by the Commission.

2. The proposed rules do not replace or modify any section currently found in the Administrative Rules of Montana.

3. The proposed interpretive rules provide as follows:

RULE I. CAR POOLS (1) Movements of persons by motor vehicle upon public highways of this state are regulated by the Public Service Commission and require a certificate of public convenience and necessity if such movements are "for hire on a commercial basis." Section 69-12-101(6), MCA.

(2) It is declared the policy of the Public Service Commission that a "car pool" does not constitute a movement "for hire on a commercial basis" and therefore, does not require a certificate of public convenience and necessity.

AUTH: 69-12-301(3), MCA; IMP. 69-12-101(6), 69-12-311, 69-12-312 and 69-12-313, MCA.

RULE II. MOVEMENTS OF PASSENGERS INVOLVING COMPENSATION (1) It is further declared the policy of the Public Service Commission that payment of compensation by passengers to the driver or owner of a motor vehicle will not in and of itself relegate the status of a movement from that of a "car pool" to that of a movement "for hire on a commercial basis." In determining the appropriate status of such a movement, other factors should be considered, including but not limited to:

(a) number of passengers in the vehicle;

(b) amount of the compensation relative to distance and other circumstances that would affect the cost of the movement;

(c) the route of the movement, particularly as it relates to the ultimate destination of the driver;

(d) the manner in which the passengers and driver or owner were brought together (advertisement, word of mouth, etc.); and

(e) circumstances behind the passenger's desire for the movement.

AUTH: 69-12-301(3), MCA; IMP. 69-12-101(6), 69-12-311, 69-12-312 and 69-12-313, MCA.

RULE III. MOVEMENTS INVOLVING COMPENSATION--NUMBER OF PASSENGERS (1) It is declared the policy of the Public Service Commission that movements of persons by motor vehicle upon public highways wherein compensation is paid to the driver or owner of the vehicle and wherein there are more than six passengers (including the driver) do not constitute a "car pool" but by their very size and nature constitute a movement "for hire on a commercial basis." Such movements will be considered by the Public Service Commission as requiring a certificate of public convenience and necessity. Conduct of such movements without having acquired the proper certificate of authority will be considered a violation of Title 69, Chapter 12, MCA.

(2) Movements of persons by motor vehicle upon public highways wherein compensation is paid to the driver or owner of the vehicle but wherein there are six or fewer passengers (including the driver) will carry no presumption one way or the other as to such movement constituting a "car pool." Rather a determination of "car pool" status versus "for hire on a commercial basis" or regulated status will be made on a case by case basis after consideration of the factors set forth in Rule II as well as any other relevant considerations. Movements involving six or less passengers may be determined to constitute a movement "for hire on a commercial basis" if consideration of factors beyond the number of passengers indicates that such a movement is "commercial" in nature and a regulated status is therefore appropriate.

AUTH: 69-12-301(3), MCA; IMP. 69-12-101(6), 69-12-311, 69-12-312 and 69-12-313, MCA.

4. The Montana Public Service Commission is proposing these interpretive rules to clarify treatment of "car pools" and operations who hold themselves out as "car pools." The Commission is of the opinion that the legislature in establishing the regulatory scheme for motor carriers entailed in Title 69, Chapter 12, MCA, did not intend that legitimate "car pools" should be regulated thereunder. Therefore, the Commission has specifically stated in Rule I that it will not attempt to regulate legitimate "car pools."

By the same token the legislature in enacting Title 69, Chapter 12, MCA, has established that authorized certificated motor carriers of passengers are entitled to protection from other attempts to move passengers by motor vehicle for hire unless there is a showing of additional public convenience and necessity not being met by existing authorized carriers. The problem arises in attempting to differentiate between movements which are legitimate "car pools" and those which are not legitimate "car pools" but commercial in nature.

Because prior attempts to develop a hard fast definition for either "car pool" or "commercial basis" have proven unsatisfactory, determinations have had to have been made on a case by case basis. Rules II and III propose to continue the case by case method of determination with the following

exception.

Because of the extensive investigation and background effort necessary to conduct a thorough case-by-case evaluation, existing certificated carriers have perhaps not been receiving the full extent of protection authorized by the legislature in Title 69, Chapter 12, MCA. Therefore, the Commission has proposed the greater-than-six-passenger standard contained in Rule III. The greater-than-six-passenger level was selected because it is the point at which the vehicle required to make such a movement would be of a type typically used in commercial operations. This is an easily enforced standard that will allow the Commission to quickly identify those situations which are clearly beyond the concept of a legitimate "car pool." This will better protect certificated carriers at least from the most blatant violations of Title 69, Chapter 12, MCA. "Border-line" cases will continue to have to be evaluated on a case by case basis.

5. Interested parties may submit their data, views or arguments concerning the proposed rules at the hearing, or in writing to Calvin Simshaw, Montana Public Service Commission, 1227 11th Avenue, Helena, Montana 59620, no later than June 24, 1982.

6. The Montana Consumer Counsel, 34 West 6th Avenue, Helena, Montana 59620 (Telephone 449-2771), is available and may be contacted to represent consumer interests in this matter.

GORDON E. BOLLINGER, Chairman

CERTIFIED TO THE SECRETARY OF STATE MAY 3, 1982.

BEFORE THE DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES OF THE
STATE OF MONTANA

In the matter of the amendment of Rules 46.12.522, 46.12.523, 46.12.524, 46.12.527, 46.12.532, 46.12.537, 46.12.542, 46.12.547, 46.12.552, 46.12.557, 46.12.567, 46.12.582, 46.12.605, 46.12.805, 46.12.806, 46.12.905, 46.12.915, 46.12.1005, 46.12.1015, 46.12.1025 and 46.12.2003 pertaining to medical services, reimbursement	NOTICE OF PUBLIC HEARING OF THE PROPOSED AMENDMENT OF RULES 46.12.522, 46.12.523, 46.12.524, 46.12.527, 46.12.532, 46.12.537, 46.12.542, 46.12.547, 46.12.552, 46.12.557, 46.12.567, 46.12.582, 46.12.605, 46.12.805, 46.12.806, 46.12.905, 46.12.915, 46.12.1005, 46.12.1015, 46.12.1025 AND 46.12.2003 PERTAINING TO MEDICAL SERVICES

TO: All Interested Persons

1. On June 3, 1982, at 9:30 a.m., a public hearing will be held in the auditorium of the Social and Rehabilitation Services Building, 111 Sanders, Helena, Montana, to consider the amendment of Rules 46.12.522, 46.12.523, 46.12.524, 46.12.527, 46.12.532, 46.12.537, 46.12.542, 46.12.547, 46.12.552, 46.12.557, 46.12.567, 46.12.582, 46.12.605, 46.12.805, 46.12.806, 46.12.905, 46.12.915, 46.12.1005, 46.12.1015, 46.12.1025 and 46.12.2003 pertaining to medical services, reimbursement.

2. The rules proposed to be amended provide as follows:

46.12.522 PODIATRY SERVICES, REIMBURSEMENT/GENERAL REQUIREMENTS AND MODIFIERS (1) The Department will pay the lowest of the following for podiatry services not also covered by medicare: the provider's actual (submitted) charge for the service; ~~the 75th percentile of the range of weighted medicaid median charges for each service covered by this rule;~~ or the department's fee schedule found in Rule 46.12.523.

The Department will pay the lowest of the following for podiatry services which are also covered by medicare: The provider's actual (submitted) charge for the services; ~~the provider's medicaid median charge for the service;~~ the amount allowable for the same service under medicare; or the department's fee schedule found in Rule 46.12.523. Services paid by report (BR) will be paid at 70% of all Montana podiatrist's 1980 usual and customary charges for the specified service.

Subsection (2) remains the same.

The authority of the department to amend the rule is based on Section 53-6-113, MCA and the rule implements Sections 53-6-101 and 53-6-141, MCA.

46.12.523 PODIATRY SERVICES, REIMBURSEMENT/MEDICINE PROCEDURES

(1) OFFICE PODIATRIC MEDICAL SERVICES

New Patient

90000 Brief service - ~~$17.13~~ 18.84

90010 Limited service - ~~$25.67~~ 28.24

90015 Intermediate service - ~~$42.80~~ 47.08

90020 Comprehensive service - ~~$59.94~~ 65.93

Established Patient

90030 Minimal service - ~~$6.85~~ 7.54

90040 Brief service - ~~$10.27~~ 11.30

90050 Limited service - ~~$13.70~~ 15.07

90060 Intermediate service - ~~$17.13~~ 18.84

90070 Extended service - ~~$25.67~~ 28.24

90080 Comprehensive service - ~~$42.80~~ 47.08

(2) HOME PODIATRIC MEDICAL SERVICES

New Patient

90100 Brief service - ~~$25.67~~ 28.24

90110 Limited service - ~~$34.23~~ 37.65

90115 Intermediate service - ~~$42.79~~ 47.07

90117 Extended service - ~~$51.35~~ 56.49

Established Patient

90130 Minimal service - ~~$12.84~~ 14.12

90140 Brief service - ~~$17.12~~ 18.83

90150 Limited service - ~~$25.67~~ 28.24

90160 Intermediate service - ~~$29.95~~ 32.95

90170 Extended service - ~~$34.23~~ 37.65

(3) HOSPITAL PODIATRIC MEDICAL SERVICES

New and Established Patient

Initial Hospital Care

90200 Brief history and examination, initiation of diagnostic and treatment programs, and preparation of hospital records - ~~$25.67~~ 28.24

90215 Intermediate history and examination, initiation of diagnosis and treatment programs, and preparation of hospital records - ~~$37.10~~ 40.81

90220 Comprehensive history and examination, initiation of diagnostic and treatment programs, and preparation of hospital records - ~~$59.92~~ 65.91

Subsequent Hospital Care

90240 Brief service - ~~$10.27~~ 11.30

90250 Limited service - ~~$12.98~~ 14.28

90260 Intermediate service - ~~$25.67~~ 28.24

90270 Extended service - ~~$34.24~~ 37.66

90280 Comprehensive service - ~~$34.24~~ 37.66

(4) SKILLED NURSING, INTERMEDIATE CARE, AND LONG-TERM CARE FACILITIES

New or Established Patient

Initial Care

90300 Brief history and physical examination, initiation of diagnostic and treatment programs, and preparation of hospital records - ~~$25.67~~ 28.24

90315 Intermediate history and physical examination, initiation of diagnostic and treatment programs, and preparation of hospital records - ~~$42.80~~ 47.08

90320 Comprehensive history and physical examination, initiation of diagnostic and treatment programs, and

preparation of hospital records - ~~$59.91~~ 65.90

Subsequent Care

90340 Brief service - ~~$10.27~~ 11.30

90350 Limited service - ~~$17.13~~ 18.84

90360 Intermediate service - ~~$25.67~~ 28.24

90370 Extended service - ~~$34.23~~ 37.65

(5) NURSING HOME, BOARDING HOME, DOMICILIARY, OR CUSTODIAL CARE MEDICAL SERVICES

New Patient

90400 Brief services - ~~$25.67~~ 28.24

90410 Limited service - ~~$34.24~~ 37.66

90415 Intermediate service - ~~$42.80~~ 47.08

90420 Comprehensive service - BR

Established Patient

90430 Minimal service - ~~$12.84~~ 14.12

90440 Brief service - ~~$17.13~~ 18.84

90450 Limited service ~~$25.67~~ 28.24

90460 Intermediate service - ~~$25.67~~ 28.24

90470 Extended service - ~~$34.24~~ 37.66

(6) EMERGENCY DEPARTMENT PODIATRIC MEDICAL SERVICES

New Patient

90500 Minimal service - ~~$6.84~~ 7.52

90505 Brief service - ~~$17.13~~ 18.84

90510 Limited service - ~~$25.67~~ 28.24

90515 Intermediate service - ~~$42.80~~ 47.08

90517 Extended service - ~~$51.35~~ 56.49

Established Patient

90530 Minimal service - ~~$6.84~~ 7.52

90540 Brief service - ~~$10.26~~ 11.29

90550 Limited service - ~~$13.46~~ 14.81

90560 Intermediate service - ~~$17.10~~ 18.81

90570 Extended service - ~~$25.67~~ 28.24

(7) CONSULTATIONS

90600 Limited consultation - ~~$25.67~~ 28.24

90605 Intermediate consultation - ~~$34.24~~ 37.66

90610 Extensive consultation - ~~$37.11~~ 40.82

90620 Comprehensive consultation - ~~$59.92~~ 65.91

90630 Complex consultation ~~$59.92~~ 65.91

Other Procedures

90699 Unlisted medical service, general - BR

(8) IMMUNIZATION INJECTIONS

90720 Immunizations, each (includes supply of materials); tetanus toxoid, - ~~$4.84~~ 5.32

(9) THERAPEUTIC INJECTIONS

90782 Therapeutic injection of medication (specify); subcutaneous or intramuscular - ~~$6.85~~ 7.54

90784 Intravenous - ~~$12.23~~ 13.45

90788 Intramuscular injection of antibiotic (specify) - ~~$6.85~~ 7.54

(10) CARDIOVASCULAR PODIATRIC MEDICAL SERVICES

Podiatric Vascular Studies

93700 Peripheral vascular disease study - BR - not to exceed - ~~$104.00~~ 114.49

93725 Plethysmography, regional - BR - not to exceed - ~~$41.64~~ 45.80

93740 Temperature gradient studies - BR - not to exceed - ~~$29.14~~ 32.05

93762 Thermogram, peripheral - BR

93770 Determination of venous pressure - ~~$8.56~~ 9.42

(11) OTHER PODIATRIC PROCEDURES

93799 Unlisted cardiovascular service or procedure (see guidelines) - BR

(12) MISCELLANEOUS PODIATRIC DIAGNOSTIC SERVICES

95831 Muscle testing, manual, per extremity with report - ~~$13.70~~ 15.07

95842 Muscle testing, electrodiagnosis (reaction of degeneration, chromaximetry, strength duration curve or cathode/tetanus ratio), one extremity, any one method - ~~$20.55~~ 22.61

95843 each additional method - ~~$20.55~~ 22.61

95851 Range of motion measurements and report, each extremity (independent procedure) - ~~$13.70~~ 15.07

95860 Electromyography, one extremity and related paraspinal area - ~~$60.48~~ 75.33

95861 Two extremities and related paraspinal area - ~~$102.71~~ 112.98

95900 Nerve conduction velocity study, motor or sensory, each nerve - ~~$27.38~~ 30.12

95905 Contralateral nerve - ~~$20.54~~ 22.59

95910 Nerve conduction velocity study, motor and sensory, each nerve - ~~$47.92~~ 52.71

95915 Contralateral nerve - ~~$41.07~~ 45.18

95920 Nerve conduction velocity study, additional ipsolateral or contralateral nerve - ~~$27.38~~ 30.12

95930 Achilles reflex response, electrical recording (ART) (For ultrasonsography, see 76500-76999) - ~~$8.56~~ 9.42

95999 Unlisted micellaneous diagnostic service or procedure (see guidelines) - BR

(13) PODIATRIC PHYSICAL MEDICINE, MODALITIES

97000 Office visit with one of the following modalities to one area:

Hot or cold packs - ~~$10.27~~ 11.30
Traction, mechanical - ~~$10.27~~ 11.30
Electrical stimulation (unattended) - ~~$10.27~~ 11.30
Vasopneumatic devices - ~~$10.27~~ 11.30
Paraffin bath - ~~$10.27~~ 11.30
Microwave - ~~$10.27~~ 11.30
Whirlpool - ~~$10.27~~ 11.30
Diathermy - ~~$10.27~~ 11.30
Infrared - ~~$10.27~~ 11.30
Ultraviolet - ~~$10.27~~ 11.30

97050 Office visit with two or more modalities to same area - ~~$11.12~~ 12.23

Procedures

97100 Office visit with one of the following procedures to one area, initial 30 minutes:

Therapeutic exercises - ~~$13.70~~ 15.07
Neuromuscular re-education - ~~$13.70~~ 15.07
Functional activities - ~~$13.70~~ 15.07
Gait training - ~~$13.70~~ 15.07
Electrical stimulation (manual) - ~~$13.70~~ 15.07
Iontophoresis - ~~$13.70~~ 15.07
Traction, manual - ~~$13.70~~ 15.07
Massage - ~~$13.70~~ 15.07
Contrast Baths - ~~$13.70~~ 15.07
Ultrasound - ~~$13.70~~ 15.07

97101 Each additional 15 minutes - ~~$4.28~~ 4.71

97200 Office visit, including combination of any modality(s) and procedure(s), initial 30 minutes - ~~$13.70~~ 15.07

97201 each additional 15 minutes - ~~$4.28~~ 4.71

Test and Measurements

97700 Office visit, including one of the following tests and measurements, with report, initial 30 minutes - ~~$20.55~~ 22.61

Orthotic checkout - ~~$20.55~~ 22.61
Prosthetic checkout - ~~$20.55~~ 22.61

97701 each additional 15 minutes - ~~$10.27~~ 11.30

97720 Extremity testing for strength, dexterity or stamina, initial 30 minutes - ~~$20.54~~ 22.59

97721 each additional 15 minutes - ~~$10.27~~ 11.30

97740 Kinetic activities to increase coordination, strength and/or range of motion, one area (any two extremities or trunk), initial 30 minutes - ~~$20.54~~ 22.59

97741 each additional 15 minutes - ~~$10.27~~ 11.30

97742 Foot imprints and/or outlines. Independent procedure for prescribing for planter foot pads or plates or for evaluating surface contact areas of feet - ~~$12.84~~ 14.12

97743 Foot, ankle and leg measurements, including foot imprints and outlines of feet for prescribing of orthotics, prosthetics or custom-hand made shoes for orthopedic foot deformities - ~~$42.79~~ 47.07

(14) PODIATRIC ORTHOMECHANICAL SERVICES AND PROCEDURES

Ankle-Foot Orthoses

97750 Ankle-foot orthoses, spring wire type with shoe attachment - BR

97754 Ankle-joint orthoses, flexible or static posterior, molded plastic shell with foot plate insert, (specify when cast by orthotist) - BR

97757 Ankle brace without modification, with or without stays (stock item), single - ~~$12.84~~ 14.12

Metal Foot Plates

97758 Shaeffer plate or any other custom made metal plate (custom made to model), single - ~~$42.79~~ 47.07

97759 Shaeffer plate (custom made to model) pair - ~~$85.58~~ 94.14

97766 Mobilization of toe or toe-joint by use of an orthodigital traction device (toe aligning sling) made to plaster model for the correction of hallux valgus, hammer toe, underlapping or overlapping toe, etc., single - ~~$34.23~~ 37.65

97767 same as for 97766 but for pair - ~~$68.46~~ 75.31

Thermoplastic Plates, (Biochemical)

97768 Stabilization and/or mobilization of foot by use of a thermoplastic orthotic (custom made to model and biomechanically), with forefoot post, single - ~~$42.79~~ 47.07

97769 same as for 97768 but for pair - ~~$85.69~~ 94.26

97770 Addition of rearfoot post, single - ~~$8.56~~ 9.42

97771 Addition of rearfoot post, pair - ~~$17.12~~ 18.83

97772 Addition of forefoot post, single - ~~$8.56~~ 9.42

97773 Addition of forefoot post, pair - ~~$17.12~~ 18.83

97774 Stabilization of heel by use of heel stabilizer, made to plaster model, single - ~~$42.79~~ 47.07

97775 same as for 97774 but for a pair - ~~$85.58~~ 94.14

97776 Heel stabilizer, (plastic heel cup), stock item, single - ~~$4.28~~ 4.71

97777 Same as 97776 but for a pair - ~~$8.56~~ 9.42

Shoes

97785 Stabilization and/or mobilization of foot by use of exterior modifications to shoes such as orthopedic heels, comma bars, heel or sole wedges, etc. pair; or buildup for shortage, per shoe - ~~$17.12~~ 18.83

97786 Stabilization and restoration of balance to feet, ankles and superstructure by use of custom built shoes made to models, measurements, imprints and

orthotic fittings and adjustments for shortage of foot and/or leg, pair - BR

Molded Inlay (Balance Inlays)

97795 The stabilization, balance and mobilization of the foot, partial or total by use of a full extension or partial molded inlay made to foot models with an elevation up to 3/4" and with a matching insert as an interior shoe modification. Removable type, (all types of balance inlays, Bergmann, Levy, Grachman, Contur-A-Mold, Molded Latex, etc.) Single with matching insert or a pair - ~~$85.50~~ 94.14

Shoe Modifications, Interior (Shoe paddings, etc.)

97796 The stabilization and removal of pressure from the affected areas of the feet by use and application of accommodative shoe paddings to the interior of the shoe, pair - ~~$17.12~~ 18.83

97797 Stabilization, equilibrium and restoration of balance to the feet and legs by use of an interior modification for the shoe by means of a removable insert formed as a prosthetic for amputation of toe, toes or forefoot. Single with matching insert to balance the normal foot - BR

Splints, Mechanical

97798 Mobilization and/or partial immobilization of joint motions in foot and leg by use of one of the following types of splints attached to shoes and adjusted to shoes and adjusted as indicated for the specific deformity:

Brachman splint - ~~$42.79~~ 47.07
Denis-Browne splint - ~~$42.79~~ 47.07
Filauer splint - ~~$42.79~~ 47.07
Ganley splint - ~~$42.79~~ 47.07
Gottler splint - ~~$42.79~~ 47.07
Friedman splint - ~~$42.79~~ 47.07
Single splint - ~~$42.79~~ 47.07

Splint, Molded

97901 Immobilization, total or partial of foot and/or ankle by use of splints, such as a posterior molded splint, made of plaster, metal or acrylic (plastic) type of material and attached to the foot and leg. Below knee splint, single, independent procedure - BR

97902 Immobilization, total or partial of foot and toes by use of a Plantar Full Extension molded splint, made of either plaster, metal or acrylic forms of material and attached to the foot for other surgical conditions, Single - BR

Cast Impressions and Models

97903 Plaster foot cast, negative impression, of a toe or part of the foot, as an independent procedure for prescribing of an orthotic or prosthetic. Single - ~~$17.12~~ 18.83

97904 Same as 97903 but for a pair - ~~$34.23~~ 37.65

99082 Usual travel (e.g., transportation and escort of patient) - BR

The authority of the department to amend the rule is based on Section 53-6-113, MCA and the rule implements Sections 53-6-101 and 53-6-141, MCA.

46.12.524 PODIATRY SERVICES, REIMBURSEMENT/PODIATRIC SURGERY PROCEDURES

(1) INTEGUMENTARY SYSTEM

(a) Skin, Subcutaneous and Areolar Tissues

Incision

10000 Incision and drainage of infected or noninfected sebaceous cyst, one lesion - ~~$13.12~~ 14.43

10001 Second lesion - ~~$6.56~~ 7.22

10002 over two, each additional lesion - ~~$3.28~~ 3.61

10003 I & D sebaceous cyst & removal of sac - ~~$19.68~~ 21.65

10060 Incision and drainage of abscess, eg, carbuncle, and other cutaneous or subcutaneous abscesses, simple - ~~$13.12~~ 14.43

10061 complicated - BR

10100 Drainage of onychia or paronychia - ~~$13.12~~ 14.43

10101 mulitiple or complicated - BR

10120 Incision and removal of foreign body, subcutaneous tissues, simple - ~~$13.12~~ 14.43

10121 complicated - BR

10140 Drainage of hematoma, simple, subcutaneous or subungual - ~~$13.12~~ 14.43

10141 Complicated - BR

10160 Puncture aspiration of abscess or hematoma or large bulla - ~~$9.85~~ 10.84

Excision-Debridement

11000 Debridement of extensive eczematous or infected skin up to 10% of body surface (eg. Tinea Pedis, eczema, etc.) - ~~$13.12~~ 14.43

11040 Debridement of abrasions, simple - ~~$9.85~~ 10.84

11041 Debridement of abrasion, extensive or complicated - BR

11050 Debridement of keratotic lesions (eg. Keratodermia, intractible plantar keratosis, porokeratosis, clavi, callosities, etc.) one leg (under Anathesia) - ~~$13.12~~ 14.43

11051 Same as in 11050 but 2-4 lesions, one leg - ~~$6.56~~ 7.22

11052 more than 4 lesions, one leg - ~~$6.56~~ 7.22

11100 Biopsy, excision of skin, subcutaneous tissue (including simple closure), unless otherwise listed (independent procedure), one - ~~$19.69~~ 21.66

11101 each additional lesion - ~~$9.85~~ 10.84

Excision-Benign Lesions

11200 Excision, skin tags, multiple fibrotaneous tags, any area up to 15 - ~~$13.12~~ 14.43

11201 each additional ten lesions - ~~$6.56~~ 7.22

11420 Excision, benign lesions unless listed elswhere), feet, lesion diameter up to 0.5 cm - ~~$26.25~~ 28.88

11421 Lesion, diameter 0.5 to 1.0 cm - ~~$32.80~~ 36.08

11422 Lesion, diameter 1.0 to 2.0 cm - ~~$39.38~~ 43.32

11423 Lesion, diameter 2.0 to 3.0 cm - BR

11424 Lesion, diameter 3.0 to 4.0 cm - BR

11426 Lesion, diameter greater than 4.0 cm - BR

11620 Excision, malignant lesions, feet lesion diameter up to 0.5 cm - ~~$64.31~~ 70.74

11621 Lesion, diameter 0.5 to 1.0 cm - ~~$98.44~~ 108.28

11622 Lesion, diameter 1.0 to 2.0 cm - ~~$131.25~~ 144.38

11660 Excision, malignant lesions, lesion diameter more than 2.0 cm complicated or unusually located, any area of foot or ankle - BR

(b) Nails

11700 Debridement nails, manual, five or less - ~~$9.83~~ 10.81

11701 each additional five or less - ~~$4.92~~ 5.41

11710 Debridement nails, electric grinder, five or less - ~~$13.12~~ 14.43

11711 each additional five or less - ~~$6.56~~ 7.22

11730 Avulsion, nail plate, partial, simple, single - ~~$13.12~~ 14.43

11731 second nail plate - ~~$6.56~~ 7.22

11732 each additional nail plate - ~~$3.28~~ 3.61

11733 Avulsion nail plate - complete simple, single - ~~$13.12~~ 14.43

11734 second nail plate and all additionals - ~~$6.56~~ 7.22

11740 Evacuation of Subungual hematoma - BR

11750 Excision nail and/or nail matrix, partial, eg., ingrown or deformed nail, for permanent removal -

~~$65.63~~ 72.19

11751 Excision nail & less matrix complete for permanent removal - ~~$98.44~~ 108.28

11755 Excision, complete (total) of nail, nail bed and/or nail fold, with excision of matrix and with partial ostectomy of distal phalanx and plasty of toe (onychectomy with dactyloplasty or terminal Symes), unilateral, single toe - ~~$132.67~~ 145.94

11756 Excision, partial to nail fold or nail lip (paraunqual tissues) only: eg., onychoplasty to nail fold or lip, one side of toe (one nail margin), unilateral, single toe - ~~$65.63~~ 72.19

11760 Reconstruction nail bed, simple - BR

11762 complicated - BR

(c) Introduction

11900 Injection, intralesional, up to and including seven lesions - ~~$13.12~~ 14.43

11901 more than seven lesions - ~~$23.62~~ 25.98

(d) Repair-Simple

12041 Linear repair, simple up to 2.5 cm. - ~~$19.68~~ 21.65

12042 2.5 to 7.5 cm. - ~~$25.67~~ 28.24

12044 7.5 to 12.5 cm. - ~~$65.63~~ 72.19

12045 12.5 to 20.0 cm. - BR

(e) Repair-Complex

13120 Linear repair, complex up to 2.5 cm. - ~~$59.06~~ 64.97

13121 2.5 tp 7.5 cm. - ~~$98.44~~ 108.28

13122 greater than 7.5 cm. - BR

(f) Adjacent Tissue Transfer or Rearrangement

14040 Adjacent tissue transfer or rearrangement, defect up to 10 sq. cm. feet - ~~$262.49~~ 288.74

14041 Adjacent tissue transfer or rearrangement, defect between 10 and 30 sq. cm. feet - ~~$328.12~~ 360.93

14042 Adjacent tissue transfer or rearrangement, more than 20 sq. cm. unusual or complicated, any area or foot or ankle - BR

(g) Free Skin Grafts

15000 Excisional preparation or creation of recipient site by excision of essentially intact skin (including subcutaneous tissues), scar, or other lesion prior to repair with free skin graft (list as separate service in addition to skin graft) - BR

15050 Pinch, split, or full thickness graft to cover small ulcer, tip of digit, or other minimal open area up to defect size 2 cm. diameter - ~~$39.37~~ 43.31

15100 Split graft, feet (except multiple digits), up to 100 sq. cm. (except 15050) - ~~$196.87~~ 216.56

15101 each additional 100 sq. cm. or part thereof - ~~$39.37~~ 43.31

15240 Full thickness graft, free, including direct closure of donor site, feet up to 20 sq. cm. - ~~$262.50~~ 288.75

15241 each additional 20 sq. cm. - ~~$131.22~~ 144.34

15440 Porcine skin dressing for skin defect - ~~$32.80~~ 36.08

(h) Pedicle Flaps (Skin and deep tissues)

15510 Formation of tube pedicle without transfer, or major delay of large flap without transfer, feet - ~~$229.68~~ 252.65

15550 Primary attachment of open tubed pedicle flap to recipient site requiring minimal preparation, feet (except 15580) - ~~$295.31~~ 324.82

15620 Intermediate delay of any flap, primary delay of small flap or sectioning pedicle of tubed or direct flap feet (except 15625) - ~~$194.67~~ 214.14

15720 Excision of lesion and/or excisional preparation of recipient site and attachment of direct or tubed pedicle flap, feet - ~~$524.99~~ 577.49

(i) **Miscellaneous Procedure**

15785 Abrasion of skin for removal of scars, tattoos, actinic changes (keratoses), primary or secondary regional - ~~$131.22~~ 144.34

15791 Superficial chemosurgery (acid peel) regional, foot and/or ankle - BR

(j) Burns Local Treatment

16000 Initial treatment, first degree burn, when no more than local treatment required - ~~$9.85~~ 10.84

16010 Dressings and/or debridement, initial or subsequent, under anesthesia, small - ~~$26.25~~ 28.88

16015 Under anesthesia, large, or with major debridement, per one-half hour - ~~$65.62~~ 72.18

16020 Without anesthesia, office or hospital, small - ~~$11.13~~ 12.24

17100 Electrosurgical desitution or chemocautery (mono-bi-trickloroacetic acid, phenol) or cryocautery (liquid N_2, CO_2) of benign or quiescent premalignant lesions of skin, with or without curettage, one lesion - ~~$13.12~~ 14.43

17101 second lesion - ~~$6.56~~ 7.22

17102 over two lesions, each additional lesion - ~~$3.28~~ 3.61

17105 complicated lesion(s) - BR

17110 flat (plane, juvenile) warts or molluscum contagiosum, milia, up to 15 - ~~$13.12~~ 14.43

17120 (Retreatment same as office visit) Destruction of nail root and matrix with partial or total excisionor evulsion of nail using one of the following methods: Negative galvanism, electrocoagulation, fulguration or dessication, phenolization, cryotherapy (CO_2, N_2), or with power surgical drill or burr. Unilateral, single toe, one nail margin - ~~$65.63~~ 72.19

17121 each additional side - ~~$32.81~~ 36.09

17125 total nail - ~~$65.62~~ 72.18

17340 Cryotherapy (CO2 slush, liquid N2) - ~~$9.85~~ 10.84

17380 Electrolysis epilation each 1/2 hour - ~~$19.69~~ 21.66

17499 Unlisted Procedure, integumentary system (see Guidelines) - BR

(k) Incision

20000 Incision of superficial soft tissue abscess secondary to osteomyelitis or other cause - ~~$13.12~~ 14.43

20005 deep or complicated - BR

20010 with perfusion technique - ~~$19.68~~ 21.65

20040 Drainage of infected bursa - ~~$19.68~~ 21.65

20043 Paracentesis (puncture or needling) of bursa for aspiration or irrigation - ~~$16.40~~ 18.04

20046 Drainage of single infected space of foot, (lumbrical, midplantar, etc. with or without sheath involvement, in hospital - BR

(l) Excision

20200 Biopsy, muscle, superficial - ~~$39.37~~ 43.31

20205 deep - ~~$78.75~~ 86.63

20220 Biopsy, trochar, bone, superficial - ~~$39.37~~ 43.31

20230 Biopsy for synovial membrane - BR

(m) Introduction or Removal

20500 Injection of sinus tract, therapeutic (Independent Procedure) - ~~$13.12~~ 14.43

20520 Removal of foreign body in muscle, simple - ~~$39.57~~ 43.53

20525 deep or complicated - BR

20550 Injection, tendon sheath, ligament or trigger points - ~~$13.15~~ 14.47

20600 Arthrocentesis, aspiration or injection, small joint, eg., toes - ~~$9.83~~ 10.81

20605 intermediate joint or bursa, eg, tarsal joint or ankle joint - ~~$13.12~~ 14.43

20650 Insertion of wire or pin for skeletal traction, including removal (independent procedure) - ~~$39.37~~ 43.31

20660 Application of tongs or halo, including removal (independent procedure) - ~~$98.42~~ 108.26

20665 Removal of tongs or halo applied by another physician - ~~$9.83~~ 10.81

20670 Removal of buried wire, pin or screw, superficial (independent procedure) - ~~$19.68~~ 21.65

20680 deep, buried, wire, pin screw, metal band, nail rod, or plate - ~~$118.12~~ 129.93

(n) Grafts or Implants

20900 Obtaining bone for graft minor or small, dowel or button, any donor area of foot or ankle - ~~$78.73~~ 86.60

20902 Major or large - ~~$157.50~~ 173.25

20924 Obtaining tendon for graft, transferred from distant part - BR

20926 Obtaining other tissues for graft, eg., paratenon, fat dermis - BR

20240 Biopsy, bone, excisional, superficial 3.o - ~~$98.42~~ 108.26

27605 Tenotomy, Achilles tendon, subcutaneous (Independent Procedure) - ~~$32.80~~ 36.08

27610 Arthrotomy, (capsulotomy), ankle, with exploration, drainage or removal of loose or foreign body - ~~$295.31~~ 324.84

27612 Posterior capsular release, with or without Achilles tendon lengthening (see also 27685) - ~~$328.12~~ 360.93

(o) Excision

27620 Arthrotonmy (capsulotomy) ankle, for biopsy - ~~$295.24~~ 324.76

27625 for synovectomy - ~~$393.73~~ 433.10

27626 for synovectomy, including teno synovectomy - ~~$400.31~~ 440.34

27630 Excision of lesion of tendon, sheath or capsule (cyst or ganglion) - ~~$118.12~~ 129.93

27635 Excision or curettage of bone cyst or benign tumor, tibia or fibula at ankle - ~~$328.12~~ 360.93

27637 with primary autogenous graft (includes obtaining graft) - ~~$426.55~~ 469.21

27638 with primary homogenous graft - ~~$426.55~~ 469.21

27640 Excision of bone, partial (craterization, saucerization, or diaphysectiomy) for osteomyelitis, tibial malleolus or fibular malleolus - ~~$393.73~~ 433.10

27645 Resection, radical for tumor, tibial malleolus or fibularmalleolus - BR

27647 Astragalus or calcaneus - BR

(p) Introduction and/or Removal

27648 Injection procedure for ankle arthrography - ~~$32.80~~ 36.08

(q) Repair Revision or Reconstruction

27649 Repair of deep wound, ankle, involving fascia, muscle, artery and/or tendon and/or nerve - BR

27650 Suture, primary, ruptured Achilles tendon - ~~$360.93~~ 397.02

27652 with graft (includes obtaining graft) - ~~$459.36~~ 505.30

27658 Repair or suture of tendon, primary (without free graft) leg, flexor, single - ~~$196.87~~ 215.56

27659 secondary with or without free graft - ~~$262.49~~ 288.74

27664 extensor, single, primary - BR

27665 Repair extensor tendon secondary with or without free graft - ~~$196.87~~ 216.56

27675 Repair dislocated personal tendons without fibular osteotomy - BR

27676 with fibular osteotomy - BR

27680 Tenolysis, leg, including tibia, fibula and ankle, flexor, single - ~~$164.07~~ 180.48

27681 multiple, through same incision - ~~$196.07~~ 216.56

27685 Lengthening or shortening of tendon, including tibia, fibula, and ankle, flexor, single (independent procedure) - ~~$229.68~~ 252.65

27686 Multiple, through same incision (the toe extensors are considered as a group to be a single tendon when transplanted into midfoot) - BR

27688 Tenoplasty for lengthening or shortening of tendon of great toe unilateral, (independent procedure) - BR

27689 Tenoplasty for lengthening or shortening of tendon, single, of any of lesser toes (independent procedure) - BR

27690 Transfer or transplant of tendon, with muscle redirection or rerouting, single, superficial, eg. anterior tibial or extensors into midfoot - ~~$262.49~~ 288.74

27691 anterior tibial or posterior tibial through interosseous space - ~~$328.12~~ 360.93

27692 each additional tendon - ~~$65.59~~ 72.15

27695 Suture, primary, torn, ruptured or severed ligament, ankle, collateral - ~~$328.12~~ 360.93

27696 both collateral ligaments - ~~$459.36~~ 505.30

27698 secondary repair, collateral ligament (eg., Watson-Jones or Evans Procedures) - ~~$459.36~~ 505.30

27700 Arthoplasty, ankle - BR

27702 with implant ("total ankle") - BR

27704 Removal of ankle implant - BR

27705 Osteotomy, tibial malleolus - ~~$393.73~~ 433.10

27707 Osteotomy, fibular malleolus - ~~$229.68~~ 252.65

27709 Osteotomy, tibial and fibular malleoli - ~~$459.36~~ 505.30

(r) Fractures and/or Dislocations

27760 Conservative treatment, tibia, distal extremity. (Medial malleolus fracture closed (without reduction) - BR

27762 Closed manipulative reduction, tibia, distal extremity (medial malleolus) fracture closed - ~~$98.42~~ 108.26

27764 Manipulative reduction, tibia, distal extremity (medial malleolus) fracture open with uncomplicated soft tissue closure - ~~$144.36~~ 158.80

27766 Open reduction and fixation, tibia, distal extremity (medial malleolus) fracture closed or open - ~~$295.31~~ 324.84

27786 Conservative treatment, fibula, distal extremity, (lateral malleolus) fracture closed - BR

27788 Closed manipulative reduction, fibula, distal extremity (lateral malleolus) fracture closed - ~~$98.42~~ 108.26

27790 Manipulative reduction, fibula, distal extremity (lateral malleolus) fracture open with uncomplicated soft tissue closure - ~~$131.22~~ 144.34

27792 Open reduction with fixation, fibula, distal extremity (lateral malleolus) fracture closed or open - ~~$295.26~~ 324.79

27808 Conservative treatment, ankle, bimalleolar fracture (including Potts) closed (without reduction) - BR

27810 Closed manipulative reduction, ankle, bimalleolar fracture (including Potts) closed - ~~$164.07~~ 180.48

27812 Manipulative reduction, ankle, bimalleolar fracture (including Potts) open with uncomplicated soft tissue closure - ~~$213.28~~ 234.61

27814 Open reduction, ankle, bimalleolar fracture (including Potts) open or closed with or without internal/ external skeletal fixation - ~~$393.73~~ 433.10

27816 Conservative treatment, ankle, trimalleolar fracture closed (without reduction) - BR

27818 Closed manipulative reduction, ankle, trimalleolar fracture, closed - ~~$196.87~~ 216.56

27820 Manipulative reduction, ankle, trimalleolar fracture open, with uncomplicated soft tissue closure - ~~$229.60~~ 252.65

27822 Open reduction, ankle, trimalleolar fracture closed or open with or without internal/external skeletal fixation - ~~$475.77~~ 523.35

27840 Manipulative reduction, ankle dislocation closed, without anesthesia - BR

27842 requiring anesthesia - ~~$65.62~~ 72.18

27844 Manipulative reduction, ankle dislocation open, with uncomplicated soft tissue closure - ~~$105.00~~ 115.50

27846 Open reduction, ankle dislocation, closed or open - ~~$393.73~~ 433.10

27848 Open reduction and fixation, distal tibiofibular joint dislocation (ankle mortise) closed or open - ~~$295.31~~ 324.84

(s) Manipulation

27860 Manipulation of ankle under general anethesia (including application of traction or other fixation apparatus) - ~~$32.81~~ 36.09

(t) Arthrodesis

27870 Fusion, ankle - ~~$557.00~~ 613.58

(2) FOOT INCISION

(a) Miscellaneous

27899 Unlisted procedure, leg or ankle - BR

28001 Incision and drainage, infected bursa - BR

28002 Deep infection, below fascia, requiring deep dissection, with or without tendon sheath involvement; single bursal space, specify - BR

28003 multiple areas - BR

28004 multiple areas with suction irrigation - BR

28005 Incision, deep, with opening of bone cortex for osteomyelitis or bone abscess; - BR

28006 with suction irrigation - BR

28008 Fasciotomy, plantar and/or toe, subcutaneous - ~~$70.75~~ 86.63

28010 Tenotomy subcutaneous, toe single - ~~$26.25~~ 28.88

28011 multiple - ~~$39.37~~ 43.31

28020 Arthrotomy, (capsulotomy, with exploration, drainage or removal of loose or foreign body, intertarsal or tarsometatarsal joint - ~~$196.87~~ 216.56

28022 metatarsophalangeal joint - ~~$118.12~~ 129.93

28024 interphalangeal joint (toe) - ~~$78.74~~ 86.61

28030 Neurectomy of intrinsic musculature of foot - BR

28035 Tarsal tunnel release (posterior tibial nerve decompression) - BR

(b) Excision

28050 Arthrotomy for synovial biopsy, intertarsal or tarsometatarsal joint - ~~$196.87~~ 216.56

28052 metatarsophalangeal joint - ~~$118.12~~ 129.93

28054 interphalangeal joint (toe) - ~~$78.74~~ 86.61

28060 Fasciectomy, excision of plantar fascia, partial (independent procedure) - ~~$196.87~~ 216.56

28062 radical (independent procedure) - BR (For plantar fasciotomy, see 28250)

28070 Synovectomy, intertarsal or tarsometatarsal joint - ~~$196.87~~ 216.56

28072 metatarsophalangeal joint - ~~$110.12~~ 129.93

28080 Excision of Morton's neuroma, single, each - ~~$110.12~~ 129.93

28086 Synovectomy, tendon sheath; flexor - BR

28088 extensor - BR

28090 Excision of lesion of tendon or fibrous sheath or capsula (cyst or ganglion), foot - ~~$110.12~~ 129.93

28092 toes - ~~$70.74~~ 86.61

28100 Excision or curettage of bone cyst or benign tumor, astragalus or oscalcis - ~~$196.87~~ 216.56

28102 with iliac or other autogenous bone graft (includes obtaining graft) - ~~$229.60~~ 252.65

28103 with homogenous bone graft - ~~$229.60~~ 252.65

28104 Excision or curettage of bone cyst or benign tumor, tarsal or metatarsal bones, except astragalus or oscalcis - ~~$158.18~~ 174.00

28106 with iliac or other autogenous bone graft (includes obtaining graft) - ~~$183.74~~ 202.11

28107 with homogenous bone graft - BR

28108 Excision or curettage of bone cyst or benign tumor, phalanges - ~~$110.12~~ 129.93

28109 with homogenous bone graft - BR

28110 Ostectomy, partial excision of fifth metatarsal head, bunionette (independent procedure) - ~~$70.73~~ 86.60

28111 Ostectomy; complete excision of first metatarsal head - BR

28112 other metatarsal head (second, third or fourth) - ~~$131.22~~ 144.34

28113 fifth metatarsal head - ~~$131.22~~ 144.34

28114 all metatarsal heads with partial proximal phalangectomies (Clayton type procedure) - ~~$393.73~~ 433.10

28116 Ostectomy, excision of tarsal coalition - ~~$229.60~~ 252.65

28118 Ostectomy, calcaneous; partial (Cotton scoop type proceudre) - ~~$229.60~~ 252.65

28119 for spur, with or without plantar fascial release - BR

28120 Partial excision of bone (craterization, saucerization, sequestrectomy, or diaphysectomy) for osteopmyelitis, talus, or calcaneous; - ~~$196.87~~ 216.56

28121 with suction irrigation - BR

28122 Partial excision of bone (craterization, saucerization, or diaphysectomy) for osteomyelitis, tarsal or metatarsal bone, except talus or calcaneus; - ~~$157.50~~ 173.25

28123 with suction irrigation - BR

28124 phalanx - ~~$118.12~~ 129.93

28126 Condylectomy, phalangeal base, single toe - BR

28130 Astragalectomy - ~~$328.12~~ 360.93

28135 Calcanectomy - BR

28140 Metatarsectomy - ~~$196.87~~ 216.56

28150 Phalangectomy - ~~$118.12~~ 129.93

28153 Resection, head of phalanx - ~~$131.25~~ 144.38

28160 Hemiphalangectomy or interphalangeal joint excision, single - ~~$98.42~~ 108.26

28162 Ostectomy, total of accessory ossicle os vesalianum - ~~$118.12~~ 129.93

28163 of os trigonum - ~~$131.25~~ 144.38

28164 of os tibiale externum - ~~$157.50~~ 173.25

28165 of supernumerary ossicle from metatarsophalangeal joint - ~~$118.12~~ 129.93

28166 of supernumerary ossicle from interphalangeal joint - ~~$98.43~~ 108.27

28170 Resection, radical, for tumor, foot - BR

(c) Introduction and/or removal

28180 Injection procedure for arthrography of any one joint of the foot; - ~~$32.80~~ 36.08

(d) Repair, Revision, or Reconstruction

28195 Repair of deep wound, foot, involving fascia, muscle, artery and/or tendon and/or nerve - BR

28200 Repair or suture of tendon, primary or secondary, without free graft, foot flexor, single - ~~$196.87~~ 216.56

28202 secondary with free graft (includes obtaining graft) - ~~$262.50~~ 288.75

28208 Repair or suture of tendon, extensor, foot single, primary or secondary - ~~$91.85~~ 101.04

28210 secondary, with graft (includes obtaining graft) - ~~$131.22~~ 144.34

28216 Repair of ruptured or divided fascia or aponeurosis; fasciorrhaphy (e.g., of plantar fascia, plantar or dorsal aponeurosis) - BR

28220 Tenolysis, flexor, foot, single - ~~$164.03~~ 180.43

28222 multiple (through same incision) - ~~$196.83~~ 216.51

28225 Tenolysis, extensor, foot, single - ~~$91.85~~ 101.04

28226 multiple, (through same incision) - ~~$118.12~~ 129.93

28230 Tenotomy, open, flexor, foot, single or multiple (independent procedure) - ~~$98.42~~ 108.26

28232 toe, single (independent procedure) - ~~$45.94~~ 50.53

28234 Tenotomy, open, extensor, foot or toe - ~~$32.81~~ 36.09

28236 Transfer of tendon, anterior tibial into tarsal bone (Lowman-Young type operation) - BR

28238 Advancement of posterior tibial tendon, with excision of accessory scaphoid bone (Kidner type operation) - BR

28239 Kidner procedure with regrooving of medial malleolus for replacement of tendon - BR

28240 Tenotomy or release, abductor hallucis muscle (McCauley type operation) - ~~$110.12~~ 129.93

28250 Division of plantar fascia and muscle, Steindler stripping (independent procedure) - ~~$196.87~~ 216.56

28260 Capsulotomy, midfoot, medial release only (independent procedure) - BR

28261 with tendon length - BR

28262 Extensive, including posterior talotibial capsulotomy and tendon(s) lengthening, as for resistiant club foot deformity - BR

28263 Desmotomy with plasty of spring ligament (plantar calcaneonavicular ligament (Mercado type operation) - BR

28264 Capsulotomy, midtarsal (Heyman type operation) - ~~$393.73~~ 433.10

28270 Capsulotomy for contracture, metatarsophalangeal joint, with or without tenorrhaphy (independent procedure) - ~~$98.42~~ 108.26

28272 interphalangeal joint (independent procedure) - ~~$45.93~~ 50.52

28280 Webbing operation (creating syndactylism of toes) for soft corn (Kelikian type operation) - ~~$110.12~~ 129.93

28285 Hammer toe operation, one toe, e.g., interphalangeal fusion, filleting, phalangectomy (independent procedure) - ~~$157.50~~ 173.25

28286 for 'cock-up' fifth toe with plastic skin closure (Ruiz-Mora type operation) - ~~$157.50~~ 173.25

28287 Arthroplasty, metatarsophalangeal joint of a lesser toe, (e.g., for repair of partial or total subluxation. Also see 28112) - ~~$157.50~~ 173.25

28288 Ostectomy, partial, exostectomy or condylectomy, single, metatarsal head, second through fifth, each metatarsal head, (separate procedure) - BR

28290 Correction of hallux valgus (bunion) by exostectomy, capsuloplasty, etc., (Silver type operation or any modification thereof) - ~~$157.50~~ 173.25

28292 by arthroplasty, (partial ostectomy, capsuloplasty, capsulorrhaphy, etc.) metatarsophalangeal joint of hallux (Keller, McBride, Mayo, or Stone type operation) - ~~$229.68~~ 252.65

28293 resection of joint with implant - BR

28294 with tendon transplants (Joplin type operation) - ~~$311.71~~ 342.88

28296 with metatarsal osteotomy (Mitchell, Lapidus, Reverdin, or similar type operation) - ~~$311.71~~ 342.88

28298 correction by phalangeal osteotomy (Akin) - ~~$262.49~~ 288.74

28299 by other methods (e.g., double osteotomy) - ~~$377.33~~ 415.06

28300 Osteotomy, including internal fixation, os calcis (Dwyer or Chambers type operation) - ~~$311.71~~ 342.88

28302 astragalus (Talus) - ~~$295.31~~ 324.84

28304 other midtarsal bones - ~~$262.49~~ 288.74

28305 other midtarsal bones, with autogenous graft (Fowler type operation), includes obtaining graft - BR

28306 metatarsals, base or shaft, single, for shortening or angular correction, first metatarsal - ~~$229.68~~ 252.65

28308 other metatarsals, base or shaft, single, for shortening or angular correction (e.g. dorsal, abductory or adductory wedge osteotomies) - ~~$183.74~~ 202.11

28309 other metatarsals, multiple, for cavus foot (Swanson type operation) - BR

28310 proximal phalanx, first toe, for shortening, angular or rotational correction - ~~$91.87~~ 101.06

28312 other phalanges, any toe, for shortening, angular or rotational correction - ~~$65.62~~ 72.18

28314 Osteotomy, for lengthening of a metatarsal bone, single, unilateral (includes obtaining graft) - ~~$229.60~~ 252.65

28320 Repair of nonunion or malunion tarsal bones (of calcis, astragalus) - BR

28322 metatarsal, with or without bone graft (includes obtaining graft) - ~~$157.50~~ 173.25

28330 Repair for syndactyly of two toes (e.g., freeing of webbed toes with flaps) - ~~$262.50~~ 288.75

28331 with use of skin grafts (includes obtaining grafts) - BR

28335 Repair for freeing toes from surgical syndactylia, with flaps, great toe with second toe; - ~~$262.50~~ 288.75

28336 with use of skin grafts (includes obtaining graft) - BR

(e) Fraction and/or Dislocation

28400 Conservative treatment, os calcis, fracture closed (without reduction) - BR

28405 Closed manipulative reduction, including Cotton or Bohler type reduction, os calcis, fracture closed - BR

28410 Manipulative reduction, os calcis, fracture open, with uncomplicated soft tissue closure - BR

28415 Open reduction, os calcis, fracture closed or open, with or without internal/external skeletal fixation - ~~$328.12~~ 360.93

28420 with primary iliac or other autogenous bone graft (includes obtaining graft) - ~~$475.77~~ 523.35

28430 Conservative treatment, astragalus, fracture closed (without reduction) - BR

28435 Closed manipulative reduction, astragulus, fracture closed - ~~$98.43~~ 108.27

28440 Manipulative reduction, astragalus, fracture open, with uncomplicated soft tissue closure - ~~$131.24~~ 144.36

28445 Open reduction, astragalus, fracture closed or open, with or without internal/external skeletal fixation - ~~$328.12~~ 360.93

28450 Conservative treatment, tarsal bone(s) (except astragalus and os calcis fracture(s) closed) - BR

28455 Closed manipulative reduction, tarsal bone(s) (except astragalus and os calcis, fracture(s) closed) - ~~$65.62~~ 72.18

28460 Manipulative reduction, tarsal bone(s) (except astragalus and os calcis), fracture open, with uncomplicated soft tissue closure) - ~~$98.42~~ 108.26

28465 Open reduction, tarsal bone(s) (except astragalus and os calcis), fracture closed or open, with or without internal/external skeletal fixation - ~~$196.87~~ 216.56

28470 Conservative treatment, metatarsal(s) closed (without reduction) - BR

28475 Closed manipulative reduction, metatarsal(s), fracture(s), closed - ~~$72.18~~ 79.40

28480 Manipulative reduction, metatarsal(s), fracture(s), open with uncomplicated soft tissue closure; - ~~$98.42~~ 108.26

28485 Open reduction, metatarsal(s), fracture(s), closed or open, with or without internal/external skeletal fixation - ~~$196.87~~ 216.56

28490 Conservative treatment, phalanx or phalanges, great toe fracture closed (without reduction) - BR

28495 Closed manipulative reduction, phalanx or phalanges, great toe, fracture closed; - ~~$39.37~~ 43.31

28500 Manipulative reduction, phalanx or phalanges, great

toe, fracture open, with uncomplicated soft tissue closure - ~~$59.06~~ 64.97

28505 Open reduction, phalanx or phalanges, great toe, fracture closed or open, with or without internal/external skeletal fixation - ~~$118.12~~ 129.93

28510 Conservative treatment, phalanx or phalanges, other than great toe, fracture closed (without reduction) - BR

28515 Closed manipulative reduction, phalanx or phalanges, other than great toe, fracture closed; - ~~$32.81~~ 36.09

28520 Manipulative reduction, phalanx or phalanges, other than great toe, fracture open, with uncomplicated soft tissue closure; - ~~$52.49~~ 57.74

28525 Open reduction phalanx or phalanges, other than great toe fracture closed or open with or without internal/external skeletal fixation; - ~~$98.44~~ 108.28

28540 Manipulative reduction, tarsal bone, dislocation closed, without anesthesia - ~~$23.63~~ 25.99

28545 requiring anesthesia - ~~$65.62~~ 72.18

28550 Manipulative reduction, tarsal bone, dislocation open with uncomplicated soft tissue closure; - ~~$91.85~~ 101.04

28555 Open reduction, tarsal bone, dislocation closed or open, with or without internal/external fixation, skeletal - ~~$196.87~~ 216.56

28570 Manipulative reduction, astragalotarsal joint, dislocation closed, without anesthesia; - ~~$32.81~~ 36.09

28575 requiring anesthesia; - ~~$78.73~~ 86.60

28580 Manipulative reduction, astragalotarsal joint, dislocation open, with uncomplicated soft tissue closure; - ~~$105.00~~ 115.50

28585 Open reduction, astragalotarsal joint, dislocation closed or open, with or without internal/external skeletal fixation; ~~$328.12~~ 360.93

28600 Manipulative reduction, tarsometatrasal joint, dislocation closed, without anesthesia; - ~~$23.62~~ 25.98

28605 requiring anesthesia - ~~$65.62~~ 72.18

28606 Treatment of closed tarsometatarsal joint dislocation with percutaneous skeletal fixation - BR

28610 Manipulative reduction, tarsometatarsal joint, dislocation open, with uncomplicated soft tissue closure; - ~~$91.85~~ 101.04

28615 Open reduction, tarsometatarsal joint, dislocation closed or open with uncomplicated soft tissue closure; - ~~$196.87~~ 216.56

28630 Manipulative reduction, metatarsolphalangeal joint, dislocation closed, without anesthesia; - BR

28635 requiring anethesia - BR

28640 Manipulative reduction, metatarsophalangeal joint, dislocation open, with uncomplicated soft tissue closure; - ~~$65.62~~ 72.18

28645 Open reduction, metatarsophalangeal joint, dislocation closed, or open with or without internal/external skeletal fixation; - ~~$131.22~~ 144.34

28660 Manipulative reduction, interphalangeal joint, dislocation closed, without anesthesia; - ~~$23.62~~ 25.98

28665 requiring anesthesia - ~~$39.37~~ 43.31

28670 Manipulative reduction, interphalangeal joint, dislocation open, with uncomplicated soft tissue closure; - ~~$52.50~~ 57.75

28675 Open reduction, interphalangeal joint, dislocation closed or open, with or without internal/external skeletal fixation; - ~~$78.73~~ 86.60

(f) Manipulation

28690 Manipulation of toe, one or more, where no other surgical procedure is performed (with or without anesthesia), and includes traction, splinting or fixation apparatus (Independent Procedure) - ~~$65.63~~ 72.19

(g) Arthrodesis

28705 Pantalar arthrodesis; - ~~$623.41~~ 685.75

28707 Arthrodesis, intra- or extra-articular, intertarsal (talonavicular, calcaneocuboid or talocalcaneal), single joint; - ~~$360.94~~ 397.03

28708 Arthrodesis, double intertarsal joints, (talocalcaneal, talonavicular, calcaneocuboid, any combination) - ~~$459.38~~ 505.32

28715 Triple arthrodesis; - ~~$492.17~~ 541.39

28725 Subtalar arthrodesis (includes Grice type procedure) - ~~$393.73~~ 433.10

28728 Arthroesis, subastragular - BR

28730 Arthrodesis, midtarsal or tarsometatarsal, multiple or transverse; - ~~$360.93~~ 397.02

28735 with osteotomy, as for flat foot correction - ~~$459.36~~ 505.30

28737 Arthrodesis, navicular-cuneiform, with tendon lengthening and advancement (Miller type operation) - BR

28740 Arthrodesis, midtarsal or tarsometatarsal, single joint - ~~$295.31~~ 324.84

28750 Arthrodesis, great toe, metatarsolphalangeal joint ~~$229.68~~ 252.65

28755 interphalangeal joint - ~~$131.24~~ 144.36

28760 interphalangeal joint, with reduction of attachment of extensor hallucis longus (Jones type operation) - ~~$196.87~~ 216.56

28765 Arthrodesis, lesser toe, metatarsolphalangeal joint, single - ~~$163.00~~ 179.30

28770 Arthrodesis, lesser toe, interphalangeal joint, without tendon transfer, single; - ~~$124.69~~ 137.16

(h) Miscellaneous

28899 Unlisted procedure, foot or toes - BR

(i) Casts

29345 Application of long leg cast (thigh to toes); - ~~$36.08~~ 39.69

29355 walker or ambulatory type - ~~$42.66~~ 46.93

29358 Application of long leg cast brace - BR

29365 Application of cylinder cast (thigh to ankle) - ~~$32.81~~ 36.09

29405 Application of short leg cast (below knee to toes); - ~~$26.25~~ 28.88

29425 walking or ambulatory type - ~~$32.81~~ 36.09

29450 Application of clubfoot cast with molding or manipulation, long or short leg; unilateral - ~~$13.13~~ 14.44

29455 bilateral - ~~$26.25~~ 28.88

29460 Application of forefoot cast - ~~$16.40~~ 18.04

(j) Splints

29505 Application of long leg splint (thigh to ankle or toes) - ~~$23.62~~ 25.98

29515 Application of short leg splint (calf to foot) - ~~$19.69~~ 21.66

(k) Strapping - Any Age

29540 Strapping, ankle - ~~$9.85~~ 10.84

29545 Strapping, foot - ~~$9.85~~ 10.84

29550 Strapping, toe - ~~$6.56~~ 7.22

29580 Strapping, Unna boot - ~~$13.13~~ 14.44

29590 Denis-Browne splint strapping - BR

(l) Removal or Repair

29705 Removal or bivalving full leg cast, below knee cast, ankle cast or foot cast - BR

29730 Windowing of cast - ~~$7.88~~ 8.67

29740 Wedging of cast (except clubfoot casts) - ~~$9.85~~ 10.84

29750 Wedging of clubfoot cast, unilateral - ~~$9.85~~ 10.84

29751 bilateral - ~~$13.13~~ 14.44

(m) Other Procedures

29799 Unlisted procedures, musculoskeletal system - BR

(n) **Cardiovascular System**

Venous

36470 Injection of sclerosing solution, single vein; - ~~$9.19~~ 10.11

36471 multiple veins, same leg (includes ankle) - ~~$13.13~~ 14.44

(o) Arterial

36600 Arterial puncture, withdrawal of blood for diagnosis - ~~$6.56~~ 7.22

37799 Unlisted podiatric procedure, cardiovascular system - BR

(p) Nervous System

Peripheral Nerves
Injection (Nerve Block)
Anesthetic Agent, Diagnostic or Therapeutic

64450 Injection anesthetic agent, peripheral nerve or branch; - ~~$19.69~~ 21.66

(q) Exploration, Neurolysis or Nerve Decompression

64702 Neurolysis, digit; - ~~$157.50~~ 173.25

64704 Neurolysis, nerve of foot; - ~~$262.49~~ 288.74

64722 Decompression; unspecified nerve(s) (specify) - BR

64726 Decompression, plantar digital nerve - BR

64727 Neurolysis, internal with or without microdissection (list separately as 64727 in addition to code number of ~~neurolysis~~ primary neuroplasty) - BR

(r) Excision

Somatic Nerves

64774 Excision of traumatic neuroma, cutaneous nerve, surgically identifiable; - ~~$98.45~~ 108.30

64776 digital nerve, one or both, same digit; - ~~$98.45~~ 108.30

64778 digital nerve, each additional digit (list separately by this number) - BR

64782 foot - ~~$196.87~~ 216.56

64783 foot each additional nerve, except same digit (list separately by this number) - BR

64787 Insertion of plastic cap on nerve end - BR

64788 Excision of neurofibroma or neurolemmoma; cutaneous nerve - ~~$196.87~~ 216.56

64790 major peripheral nerve - BR

64792 extensive (including malignant type) - ~~$656.23~~ 721.85

Repair (Neurorrhaphy)

64830 Microdissection and/or microrepair of nerve (list separately using 64830 in addition to code for nerve repair - BR

64831 Suture of nerve (neurorrhaphy), digital, foot, one nerve; - ~~$328.12~~ 360.93

64832 each additional digital nerve - ~~$39.37~~ 43.31

64834 Suture of one nerve, foot, sensory - ~~$262.49~~ 288.74

64840 Suture of nerve, foot, posterior tibial nerve primary or secondary; - BR

64837 suture of each addtional nerve, foot - BR

Other Procedures

64999 Unlisted procedure, nervous system - BR

Diagnostic Radiology

(For biomechanical determination and diagnostic evaluation)

73500 Radiologic examination, hip, unilateral, one view; - ~~$21.41~~ 23.55

73510 complete, minimum of two views - ~~$26.72~~ 29.39

73520 Radiologic examination, hips, bilateral, minimum of two views, of each hip, including anteroposterior view of pelvis; - ~~$41.09~~ 45.20

73540 Radiologic examination, pelvis and hips, infant or child minimum of two views; - ~~$27.38~~ 30.12

73550 Femur, anteroposterior and lateral views; - ~~$25.67~~ 28.24

73560 Radiologic examination, knee, anteroposterior and lateral views - ~~$18.83~~ 20.71

73570 knee, three or more views - ~~$27.38~~ 30.12

73590 Radiologic examination, tibia and fibula, anterioposterior and lateral views; - ~~$20.55~~ 22.61

73592 lower extremity, infant, minimum of two views - ~~$20.55~~ 22.61

73600 Radiologic examination, ankle, anteroposterior and lateral views; - ~~$18.83~~ 20.71

73610 complete, minimum of three views; - ~~$25.67~~ 28.24

73620 Radiologic examination, foot, anteroposterior and lateral views; - ~~$17.13~~ 18.84

73630 complete, minimum of three views; - ~~$18.55~~ 19.31

73650 Radiologic examination, os calcis, minimum of two views; - ~~$18.83~~ 20.71

73660 toe or toes, minimum of two views - ~~$15.40~~ 16.94

(s) Miscellaneous

76020 Radiologic examination, bone age studies, - ~~$25.67~~ 28.24

76040 bone length studies (orthoroentgenogram) - ~~$42.80~~ 47.08

76080 Radiologic examination, fistual or sinus tract study, supervision and interpretation only; - ~~$51.36~~ 56.50

76081 complete procedure - BR

76127 Procedures using Polaroid or similar photographic media - BR

76130 Radiologic examination at bedside or in operating room, not otherwise specified - BR

76134 in home - BR

76137 outside regular hours - BR

76140 Consultation on x-ray examination made else where, written report; - BR

76300 Themography - BR

76499 Unlisted diagnostic radiologic procedure - BR

(t) Peripheral Vascular System

76900 Periperhal flow study (Doppler), arterial - ~~$64.20~~ 70.62

76910 venous - ~~$64.20~~ 70.62

76920 arterial and venous (76900 and 76910 combined) - ~~$77.46~~ 85.21

(u) Micellaneous

76970 Ultrasound study follow-up (not listed above) - BR

76999 Unlisted diagnostic ultrasound examination - BR

(v) Microbiology

87081 Culture, all other sources, screening only, for single organism per plate or tube; - ~~$5.71~~ 6.28

87085 including sensitivity study, up to 20 disks; - ~~$17.82~~ 19.60

87101 Culture, fungi, isolation, skin; - ~~$6.70~~ 7.46

87102 other source - ~~$8.21~~ 9.03

87106 definitive identification - ~~$13.55~~ 14.91

87205 Smear, primary source, with interpretation; routine stain for bacteria, fungi, or cell types - ~~$7.15~~ 7.87

The authority of the department to amend the rule is based on Section 53-6-113, MCA and the rule implements Sections 53-6-101 and 53-6-141, MCA.

46.12.527 OUTPATIENT PHYSICAL THERAPY SERVICES, REIMBURSEMENT (1) The department will pay the lowest of the following for outpatient physical therapy services not also covered by medicare: the provider's actual (submitted) charge for the service; ~~the provider's medicaid median charge for the service; the 75th percentile of the range of weighted medicaid median charges for each service covered by this rule;~~ or the department's fee schedule contained in this rule.

The department will pay the lowest of the following for outpatient physical therapy services which are also covered by medicare: the provider's actual (submitted) charge for the service; the amount allowable for the same service under medicare; or the department's fee schedule contained in this rule.

(2) Outpatient physical therapy fee schedule:

A. D. L.	~~$10.15~~	19.97
Consultation	~~$30.25~~	33.28
Electrophysiological evaluation	~~$30.25~~	33.28
Electromyography	~~$60.50~~	66.55
Physical Therapy Evaluation	~~$30.25~~	33.28
Home Instruction	~~$30.25~~	33.28
Muscle Testing	~~$30.25~~	33.28
Hubbard Tub	~~$24.20~~	26.62
Hubbard Tub + 1 modality	~~$24.20~~	26.62
Hubbard Tub + 2 modalities	~~$27.03~~	30.61
Hubbard Tub + 3 modalities	~~$30.25~~	33.28
Isolation Hubbard Tub	~~$24.20~~	26.62
Whirlpool	~~$14.52~~	15.97
Whirlpool + 1 modality	~~$15.73~~	17.30
Whirlpool + 2 modalities	~~$24.20~~	26.62
Whirlpool + 3 modalities	~~$36.30~~	39.93
Gait Training	~~$24.20~~	26.62
Postural Drainage	~~$15.73~~	17.30
Therapeutic Exercise	~~$10.15~~	19.97
One Modality	~~$12.10~~	13.31
Two Modalities	~~$13.31~~	14.64
Three Modalities	~~$10.15~~	19.97
Four Modalities	~~$10.15~~	19.97
Five Modalities	~~$21.78~~	23.96

The authority of the department to amend the rule is based on Section 53-6-113, MCA and the rule implements Sections 53-6-101 and 53-6-141, MCA.

46.12.532 SPEECH PATHOLOGY SERVICES, REIMBURSEMENT (1) The department will pay the lowest of the following for speech pathology services not covered by medicare: the provider's actual (submitted) charge for the service; ~~the provider's medicaid median charge for the service; the 75th percentile of the range of weighted medicaid median charges for each service covered by this rule;~~ or ~~$23.65~~ 26.01 per hour.

The department will pay the lowest of the following for speech pathology services which are also covered by medicare: the provider's actual (submitted) charge for the service; the amount allowable for the same service under medicare, or $23.65 per hour.

The authority of the department to amend the rule is based on Section 53-6-113, MCA and the rule implements Sections 53-6-101 and 53-6-141, MCA.

46.12.537 AUDIOLOGY SERVICES, REIMBURSEMENT (1) The department will pay the lowest of the following for audiology services not also covered by medicare: the provider's actual (submitted) charge for the service; ~~the provider's medicaid median charge for the service; the 75th percentile of the range of weighted medicaid median charges for each service covered by this rule;~~ or the department's fee schedule contained in this rule.

The department will pay the lowest of the following for audiology services which are also covered by medicaid: the provider's actual (submitted) charge for the service; the amount allowable for the same service under medicaid; or the department's fee schedule contained in this rule.

(2) Audiology fee schedule:

~~AUDIOLOGY FEE SCHEDULE~~

Basic Audio Assessment (BAA)	~~$44.00~~	48.40
Hearing Aid Evaluation (HAE)	~~22.00~~	24.20
Speech Discrimination Test	~~8.80~~	9.68
Speech Reception Threshold	~~8.80~~	9.68
Pure Tone Air Threshold	~~8.80~~	9.68
Pure Tone Bone Threshold	~~8.80~~	9.68
Tympanogram (unilateral)	~~3.30~~	3.63
Tympanogram (bilateral)	~~6.60~~	7.26
Acoustic Reflex (bilateral)	~~8.80~~	9.68
Static Compliance	~~6.60~~	7.26
Bekesy	~~11.00~~	12.10
SISI (two or more frequency)	~~11.00~~	12.10
Loudness Balance or ABLB	~~11.00~~	12.10
Stenger	~~11.00~~	12.10
Doefler - Stewart	~~11.00~~	12.10
Lombard	~~11.00~~	12.10

The authority of the department to amend the rule is based on Section 53-6-113, MCA and the rule implements Section 53-6-101, MCA.

46.12.542 HEARING AID SERVICES, REIMBURSEMENT (1) The department will pay the lowest of the following for hearing aid services not also covered by medicare: the provider's actual (submitted) charge for the service~~, the provider's medicaid median charge for the service, the 75th percentile of the range of weighted medicaid median charges for each service covered by this rule,~~ or the department's fee schedule contained in this rule.

The department will pay the lowest of the following for hearing aid services which are also covered by medicaid: the provider's actual (submitted) charge for the service; the amount allowable for the same service under medicare; or the department's fee schedule contained in this rule.

(2) Hearing aid fee schedule:

List of Services	Fee
Purchase of instrument	Wholesale cost & ~~$275.00~~ 302.50 dispensing fee
Hearing aid rental	~~$1.10~~ 1.21 per day
Hearing aid service & repair (which includes a 6 month warranty)	~~$66.00~~ 72.60 maximum per year per aid
Hearing aid recasing	~~$33.00~~ 36.30 maximum per year per aid
Accessories (cords, receivers, etc.)	~~$38.50~~ 42.35 maximum per year per aid
Bone ossilator	~~$71.50~~ 78.65 maximum per year per aid
Ear mold replacement	~~$16.50~~ 18.15
Hearing aid batteries	~~$8.25~~ 9.08/silver oxide standard package ~~$5.50~~ 6.05 /all other standard package

The authority of the department to amend the rule is based on Section 53-6-113, MCA and the rule implements Sections 53-6-101 and 53-6-141, MCA.

46.12.547 OUTPATIENT OCCUPATIONAL THERAPY SERVICES, REIMBURSEMENT (1) The department will pay the lowest of the following for outpatient occupational therapy services not also covered by medicare: the provider's actual (submitted) charge for the service; ~~the provider's medicaid median charge for the service; the 75th percentile of the range of weighted medicaid median charges for each service covered by this rule;~~ or the department's fee schedule contained in this rule.

The department will pay the lowest of the following for outpatient occupational therapy services which are also covered by medicare: the provider's actual (submitted) charge for the service; the amount allowable for the same service under medicare; or the department's fee schedule contained in this rule.

(2) Outpatient occupational therapy fee schedule:

A. D. L.	~~18.15~~	19.97
Occupational Therapy Evaluation	~~30.25~~	33.28
Home Instruction	~~30.25~~	33.28
One Modality	~~12.10~~	13.31
Two Modalities	~~13.31~~	14.64
Three Modalities	~~18.15~~	19.97
Four Modalities	~~18.15~~	19.97
Five Modalities	~~21.70~~	23.96

The authority of the department to amend the rule is based on Section 53-6-113, MCA and the rule implements Sections 53-6-101 and 53-6-141, MCA.

46.12.552 HOME HEALTH SERVICES, REIMBURSEMENT

Subsections (1) through (4) remain the same.

(5) Reimbursement for nursing service provided by a licensed registered nurse in geographic areas not covered by a home health agency will be ~~$7.50~~ 8.25 per hour.

Subsection (6) remains the same.

The authority of the department to amend the rule is based on Section 53-6-113, MCA and the rule implements Sections 53-6-101 and 53-6-141, MCA.

46.12.557 PERSONAL CARE SERVICE, REIMBURSEMENT (1) The department will pay the lowest of the following for personal care services not covered by medicare: the provider's actual (submitted) charge for the service; ~~the provider's medicaid median charge for the service; the 75th percentile of the range of weighted medicaid median charges for each service covered by this rule;~~ or the department's fee schedule contained in this rule.

The department will pay the lowest of the following for personal care services which are also covered by medicare: the provider's actual (submitted) charge for the service; the amount allowable for the same service under medicare; or the

department's fee schedule contained in this rule.

~~(1)~~ (2) Payment for personal care service shall be minimum wage plus 15 percent in lieu of fringe benefits except where exigent circumstances exist, a reasonable payment rate may be negotiated between the department and the provider.

~~(2)~~ (3) On a weekly basis, payment shall not exceed 80 percent of the cost of nursing home per diem except when prior authorized.

~~(3)~~ (4) Payment for registered nurse supervision shall be:

(a) established by a contract with the department when provided by a licensed home health agency;

(b) ~~$8.25~~ 9.08 per hour when provided by an independent registered nurse; or

(c) where exigent circumstances exist, a reasonable payment rate may be negotiated between the department and the provider.

The authority of the department to amend the rule is based on Section 53-6-113, MCA and the rule implements Sections 53-6-101 and 53-6-141, MCA.

46.12.567 PRIVATE DUTY NURSING SERVICE, REIMBURSEMENT The department will pay the lowest of the following for private duty nursing services not also covered by medicare: the provider's actual (submitted) charge for the service; ~~the provider's medicaid median charge for the service; the 75th percentile of the range of weighted medicaid median charges for each service covered by this rule;~~ or ~~$44.00~~ 48.40 per eight (8) hour shift.

The department will pay the lowest of the following for private duty nursing services which are also covered by medicare: the provider's actual (submitted) charge for the service; the amount allowable for the same service under medicare; or ~~$44.00~~ 48.40 per eight (8) hour shift.

The authority of the department to amend the rule is based on Section 53-6-113, MCA and the rule implements Sections 53-6-101 and 53-6-141, MCA.

46.12.582 PSYCHOLOGICAL SERVICES, REIMBURSEMENT (1) The department will pay the lowest of the following for psychological services not also covered by medicare: the provider's actual (submitted) charge for the service; ~~the provider's medicaid median charge for the service; the 75th percentile of the range of weighted medicaid median charges for each service covered by this rule;~~ or the department's fee schedule found in this rule.

The department will pay the lowest of the following for psychological services which are also covered by medicare: the provider's actual (submitted) charge for the service; the amount allowable for the same service under medicare; or the

department's fee schedule contained in this rule.

~~(1)~~ (2) ~~$37.69~~ 41.46 for individual psychological services; or

~~(2)~~ (3) ~~$11.30~~ 12.43 for group psychological services.

The authority of the department to amend the rule is based on Section 53-6-113, MCA and the rule implements Sections 53-6-101 and 53-6-141, MCA.

46.12.605 DENTAL SERVICES, REIMBURSEMENT The department will pay the lowest of the following for dental services not also covered by medicare: the provider's actual (submitted) charge for the service; ~~the provider's medicaid median charge for the service; the 75th percentile of the range of weighted medicaid median charges for each service covered by this rule;~~ or the department's fee schedule found in this rule.

The department will pay the lowest of the following for dental services which are also covered by medicare: the provider's actual (submitted) charge for the service; ~~the provider's medicaid median charge for the service;~~ the amount allowable for the same service under medicare; or the department's fee schedule contained in this rule.

(1) Preventive and diagnostic services:

(a) examination and execution of forms - ~~9.36~~ 10.30;

(b) complete intra-oral radiograms, minimum 14 films - ~~26.00~~ 28.60;

(c) single periapical radiograms, first film - ~~5.20~~ 5.72;

(d) each additional film, periapical - ~~2.60~~ 2.86;

(e) bite-wing radiograms, 2 films - ~~9.36~~ 10.30;

(f) intra-oral occlusal maxillary or mandibular - ~~6.50~~ 7.15;

(g) cephalometric radiograms or panorex, diagnostic only - ~~26.00~~ 28.60;

(h) extra-oral radiograms, maxillary or mandibular lateral film - ~~19.50~~ 21.45;

(i) allowable charges for x-rays in a single visit shall not exceed the allowable charges for a full mouth x-ray;

(j) consultation fee (necessity to be shown) per session - ~~13.00~~ 14.30;

(k) hospital calls - ~~19.50~~ 21.45;

(l) simple operations under general anesthesia in hospital - ~~39.00~~ 42.90;

(m) house calls and nursing home calls - ~~9.10~~ 10.01;

(n) vitality tests one tooth or per quadrant - ~~7.00~~ 8.54;

(o) palliative (emergency treatment of dental pain (includes only minor procedures, i.e., temporary fillings, incision and drainage, topical medicaments, irrigation, pericoronitis, etc.) - ~~7.00~~ 8.54;

(p) stannus flouride 8%, one treatment, including prophylaxis - ~~22.10~~ 24.31;
(q) flouride - ~~7.70~~ 8.47;
(r) prophyliaxis, includes routine scaling and polishing/adults and children - ~~16.90~~ 18.59;
(2) Amalgam restorations:
(a) deciduous, one surface - ~~14.70~~ 16.26;
(b) deciduous, two surface - ~~24.19~~ 26.61;
(c) deciduous, three surface - ~~33.79~~ 37.17;
(d) each additional surface, deciduous - ~~3.30~~ 3.63;
(e) one surface, permanent - ~~14.70~~ 16.26;
(f) two surface, permanent - ~~24.19~~ 26.61;
(g) three surface, permanent - ~~33.79~~ 37.17;
(h) each additional surface (includes cusp restoration, veneer, groove extension, etc.) permanent - ~~5.76~~ 6.34;
(i) pins for retention (maximum 2) each pin - ~~3.90~~ 4.29.
(3) Silicates and fiberglass restorations (per surface):
(a) silicate - ~~13.00~~ 14.30;
(b) compost resin (addent, dakor, adaptic, concise, prestige, etc.) - ~~23.04~~ 25.34.
(c) composite fillings for posterior teeth will be paid at the rate of a similar amalgam restoration except for buccal surfaces.
(4) Additional operative procedures:
(a) acrylic jacket, immediate treatment for fractured anterior - ~~26.00~~ 28.60;
(b) treatment filling (emergency) - ~~6.50~~ 7.15;
(c) recement inlay - ~~6.50~~ 7.15;
(d) pulpotomy - need authorization - ~~23.04~~ 25.34;
(e) no extra fee for pulp capping or bases.
(5) Crown and bridge:
(a) three-quarter cast crown - ~~125.45~~ 138.00;
(b) full cast crown - ~~125.45~~ 138.00;
(c) cured acrylic jacket crown, laboratory processed - ~~104.00~~ 114.40;
(d) porcelain jacket - ~~143.00~~ 157.30;
(e) porcelain veneer (microbond, ceramco, etc.) - ~~220.80~~ 242.88;
(f) full cast crown with acrylic facing - ~~184.00~~ 202.40;
(g) gold and semi-precious crowns will be reimbursed at the same rate.
(6) Pedodontics, spacers, crowns, etc. amalgam restorations same as permanent teeth:
(a) chrome crown - ~~48.00~~ 52.80;
(b) immediate treatment of fractured anterior permanent tooth, includes pulp testing, pulp capping and use of metal band or crown form with sedative filling - ~~20.80~~ 22.88;
(c) chrome crown and loop spacer or other types (space maintainer) - ~~52.00~~ 57.20;
(d) bilateral space maintainer or lingual arch - ~~82.50~~ 90.75;

(e) acrylic denture, without clasps, supplying 1 to 4 (flipper) - ~~65.00~~ 71.50;
(f) each additional tooth, permanent on acrylic denture (flipper) - ~~6.50~~ 7.15;
(g) chrome wire clasps, adams, t or ball, each - ~~6.50~~ 7.15;
(h) stainless steel band - ~~12.00~~ 13.20.
(7) Prosthodontics:
(a) complete maxillary denture, acrylic, plus necessary adjustment - ~~336.00~~ 369.60;
(b) complete mandibular denture, acrylic, plus necessary adjustment - ~~336.00~~ 369.60;
(c) acrylic upper or lower partial denture with cast chrome clasps and rests replacing at least 4 posterior teeth plus adjustments - ~~260.00~~ 286.00;
(d) maxillary cast chrome partial denture, acrylic saddles, 2 clasps and rests, replacing missing posterior teeth and one or more anterior teeth, plus adjustments - ~~325.00~~ 357.50.
(8) Relines and repairs, etc.:
(a) cured resin reline, lower - ~~86.45~~ 95.10;
(b) cured resin reline, upper - ~~86.45~~ 95.10;
(c) broken denture repair, no teeth, metal involved - ~~38.40~~ 42.24;
(d) denture adjustment - only where dentist did not make dentures - ~~7.80~~ 8.58;
(e) replacing broken tooth on denture, first tooth - ~~24.00~~ 26.40;
(f) each additional tooth after procedure (e) and (g) - ~~6.50~~ 7.15;
(g) adding teeth to partial to replace extracted natural teeth, first tooth - ~~32.50~~ 35.75;
(h) replacing clasp, new clasp - ~~45.50~~ 50.05;
(i) repairing (welding or soldering) palatal bars, lingual bars, metal connectors, etc. on chrome partials - ~~84.50~~ 92.95;
(j) duplicate (jump) upper complete denture - ~~110.50~~ 121.55;
(k) lower jump or duplicate - ~~110.50~~ 121.55;
(l) placing name on new, full or partial dentures - ~~10.00~~ 11.00.
(9) Pontics:
(a) steele's facing type,
(i) per tooth up to 2 teeth - ~~97.50~~ 107.25;
(ii) each additional tooth - ~~32.50~~ 35.75;
(b) pontic - ceramic only, each tooth - ~~147.50~~ 162.25;
(c) cured acrylic, laboratory processed, veneer, each tooth - ~~97.50~~ 107.25;
(10) Repairs:
(a) recement bridge - ~~13.00~~ 14.30;
(b) recement crown - ~~6.50~~ 7.15;

(c) porcelain facing - ~~26.00~~ 28.60;
(d) replace broken steele's facing, post intact - ~~22.00~~ 24.20;
(e) gold post - ~~55.00~~ 60.50;
(f) steel post or dowel with amalgum buildup - ~~26.00~~ 28.60;
(g) replace broken steele's facing, post broken - ~~32.50~~ 35.75.
(11) Oral surgery:
(a) I and D of abcess intra-oral - ~~50.00~~ 55.00;
(b) removal of tooth (includes shaping of ridge bone) - ~~17.85~~ 19.64;
(c) surgical removal of tooth, soft tissue impaction - ~~32.50~~ 35.75;
(d) surgical removal of tooth, partial bone impaction - ~~58.50~~ 64.35;
(e) surgical removal of tooth, complete bone impaction - ~~97.50~~ 107.25;
(f) alveolectomy, not in conjection with extractions, per quadrant - ~~32.50~~ 35.75;
(g) excision of hyperplastic tissue/each quad - ~~32.50~~ 35.75;
(h) removal of retained, residual roots, foreign bodies in bony tissue - ~~32.50~~ 35.75;
(i) removal of cyst - ~~50.00~~ 55.00;
(j) removal of retained, residual roots, foreign bodies in maxillary sinus - ~~97.50~~ 107.25;
(k) frenectomy - ~~45.50~~ 50.05;
(l) removal of exostosis torus, maxillary or mandibular - ~~65.00~~ 71.50;
(m) biopsy, including pathology lab charges - ~~26.00~~ 28.60;
(n) maxilla, open reduction - ~~326.30~~ 358.93;
(o) fracture, simple, maxilla, treatment and care - ~~253.50~~ 278.85;
(p) mandible, open reduction - ~~436.80~~ 480.48;
(q) fracture, simple, mandible, treatment and care - ~~253.50~~ 278.85;
(r) facial surgery - usual and customary charges which are reasonable.
(12) Endodontics:
(a) root canal chemotherapy and mechanical preparation, scaling and filing - ~~112.00~~ 123.20;
(b) root canal, each additional root up to two - ~~30.00~~ 33.00;
(c) root canal and apicoectomy combined operation - ~~117.00~~ 128.70;
(d) apicoectomy not in conjunction with root canal - ~~58.50~~ 64.35.
(13) Anesthesia:
(a) general anesthesia administered in office - ~~39.00~~

42.90;

(b) nitrous oxide - ~~4.00~~ 4.40;

(c) oral premedication - ~~$10.00~~ 11.00;

(d) parenteral premedication - ~~$39.00~~ 42.90

(14) Periodontal services:

(a) periodontal prophylaxis per quadrant - ~~16.90~~ 18.59;

(b) gingival resection - ~~32.50~~ 35.75;

(15) Dentist examining more than one medicaid recipient in a long-term care facility on the same day shall be allowed payment for one nursing home call over the examination fees. Examination is considered a recorded evaluation.

(16) Reimbursement - orthodontia:

(a) examination - ~~9.36~~ 10.30;

(b) full treatment - records and diagnosis - ~~54.60~~ 60.06;

(c) full treatment, initial fee - includes appliances - ~~315.00~~ 346.50;

(d) full treatment, monthly fee (prior authorization will state maximum number at months) - ~~31.50~~ 34.65;

(e) full treatment, retention service - ~~3.50~~ 3.85;

(f) serial extractions, supervision - ~~3.50~~ 3.85;

(g) partial treatment, expansion appliance - ~~175.00~~ 192.50;

(h) partial treatment - head gear appliance - ~~175.00~~ 192.50;

(i) special appliance, bilateral space maintainer, upper and lower - ~~82.50~~ 90.75;

(j) special appliance, unilateral space maintainer - ~~52.00~~ 57.20;

(k) special appliance, expansion appliance - ~~175.00~~ 192.50;

(l) special appliance, retainer - ~~87.50~~ 96.25;

(m) special appliance, habit appliance - ~~87.50~~ 96.25.

The authority of the department to amend the rule is based on Section 53-6-113, MCA and the rule implements Sections 53-6-101 and 53-6-141, MCA.

46.12.805 PROSTHETIC DEVICES, DURABLE MEDICAL EQUIPMENT, AND MEDICAL SUPPLIES, REIMBURSEMENT/GENERAL REQUIREMENTS

(1) The department will pay the lowest of the following for prosthetic devices, durable medical equipment, and medical supplies not also covered by medicare: the provider's actual (submitted) charge for the item; or the medicaid fee schedule; ~~the provider's medicaid median charge for the item; the 75th percentile of the range of weighted medicaid median charges for each item covered by this rule.~~

The department will pay the lower of the following for prosthetic devices, durable medical equipment and medical supplies which are also covered by medicare: the provider's actual (submitted) charge for the item; the medicaid fee

schedule; or the amount allowable for the same item under medicare.

Subsections (2) through (4) remain the same.

The authority of the department to amend the rule is based on Section 53-6-113, MCA and the rule implements Sections 53-6-101 and 53-6-141, MCA.

46.12.806 PROSTHETIC DEVICES, DURABLE MEDICAL EQUIPMENT, AND MEDICAL SUPPLIES, REIMBURSEMENT/FEE SCHEDULE

(1) MEDICAID FEE SCHEDULE FOR RENTAL OF MEDICAL SUPPLIES AND EQUIPMENT

Crutches, stand, wood/per month - ~~$6.00~~ 6.60

Crutches, for arm/per month - ~~$13.20~~ 14.52

Crutches, special/per month - ~~$14.30~~ 15.73

Hospital bed, standard with mattress/per month - ~~$39.00~~ 42.90

Hospital bed, electric with mattress/per month - ~~$81.00~~ 89.10

Hospital bed, electric or standard, side rails/per month - ~~$13.00~~ 14.30

Trapeze bar with stand/per month - ~~$27.00~~ 29.70

Trapeze bars/per month - ~~$13.00~~ 14.30

Walker, regular/per month - ~~$16.00~~ 17.60

Walker, wheeled/per month - ~~$19.00~~ 20.90

Wheelchair, standard, folding/per month - ~~$49.50~~ 54.45

Wheelchair, standard hospital/per month - ~~$38.50~~ 42.35

Wheelchair, standard with accessory/per month - ~~$49.50~~ 54.45

Wheelchair, standard, motor/per month - ~~$55.00~~ 60.50

Wheelchair, child, with accessory/per month - ~~$28.60~~ 31.46

Wheelchair, custom, special/per month - ~~$44.00~~ 48.40

Wheelchair accessory/per month - ~~$49.50~~ 54.45

Raised toilet seat/per month - ~~$7.70~~ 8.47

Miscellaneous supplies and equipment/per month - BR

Standard commode/per month - ~~$13.00~~ 14.30

Wheeled commode/per month - ~~$16.00~~ 17.60

Hoyerlift/per month - ~~$55.00~~ 60.50

Seat lift/per month - ~~$55.00~~ 60.50

Ultrasonic nebulizer/per month - ~~$49.50~~ 54.45

Asthmastix/per month - BR

IPPB/per month - ~~$60.00~~ 66.00

Portabird/per month - ~~$55.00~~ 60.50

Handevent/per month - ~~$55.00~~ 60.50

Respirator/per month - ~~$49.50~~ 54.45

Linde reservoir/per month - ~~$44.00~~ 48.40

Linde walker unit/per month - ~~$38.50~~ 42.35

PCU container/per month - ~~$44.00~~ 48.40

LV 160/per month - ~~$38.50~~ 42.35

Liberator stroller/per month - ~~$99.00~~ 108.90

Mada Duo-pak 13 B/per month - ~~$27.50~~ 30.25

Lifesaving unit 5000/per month - ~~$26.40~~ 29.04

Lifesaving unit 5010/per month - ~~$26.40~~ 29.04

Oxygen regulator/per month - ~~$18.50~~ 20.35

Cylinder/per month - ~~$6.60~~ 7.26

Regular humid unit/per month - ~~$16.50~~ 18.15

Oxygen tent/per month - ~~$33.00~~ 36.30

Port-carry unit with E tank/Reg/per month - ~~$22.00~~ 24.20

Liberator/per month - ~~$60.50~~ 66.55

Briox oxyeconcentrator/per month - ~~$264.00~~ 290.40

Water mattress/per month - ~~$38.50~~ 42.35

Raised toilet seat/per month - ~~$7.70~~ 8.47

Dialysis equipment/per month - BR

Dialysis Unibed tank/per month - ~~$22.00~~ 24.20

Dialysis Duo bed tank/per month - ~~$44.00~~ 48.40

Dialysis Tri bed tank/per month - ~~$66.00~~ 72.60

Jobst pressure pump/per month - ~~$44.00~~ 48.40

(2) MEDICAID FEE SCHEDULE FOR PURCHASE OF MEDICAL SUPPLIES AND EQUIPMENT

Surgical Supplies

Syringes -

Insulin (glass)/each - $ ~~.22~~ .24

Tuberculin (glass)/each - $ ~~.22~~ .24

General (glass)/each - BR

Special (glass)/each - ~~$12.10~~ 13.31

Insulin (disposable)/each - $ ~~.22~~ .24

Tuberculin (disposable)/each - $ ~~.22~~ .24

General (disposable)/each - $ ~~.29~~ .32

Special (disposable)/each - $ ~~.29~~ .32

Asepto syringes/each - $ ~~.25~~ .28

Needles

Regular (permanent)/each - $ ~~.19~~ .21

Regular (disposable)/each - $ ~~.25~~ .28

Special (permanent)/each - $ ~~.22~~ .24

Special (disposable)/each - $ ~~.33~~ .36

Analysis Reagents and Equipment

Urine test - BR

Tes-tape/roll - ~~$4.00~~ 4.40

Clinitest tablets/each - ~~$.0475~~ .0523

Clinitest tablets (foilrap roll)/each - $ ~~.05~~ .06

Clinitest strips/each - $ ~~.06~~ .07

Albustix strips/each - BR

Keto-Diastix/each - $ ~~.11~~ .12

Combistix strips/each - $ .04

Uristix strips/roll - BR

Acetest tablet roll/per tablet - ~~$.080~~ .10

Acetest tablets/each - $ ~~.09~~ .10

Ketostix strips/each - $ ~~.16~~ .18

Diastix/each - $ ~~.06~~ .07

Durable Sick Room Apparatus

Cane, regular - ~~$12.00~~ 13.20

Cane, quad - ~~$32.85~~ 36.14

Crutches, stand, wood - ~~$21.95~~ 24.15

Crutches, stand, metal - ~~$27.50~~ 30.25

Crutches, for arm - ~~$52.80~~ 58.08

Crutches, special - ~~$28.60~~ 31.46

Dialysis equipment - BR

Hospital bed, standard with mattress - ~~$824.18~~ 906.60

Hospital bed, electric with mattress - ~~$1,149.25~~ 1,264.18

Hospital bed, standard, side rails/per rail - ~~$55.00~~ 60.50

Hospital bed, electric, side rails/per rail - ~~$55.00~~ 60.50

Postural drainage board - ~~$49.50~~ 54.45

Alternating pressure pad - ~~$33.00~~ 36.30

Alternating pressure pad with pump - ~~$335.94~~ 369.53

Hoyer lift - ~~$577.50~~ 635.25

Seat lift - ~~$1,050.50~~ 1,155.55

Standard commode - ~~$71.50~~ 78.65

Wheeled commode - ~~$110.00~~ 121.00

General Equipment

Bed pan, regular - ~~$11.14~~ 12.25

Bed pan, fracture - ~~$7.69~~ 8.46

Thermometer, fever/each - ~~$1.60~~ 1.76

Emesis basin - ~~$7.00~~ 7.70

Urinal, female, metal - ~~$29.32~~ 32.25

Urinal, male, metal - ~~$34.00~~ 37.40

Heating pad - ~~$17.54~~ 19.29

Traction, hip - BR

Traction, neck - ~~$26.40~~ 29.04

Vaporizer, steam type - ~~$13.15~~ 14.47

Humidifier - ~~$29.26~~ 32.19

Vaporizer, cool type - ~~$21.84~~ 24.02

Handheld nebulizer - ~~$6.55~~ 7.21

Whirlpool bath (portable) - ~~$320.00~~ 352.00

Sitz bath - ~~$55.00~~ 60.50

Cervical collar - ~~$21.45~~ 23.60

Trapeze bars - ~~$20.00~~ 22.00

Walker, regular - ~~$60.45~~ 66.50

Walker, wheeled - ~~$154.00~~ 169.40

Wheelchair, standard folding - ~~$625.00~~ 687.50

Wheelchair, standard hospital - ~~$363.00~~ 399.30

Wheelchair, standard with accessory - ~~$755.00~~ 830.50

Wheelchair, standard motor - ~~$1,556.60~~ 1,712.26

Wheelchair, child, folding - ~~$550.00~~ 605.00

Wheelchair, child, with accessory - ~~$443.00~~ 487.30

Wheelchair, custom special - ~~$973.50~~ 1,070.85

Waterpik - ~~$39.55~~ 43.51

Bathtub stool - ~~$50.60~~ 55.66

Wheelchair accessory - BR

Flotation cushion wheelchair/each - ~~$30.00~~ 33.00

Bathtub seat - ~~$70.94~~ 78.03

Bathtub rails/each - BR, not to exceed ~~$36.95~~ 40.65

Raised toilet seat - ~~$50.30~~ 55.33

Wheelchair repair - BR

Ostomy pouch, self administered - ~~$11.00~~ 12.10

Disposable colostomy bags - ~~$12.05~~ 13.26

Disposable colostomy appliance accessory - ~~$15.92~~ 17.51

Disposable colostomy appliance - BR

Colostomy shield appliance - ~~$7.70~~ 8.47

Colostomy irrigating appliance - ~~$6.60~~ 7.26

Colostomy irrigate accessory - ~~$ .74~~ .81

Colostomy appliance (non-disposable) - BR

Colostomy appliance accessory - ~~$5.45~~ 6.00

Disposable ileostomy appliance - ~~$44.46~~ 48.91

Disposable ileostomy accessory - ~~$35.15~~ 38.67

Disposable urostomy bags/each - ~~$1.55~~ 1.71

Male urinal, complete/each - ~~$9.75~~ 10.73

Urinal bag (each) - ~~$3.17~~ 3.49

Suspensory (for use with urinal) - ~~$20.86~~ 22.95

Disposable urinal collect bag/each - ~~$3.17~~ 3.49

Urinal accessories (drainage tube) - ~~$7.98~~ 8.78

Bedside collect unit, complete - ~~$9.96~~ 10.96

Bedside drainage bags - ~~$6.38~~ 7.02

Incontinance clamp - ~~$31.55~~ 34.71

Urethral catheter with tray (rubber silicone)/each - ~~$4.97~~ 5.47

Urethral catheter, each - ~~$.77~~ .85

Indwelling catheter (Foley, balloon retention)/each - ~~$7.55~~ 8.31

Feeding tube/per foot - BR

Colon tube/per foot - BR

Gastric tubes/per foot - $ ~~.45~~ .50

Syringe tubing - BR

Wrist splint - ~~$17.22~~ 18.94

Arm splint - ~~$8.80~~ 9.68

Finger splint - $ ~~.83~~ .91

Leg splint - ~~$29.66~~ 32.63

Installment DME or machine set-up - BR

Ultrasonic nebulizer - ~~$467.50~~ 514.25

Asthmastix - BR

IPPB, air - ~~$462.00~~ 508.20

IPPB, oxygen - ~~$462.00~~ 508.20

Portabird - ~~$520.00~~ 572.00

Handevent - ~~$114.40~~ 125.84

Respirator - ~~$434.50~~ 477.95

Mada Duo-pak (with adjustable flow regulator) - ~~$209.72~~ 230.69

Lifesaving unit 5000 - ~~$140.45~~ 154.50

Lifesaving unit 5010 - ~~$184.00~~ 203.28

Regular humidifier unit - ~~$18.45~~ 20.30

D cylinder - BR

E cylinder - ~~$75.60~~ 83.25

R cylinder - BR

Cylinder No 5 - BR

02 contents Linde Reservoir - ~~$41.25~~ 45.38

02 contents Liberator - ~~$45.10~~ 49.61

02 contents L V 160 - ~~$313.50~~ 344.85

02 contents PCU Reservoir - ~~$39.60~~ 43.56

02 contents G P 45 - ~~$264.00~~ 290.40

02 contents D cylinder - ~~$11.55~~ 12.71

02 contents E cylinder - ~~$11.55~~ 12.71

02 contents GDL-K cylinder - ~~$19.53~~ 21.48

02 contents H cylinder - ~~$19.53~~ 21.48

02 contents J cylinder - ~~$23.21~~ 25.53

02 contents M cylinder - ~~$9.46~~ 10.41

02 contents O cylinder - BR

02 contents Q cylinder - ~~$13.20~~ 14.52

02 contents R cylinder - ~~$9.90~~ 10.89

02 contents S cylinder - ~~$12.30~~ 13.62

IPPB Kit - BR

Cannula - ~~$2.50~~ 2.75

Connective tubing/per foot - $ ~~.44~~ .48

Portable aspirator - ~~$9.96~~ 10.96

Connectors - $ ~~.88~~ .97

Face mask - ~~$2.75~~ 3.03

Mouth piece - $ ~~.66~~ .73

Nasal catheter - ~~$1.49~~ 1.64

Disposable IPPB tubing - ~~$3.85~~ 4.24

Disposable humidifiers - ~~$1.57~~ 1.73

Extension hoses - ~~$1.65~~ 1.82

Mada plastic nebulizer W mask & tube - ~~$6.60~~ 7.26

Nasal 02 kit - ~~$16.50~~ 18.15

02 tubing - ~~$1.93~~ 2.12

Delivery charge - BR

Oxygen regulator - ~~$16.50~~ 18.15

Liquid 02 330 - BR

Liquid 02 80 - BR

Aquapak - ~~$4.13~~ 4.54

Anatomical Supports

Appliances, surgical - BR

Scrotal truss - ~~$43.23~~ 47.55

Umbilical truss - BR

Shoulder brace - ~~$15.40~~ 16.94

Sacroiliac support - ~~$13.25~~ 14.58

Lumbosacral support (corsets) - ~~$93.50~~ 102.85

Post hernia truss - ~~$11.54~~ 12.69

Hinged joint steel knee cap - BR

Knee brace - ~~$15.35~~ 16.89

Wrist brace - BR

Corsets - ~~$66.00~~ 72.60

Abdominal support - ~~$12.65~~ 13.92

Dorso lumbar support - ~~$103.20~~ 113.52

Mastectomy support - ~~$27.50~~ 30.25

Orthopedic brace - BR

Acrylic neck brace - ~~$26.40~~ 29.04

Foam cervical collar - ~~$10.40~~ 11.44

Dennis Brown splint - ~~$22.00~~ 24.20

Ankle brace - BR

Orthopedic shoes, brace - ~~$201.50~~ 221.74

Orthotic appliances - BR

Girdle attachment brace - BR

Rib belt - BR

Repair of prosthesis - BR

Repair orthopedic appliance - BR

Elastic supports - BR

Elastic stockings (sheer type, Jobst or similar) - ~~$24.60~~ 27.06

Elastic stockings (surgical type) - ~~$24.60~~ 27.06

Miscellaneous Supplies and Equipment

Miscellaneous supplies and equipment - BR

Gel cushion - ~~$42.30~~ 46.53

Enema supplies - ~~$11.00~~ 12.10

Allergenic extract - BR

Injection supplies - BR

Isotopes - ~~$47.61~~ 52.37

Eye prosthesis - ~~$330.00~~ 363.00

Overbed table - ~~$12.65~~ 13.92

Foam cushion - ~~$9.85~~ 10.84

Water mattress - ~~$96.00~~ 105.60

Foam mattress - ~~$69.50~~ 76.45

Tracheotomy tubes - ~~$11.00~~ 12.10

Stump sox/pair - ~~$15.00~~ 16.50

Protective helmet - ~~$26.50~~ 29.15

Transfer board - ~~$12.50~~ 13.75

Helping Hand - ~~$22.00~~ 24.20

Disposable gloves/each - $ ~~.00~~ .09

Gauze, bandages, tape - BR

Rest-On foam pads - ~~$3.98~~ 4.38

Disposable under pads/each - $ ~~.29~~ .32

Sheepskin - BR

Oversponges/each - $ ~~.06~~ .07

Arm sling - ~~$3.60~~ 3.96

Dermacin - ~~$2.20~~ 2.42

Contraceptives

Diaphragm - ~~$6.60~~ 7.26

Condoms/one dozen - ~~$3.00~~ 3.30

IUD's - CU7 - ~~$20.00~~ 22.00

IUD's - Progestasert - ~~$9.00~~ 9.90

IUD's - others - ~~$6.00~~ 6.60

Pills/one cycle - ~~$3.00~~ 3.30

Foam, jelly, creme - ~~$3.30~~ 3.63

The authority of the department to amend the rule is based on Section 53-6-113, MCA and the rule implements Sections 53-6-101 and 53-6-141, MCA.

46.12.905 OPTOMETRIC SERVICES, REIMBURSEMENT (1) The department will pay the lowest of the following for optometric services not also covered by medicare: the provider's actual (submitted) charge for the service; ~~the 75th percentile of the range of weighted medicaid median charges for each service covered by this rule;~~ or the department's fee schedule contained in this rule.

The department will pay the lowest of the following for optometric services which are also covered by medicare: the provider's actual (submitted) charge for the service; the amount allowable for the same service under medicare; or the department's fee schedule contained in this rule.

(~~1~~2) Visual Examination for diagnosis only. The following procedures are included:

(a) Case history, symptoms, and occupational vision evaluation

(b) Analysis and neutralization of patients current lenses and frames

(c) Visual acuity testing, distance and near

(d) Eye health examination

(i) pupillary reflexes (direct, consensual, and accommodative)

(ii) ophthalmoscopy (media and fundus inspection)

(iii) external inspection (cornea, lids, and adnexa)

(iv) ocular motility (versions)

(e) Visual Analysis

(i) keratometry or ophthalmometry

(ii) preliminary oculomoter coordination evaluation (pursuits, saccadics, cover tests, N.P.C.)

(iii) refraction at far point: static retinoscopy, subjective refraction

(iv) refraction at near point: dynamic retinoscopy, subjective refraction

(v) phorometric tests at far point and near point: phorias, ductions, blur points, accommodative measurements

(f) The fee is: ~~$25.57~~ 28.13

(~~23~~) Visual Examination, prescription, and follow-up. The following procedures are included:

(a) Case history, symptoms, and occupational vision evaluation,

(b) Analysis and neutralization of patients current lenses and frames

(c) Visual acuity testing, distance and near

(d) Eye health examination

(i) pupillary reflexes (direct, consensual, and accommodative)

(ii) ophthalmoscopy (media and fundus inspection)

(iii) external inspection (cornea, lids, and adnexa)

(iv) ocular motility (versions)

(e) Visual Analysis

(i) keratometry or ophthalmometry

(ii) preliminary oculomoter coordination evaluation (pursuits, saccadics, cover tests, N.P.C.)

(iii) refraction at far point: static retinoscopy, subjective refraction

(iv) refraction at near point: dynamic retinoscopy, subjective refraction

(v) phorometric tests at far point and near point: phorias, ductions, blur points, accommodative measurements

(f) Prescribing: writing ophthalmic lens power prescription(s)

(g) Follow-up observation at visit following the delivery and fitting of new lens prescription: observation of patient's reactions and evaluation of visual performance with new glasses or other therapy performing of any indicated frame or lens adjustments re-prescribing of lens and/or frame if indicated

(h) The fee is: ~~$34.10~~ 37.51

(~~34~~) Measuring:

(a) measuring, verifying, single vision service (for standard frame and basic power ophthalmic lenses) - ~~$10.23~~ 11.25

(b) measuring, verifying, bifocal lens service - ~~$13.64~~ 15.00

(c) measuring, verifying, trifocal lens service - ~~$17.05~~ 18.76

(d) measuring, verifying, cataract lens service - ~~$25.57~~ 28.13

(~~45~~) Fitting:

(a) fitting, servicing, single vision frame service - ~~$10.23~~ 11.25

(b) fitting, servicing, bifocal frame service - ~~$13.64~~ 15.00

(c) fitting, servicing, trifocal frame service - ~~$17.05~~ 18.76

(d) fitting, servicing, cataract frame service - ~~$25.57~~ 28.13

(56) Hearing Aid Dispensing Services
(a) Add to measuring and verifying services - ~~$8.52~~ 9.37
(b) Add to fitting services - ~~$8.52~~ 9.37
(67) Non-basic Diagnostic Services
(a) Visual examination, additional visits - ~~$8.52~~ 9.37
(b) Visual field, Peripheral field examination, using perimeter or equivalent, white fields - ~~$8.52~~ 9.37
(c) Visual fields, peripheral field examination using perimeter or equivalent, color fields - ~~$11.93~~ 13.12
(d) Visual fields, central field examination using tangent screen or equivalent
(i) white fields - ~~$8.52~~ 9.37
(ii) color fields - ~~$11.93~~ 13.12
(e) Screening, visual skills examination, using keystone tests or equivalent - ~~$6.82~~ 7.50
(f) Screening, multiple pattern visual fields, using harrington-flecks or equivalent - ~~$5.11~~ 5.62
(g) Screening, limited tests for completion of insurance, government or school forms - ~~$6.82~~ 7.50
(h) Color vision tests, using 20 isochromatic or equivalent - ~~$3.41~~ 3.75
(i) Tonometry, tension - ~~$6.82~~ 7.50
(j) Biomicroscopy - ~~$6.82~~ 7.50
(k) Special reports - ~~$51.15~~ 56.27 per hour
(l) Consultation (schools, government) - ~~$51.15~~ 56.27 per hour
(m) Office Consultation - ~~$6.82~~ 7.50
(n) Out-of-office calls (add to other service)
(i) day-time - ~~$8.52~~ 9.37
(ii) night-time - ~~$13.64~~ 15.00
(o) Mileage charge (beyond 10 miles from office) - ~~$.17~~ .19 per mile
(p) Post cataract diagnostic examinaiton - ~~$25.57~~ 28.13
(q) Cataract lens change or regrind - ~~$17.05~~ 18.76
(~~7~~8) Non-Basic Ophthalmic Lens Services
(a) Non-Basic spherical and Shero-Cylindric Powers (+ = + or - = +) for each 4 diopters of sphere over Basic Power up to 12.00D (not applicable to cataract lenses) - add, per pair ~~$5.11~~ 5.62
(b) For each 2 diopters cylinder over basic power - add, per pair ~~$5.11~~ 5.62
(c) Special base curve - add, per pair ~~$3.41~~ 3.75
(d) Prism Power
(i) total prism power less than 5 prism diopters - add, per pair ~~$5.11~~ 5.62
(ii) total prism power 5 diopters or more - add, per pair ~~$8.52~~ 9.37
(e) Lenticular grinding
(i) concave - add, per pair ~~$8.52~~ 9.37
(ii) convex - add, per pair ~~$8.52~~ 9.37
(f) Slab-off grinding - add, per pair ~~$8.52~~ 9.37

(g) Tinted or colored glass
(i) single vision lenses - ~~$3.41~~ 3.75
(ii) multifocal lenses - ~~$3.41~~ 3.75
(h) Oversize, fused flat top multifocal segment, 35 & 45 mm wide - ~~$3.41~~ 3.75
(i) Dual segment bifocal (to be added to bifocal value units) - add, per pair ~~$17.05~~ 18.76
(j) Dual segment trifocal (to be added to trifocal value units) - add, per pair ~~$17.05~~ 18.76
(k) High add fused bifocal, 3.00 - 4.00 diopters - add, per pair ~~$3.41~~ 3.75
(l) High add fused bifocal, over - 4.00 - add, per pair ~~$8.52~~ 9.37
(m) High add one-piece bifocal over 4.00 diopters - add, per pair ~~$8.52~~ 9.37
(n) Plastic single vision lens - add, per pair ~~$3.41~~ 3.75
(o) Plastic multifocal lens - add, per pair ~~$8.52~~ 9.37
(p) Coating, anti-reflection or color - add, per pair ~~$3.41~~ 3.75
(q) Iseikonic lens - add, per pair ~~$153.45~~ 168.80
(r) Safety Hardening - add, per pair ~~$3.41~~ 3.75
(~~8~~9) Service Code for metal frames - ~~$6.82~~ 7.50
(9~~10~~) Contact Lens Therapy: These services to be performed at visits following the visual examination.
(a) Contact lens diagnostic examination include biomicroscopy, corneal measurements, ocular adnexa measurements, control lens observations, and contact lens refraction - ~~$17.05~~ 18.76
(b) Fitting Procedure, basic spherical lens include:
(i) integration of all diagnostic data to determine physical specifications and refractive prescription of initial lens,
(ii) ordering from laboratory,
(iii) verifying finished lenses for physical specifications and refractive properties,
(iv) biomicroscopic and fluorescein evaluation of finished lenses in patients eye,
(v) contact lens refraction with finished lens,
(vi) instructing patient in insertion and removal procedures,
(vii) subsequent office visits to evaluate lens performance as wearing-time is increased (biomicroscopic and fluorscein inspections),
(viii) determination of necessary lens modifications or complete lens changes, as indicated,
(ix) re-specifying, re-prescribing, and re-ordering of lenses as indicated,
(x) office laboratory modifications as indicated, and
(xi) re-verifying of new or modified lenses.
(xii) The fee is: ~~$255.75~~ 281.33

(c) The following fees may be added to contact lens diagnostic examination or contact lens fitting procedure, basic spherical lens.

(i) Fitting Procedures, Spherical Prism Ballast Lenses - ~~$82.25~~ 90.48

(ii) Fitting Procedures, Lenticular and/or Aphakic Lenses - ~~$42.62~~ 46.88

(iii) Fitting Procedures, Toric Lenses - ~~$85.25~~ 93.78

(iv) Fitting Procedures, Bifocal Lenses - ~~$170.50~~ 187.55

(v) Fitting Procedures, Keratoconus Lenses - ~~$170.50~~ 187.55

(vi) Office Call, observation and consultation - ~~$8.52~~ 9.37

(~~10~~11) The following are independent procedures:

(a) Instruction visit for previous contact lens wearer;

(i) fitted elsewhere - ~~$25.57~~ 28.13

(ii) fitted in your office - ~~$11.93~~ 13.12

(b) Fitting Procedure for previous contact lens wearer - ~~$165.00~~ 181.50

(c) Duplication of new contact lenses - ~~$63.93~~ 70.32

(d) Fitting Procedure, monocular only - ~~$165.00~~ 181.50

(~~11~~12) Contact Lens Laboratory Adjustments

(a) This service applies to new patients fitted elsewhere and your patients past customary servicing period. It includes edge-refinishing, size reducing, fenestrating, repolishing and bleeding - ~~$8.52~~ 9.37.

(b) Analysis and neutralization of contact lenses - ~~$10.23~~ 11.25

(~~12~~13) Servicing and Repairs, Frame Adjustments. Apply to: new patients fitted elsewhere and your patients past customary servicing period

(a) Conventional frame (minor adjustments) - ~~$3.41~~ 3.75

(b) Conventional frame (complete realignment) - ~~$6.82~~ 7.50

(c) Iseikonic lenses ~~$6.82~~ 7.50

(d) Low vision aid - ~~$8.52~~ 9.37

(e) Special frame - ~~$8.52~~ 9.37

(f) Hearing aid frame - ~~$8.52~~ 9.37

(~~13~~14) Servicing and Repairs: Frame Replacements (standard frame)

(a) Duplicate frame (½ 003 + 004 using single vision service units) - ~~$15.34~~ 16.87

(b) Different frame (requiring lens or frame reshaping) - ~~$18.75~~ 20.63

(c) Front Replacement (¼ 003 + 004 using single vision service units) - ~~$12.78~~ 14.06

(d) Temple Replacement, per temple (service per pair) - ~~$4.62~~ 5.08

(e) Hinge Repair - ~~$5.11~~ 5.62

(f) Ptosis Crutch - ~~$17.05~~ 18.76

(~~14~~15) Servicing and Repairs: Minor Frame Reports

(a) Replace Screws - ~~$1.70~~ 1.87
(b) Supply Jumbo Pads - ~~$1.70~~ 1.87
(c) Supply Temple Covers - ~~$1.70~~ 1.87
(d) Supply Pad Covers - ~~$1.70~~ 1.87
(e) Supply Hinge Springs or Tension Washers - ~~$3.41~~ 3.75
(f) Solder Repair - ~~$3.41~~ 3.75
(g) Rocking Pads added to Zyl or aluminum frame - ~~$3.41~~ 3.75
(h) Rightening hinge to front or temple - ~~$1.70~~ 1.87
(i) New top-rims - ~~$3.41~~ 3.75

(~~15~~16) Servicing and Repairs: Lens
(a) Neutralization of Lenses for Copy of Prescription - ~~$5.11~~ 5.62
(b) Lens replacment, one lens, single vision service - ~~$10.23~~ 11.25
(c) Lens replacement, one lens, bifocal service - ~~$13.64~~ 15.00
(d) Lens replacement, one lens, trifocal service - ~~$17.05~~ 18.76

(~~16~~17) Diagnostic Drug Procedures
(a) Cycloplegic examination/refraction, independent procedure - ~~$42.62~~ 46.88
(b) Supplemental mydiadic, add to fee for other procedures - ~~$8.52~~ 9.37
(c) Supplemental cycloplegic including post-cycloplegic office visit - ~~$17.05~~ 18.76
(d) Ophthalmoscopy, independent procedures, with mydriasis, direct and/or indirect - ~~$17.05~~ 18.76
(e) Ophthalmoscopy with contact fundus lens procedure, add to fee for other procedures - ~~$11.91~~ 13.10
(f) Gonioscopy, add to fee for other procedure - ~~$13.64~~ 15.00
(g) Gonioscopy, independent procedure - ~~$23.87~~ 26.26
(h) Tonography, independent procedure - ~~$34.10~~ 37.51
(i) Intra-ocular photography, independent procedure, anterior segment - ~~$17.05~~ 18.76
(j) Intra-ocular photography, independent procedure, posterior segment - ~~$34.10~~ 37.51
(k) Supplemental differential diagnostic procedures using topical pharmaceuticals, add to fee for other procedures - ~~$11.93~~ 13.12
(l) Ophthalmoscopy with contact fundus lens procedure, independent procedure - ~~$23.87~~ 26.26
(m) Ophthalmodynamometry, supplemental procedure, add to fee for other procedures - ~~$10.23~~ 11.25
(n) Ophthalmodynamometry, independent procedure - $17.05

(~~16~~17) Visual training shall be reimbursed at the lowest of usual and customary charges, which are reasonable, the amount payable by medicare or ~~$19.80~~ 21.78 per hour.

The authority of the department to amend the rule is based on Section 53-6-113, MCA and the rule implements Sections 53-6-113 and 53-6-141, MCA.

46.12.915 EYEGLASSES, REIMBURSEMENT (1) The department will pay the lowest of the following for eyeglasses not also covered by medicare: the provider's actual (submitted) charge for the service~~, the provider's medicaid median charge for the service, the 75th percentile of the range of weighted medicaid median charges for each service covered by this rule,~~ or the department's fee schedule contained in this rule.

The department will pay the lowest of the following for eyeglasses which are also covered by medicare: the provider's actual (submitted) charge for the service; the amount allowable for the same service under medicare; or the department's fee schedule contained in this rule.

~~(1)~~ (2) Lab costs for eyeglasses - optometrist

	Per Pair	
Hardened lenses-single vision	~~$21.78~~ 23.96	
Hardened lenses-bifocals	~~33.00~~ 36.30	
Hardened lenses-trifocals	~~39.93~~ 43.92	
Plastic lenses		
Add to single lenses	~~2.42~~ 2.66	
Add to bifocal/trifocal	~~7.26~~ 7.99	
Tinting, add to lense	~~3.63~~ 3.99	
Frames	~~23.10~~ 25.41	
Contact lenses	~~38.50~~ 42.35	
Cataract lense	~~67.76~~ 74.54	per lense
Balance lense	~~24.20~~ 26.62	per lense

~~(2)~~ (3) Costs for eyeglasses - opticians and opthamologist

	Per Pair	
Single vision	~~$33.00~~ 36.30	
Bifocal	~~47.30~~ 52.03	
Trifocal	~~60.50~~ 66.55	
Plastic lenses		
Add to single lenses	~~4.40~~ 4.84	
Add to bifocal/trifocal	~~12.10~~ 13.31	
Tint (soft light 1, 2, and 3)	~~3.63~~ 3.99	
Frame	~~28.60~~ 31.46	
Metal frame	~~33.00~~ 36.30	
Cataract lense	~~67.76~~ 74.54	per lense
Balance lense	~~24.20~~ 26.62	per lense
4 drop cataract		
Single vision	~~181.50~~ 199.65	
Bifocal	~~209.00~~ 229.90	
Balance lense	~~74.25~~ 81.68	
Frame (for 4 drop cataract)	~~33.00~~ 36.30	

The authority of the department to amend the rule is based on Section 53-6-113, MCA and the rule implements Sections 53-6-113 and 53-6-141, MCA.

46.12.1005 TRANSPORTATION AND PER DIEM, REIMBURSEMENT (1) The department will pay the lowest of the following for transportation and per diem not also covered by medicare: the provider's actual (submitted) charge for the service; ~~the provider's medicaid median charge for the service; the 75th percentile of the range of weighted medicaid median charges for each service covered by this rule;~~ or the department's fee schedule contained in this rule.

The department will pay the lowest of the following for transportation and per diem which are also covered by medicare: the provider's actual (submitted) charge for the service; the amount allowable for the same service under medicare; or the department's fee schedule contained in the rule.

~~(1)~~ (2) Reimbursement for common carrier will be paid on the basis of usual and customary charges.

~~(2)~~ (3) Reimbursement for transportation by private vehicle will be at the current state rate for state employees.

~~(3)~~ (4) Reimbursement for per diem when lodging expenses are necessary shall be actual expenses incurred up to a maximum of ~~$20.40~~ 22.44 per recipient and ~~$20.40~~ 22.44 per attendant, when necessary. When lodging expenses are not necessary, medicaid payment for meals shall not exceed the following rates:

Morning	(12:01 a.m. to 10:00 a.m.)	~~$2.50~~ 2.75
Mid-day	(10:01 a.m. to 3:00 p.m.)	~~$3.00~~ 3.30
Evening	(3:01 p.m. to 12:00 midnight)	~~$6.00~~ 6.60

~~(4)~~ (5) Reimbursement for private air charter shall be ~~$1.11~~ $1.22 per nautical mile for the round trip.

The authority of the department to amend the rule is based on Section 53-6-113, MCA and the rule implements Sections 53-6-101 and 53-6-141, MCA.

46.12.1015 SPECIALIZED NONEMERGENCY MEDICAL TRANSPORTATION, REIMBURSEMENT (1) The department will pay the lowest of the following for specialized nonemergency medical transportation not also covered by medicare: the provider's actual (submitted) charge for the service; ~~the provider's medicaid median charge for the service; the 75th percentile of the range of weighted medicaid median charges for each service covered by this rule;~~ or the department's fee schedule contained in this rule.

The department will pay the lowest of the following for specialized nonemergency transportation which are also covered by medicare: the provider's actual (submitted) charge for the service; the amount allowable for the same service under

medicare; or the department's fee schedule contained in this rule.

~~(1)~~ (2) The provider's rates as approved by the public service commission or the rates allowed by the following specialized nonemergency medical transportation fee schedule.

~~(2)~~ (3) Specialized nonemergency medical transportation fee schedule.

(a) Transportation under 16 miles....$ ~~8.80~~ 9.68 one way
~~$15.40~~ 16.94 round trip

Transportation over 16 miles.....$ ~~.55~~ .61 per mile

Waiting time for transportation over 16 miles.....$ ~~4.40~~ 4.84 per hour
Computed in 15 minute increments or fraction thereof

Waiting time for under 16 miles..No payment

When one way transportation is over 16 miles and the unloaded miles exceeds ten percent of the loaded miles, the miles from the departure point to the pick-up point plus the miles from the delivery point to the departure point shall be paid for at the rate of.....$ ~~.20~~ .31 per mile

(b) There shall be no charge for usual passenger baggage which is not cargo.

(c) Children under six years of age accompanied by an adult paying passenger shall be carried free.

The authority of the department to amend the rule is based on Section 53-6-113, MCA and the rule implements Sections 53-6-101 and 53-6-141, MCA.

46.12.1025 AMBULANCE SERVICES, REIMBURSEMENT

Subsections (1) through (4) remain the same.

(5) The department will pay the lowest of the following for ambulance services not also covered by medicare: the provider's actual (submitted) charge for the service; ~~the provider's medicaid median charge for the service, the 75th percentile of the range of weighted medicaid median charges for each service covered by this rule,~~ or the individual provider's ~~July 1980~~ January 1982 medicaid rate plus 10 percent. The department will pay the lowest of the following for

ambulance services which are also covered by medicare: the provider's actual (submitted) charge for the service; the amount allowable for the same service under medicare; or the individual provider's ~~July--1980~~ January 1982 medicaid rate plus 10 percent.

The authority of the department to amend the rule is based on Section 53-6-113, MCA and the rule implements Sections 53-6-101 and 53-6-141, MCA.

46.12.2003 PHYSICIAN SERVICES, REIMBURSEMENT/GENERAL REQUIREMENTS AND MODIFIERS The department will pay the lowest of the following for physician services not also covered by medicare: the provider's actual (submitted) charge for the service; ~~the provider's medicaid median charge for the service; the 75th percentile of the range of weighted medicaid median charges for each service covered--by this rule;~~ or the department's fee schedule found in rules 46.12.2004, 46.12.2005, 46.12.2006, 46.12.2007, and 46.12.2008; plus 21% for those services for which a dollar amount is specified.

The department will pay the lowest of the following for physician services which are also covered by medicare: the provider's actual (submitted) charge for the service; ~~the provider's medicaid median charge for the service; the amount~~ allowable for the same service under medicare; or the department's fee schedules found in rules 46.12.2004, 46.12.2005, 46.12.2006, 46.12.2007, and 46.12.2008 plus ~~10~~ 21% for those services for which a dollar amount is specified. The following reimbursement fee schedule and modifiers ~~applies~~ apply to all rules in this sub-chapter.

(1) Services paid by report (BR) will be paid at 94.6000% of the fees which are comparable to usual and customary charges established by the provider in 1976.

Subsection (2) remains the same.

The authority of the department to amend the rule is based on Section 53-6-113, MCA and the rule implements Sections 53-6-113 and 53-6-141, MCA.

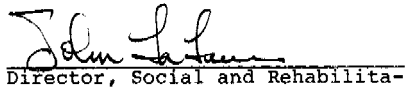
3. This amendment is proposed to provide a 10% increase in Medicaid reimbursement for all Medicaid providers (other than hospitals, nursing homes, home health agencies and pharmacies which are allowed a cost reimbursement basis) beginning July 1, 1982. HB 500, an appropriation bill passed by the 47th Montana Legislature provided for two increases in provider fees. This proposed amendment will implement the second increase.

The use of Medicaid median charges for a service and the 75th percentile of the range of weighted Medicaid median charges are proposed to be eliminated as upper limits on reimbursement. Those limits had been mandated by federal

regulation but were made optional by the 1981 Omnibus Reconciliation Act. Those limits are proposed to be eliminated because their continued application has caused an undue hardship on some Montana providers due to the manner in which actual historical charges are computed by the department utilizing these limits. Further, the limits were not utilized when the FY 1983 budget was submitted and are not essential for the department to stay within its budget limits.

4. Interested parties may submit their data, views, or arguments either orally or in writing at the hearing. Written data, views or arguments may also be submitted to the Office of Legal Affairs, Department of Social and Rehabilitation Services, P.O. Box 4210, Helena, Montana 59604, no later than June 11, 1982.

5. The Office of Legal Affairs, Department of Social and Rehabilitation Services has been designated to preside over and conduct the hearing.



Director, Social and Rehabilitation Services

Certified to the Secretary of State April 30, 1982.

BEFORE THE DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES OF THE
STATE OF MONTANA

In the matter of the adoption of rules and the repeal of Rules 46.9.201, 46.9.202, 46.9.203, 46.9.204 and 46.9.205 pertaining to supplemental payments to recipients of supplemental security income.	))))))	NOTICE OF PUBLIC HEARING ON ADOPTION OF RULES AND REPEAL OF RULES 46.9.201, 46.9.202, 46.9.203, 46.9.204 AND 46.9.205 PERTAINING TO SUPPLEMENTAL PAYMENTS TO RECIPIENTS OF SUPPLEMENTAL INCOME.

TO: All Interested Persons

1. On June 8, 1982, at 1:30 a.m., a public hearing will be held in the auditorium of the Social and Rehabilitation Services Building, 111 Sanders, Helena, Montana, to consider the adoption of rules and the repeal of Rules 46.9.201, 46.9.202, 46.9.203, 46.9.204 and 46.9.205 pertaining to supplemental payments to recipients of supplemental security income.

2. Rule 46.9.201 proposed to be repealed is on page 46-625 of the Administrative Rules of Montana.

3. The authority of the agency to repeal this rule is based on 53-2-201, MCA and the rule implements 53-2-204, MCA.

4. Rule 46.9.202 proposed to be repealed is on page 46-626 of the Administrative Rules of Montana.

5. The authority of the agency to repeal this rule is based on 53-2-201, MCA and the rule implements 53-2-204, MCA.

6. Rule 46.9.203 proposed to be repealed is on page 46-627 of the Administrative Rules of Montana.

7. The authority of the agency to repeal this rule is based on 53-2-201, MCA and the rule implements 53-2-204, MCA.

8. Rule 46.9.204 proposed to be repealed is on page 46-627 of the Administrative Rules of Montana.

9. The authority of the agency to repeal this rule is based on 53-2-201, MCA and the rule implements 53-2-204, MCA.

10. Rule 46.9.205 proposed to be repealed is on page 46-628 of the Administrative Rules of Montana.

11. The authority of the agency to repeal this rule is based on 53-2-201, MCA and the rule implements 53-2-204, MCA.

12. The rules as proposed to be adopted provide as follows:

RULE I PURPOSE (1) A supplemental payment may be made by the state to recipients of supplemental security income for the aged, blind, or disabled under Title XVI of the Social Security Act of the United States as amended (42 U.S.C. 1300 et. seq.). The purpose of the supplemental payment is to enhance the recipient's ability to be as self-sufficient as possible and to be integrated into the social life of the community. The payment is intended to provide for the basic living needs of recipients who, due to social, physical and environmental factors, can not currently live independent from special programs and facilities as defined in Rule III.

The authority of the agency to adopt the rule is based on Section 53-2-201, MCA and the rule implements 53-2-204, MCA.

RULE II INDIVIDUAL ELIGIBILITY FOR STATE SUPPLEMENT (1) Recipients of federal supplemental security income who reside in one of the facilities described in Rule III are eligible for state supplement.

(2) Applications for state supplement are made to the county welfare department. Determination of eligibility is made by the social worker based on formal assessment of the appropriateness of the placement for the applicant. Eligibility shall be redetermined every six months.

(3) Financial eligibility and actual payment amount for each individual based on all resources available is determined by the social security administration.

The authority of the agency to adopt the rule is based on Section 53-2-201, MCA and the rule implements 53-2-204, MCA.

RULE III ELIGIBILITY BASED ON LIVING ARRANGEMENT (1) In order for an individual to receive a state supplement, that individual must be a resident of one of the residential types of service facilities specified and defined in this rule.

(a) Residential care facilities licensed by the department of health and environmental sciences either as personal care facilities or as room and board facilities and which for the purposes of this rule the department of social and rehabilitation services determines:

(i) provide 24-hour on-duty personal care services that include:

(A) three nutritious meals daily served in a family setting or separate dining area;

(B) individual beds and sleeping areas available;

(C) washing and drying of personal clothes and linens with such frequency as to provide for proper hygiene;

(D) protective oversight of residents meaning enhance-

ment of their ability to live in and be integrated into the community and includes recreational activities, social activities, and assurance that individual needs are met;

(E) transportation to medical, social, therapeutic, church and other activities;

(F) preparation of special diets if required by the physician;

(G) assistance with personal daily living activities as needed, e.g., eating, dressing, shaving, hair care, bathing, and getting in and out of bed; and

(H) supervision of self-administered medication prescribed for the recipient by a physician or dentist. Supervision includes observing and recording that the medication was taken.

(ii) Provide care only to residents who are ambulatory or ambulatory with assistance from a personal attendant or mechanical devices.

(iii) Provide to the department of social and rehabilitation services information and documentation as requested to implement the supplemental payment.

(b) Community homes for the developmental disabled, defined in part 3 of Title 53, chapter 20, MCA and licensed in accordance with sub-chapter 8 of Title 46, chapter 5, ARM by the department of social and rehabilitation services.

(c) Group homes for the mentally disabled licensed by the department of health and environmental sciences as room and board facilities, having services approved by the appropriate regional mental health center, and serving only mentally disabled individuals identified by a mental health professional.

(d) Foster care homes defined in part 3 of Title 53, chapter 5, MCA or part 3 of Title 41, chapter 5, MCA and licensed in accordance with sub-chapter 7 of Title 46, chapter 5, ARM or sub-chapter 5 of Title 46, chapter 5, ARM by the department of social and rehabilitation services.

(e) Semi-independent program facilities approved by the department of social and rehabilitation services and designed to enhance or maintain the independence of adults by providing individualized 24-hour on-call supervision, home and community life training, service coordination and support services to the residents. A semi-independent program facility is usually a cluster of apartments with one to three persons residing in each unit consisting of a kitchen, one or more bedrooms, a living room and a bathroom.

The authority of the agency to adopt the rule is based on Section 53-2-201, MCA and the rule implements 53-2-204, MCA.

RULE IV PAYMENT STANDARDS (1) The department of social and rehabilitation services will, within legislative appropriations, set payment standards for each of the five

facilities listed in Rule III. The payments will be administered by the federal social security administration according to a state-federal agreement.

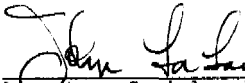
(2) A recipient must receive for personal needs a minimum amount of forty dollars ($40) total from the state supplement and the federal supplemental security income per month.

The authority of the agency to adopt the rule is based on Section 53-2-201, MCA and the rule implements 53-2-204, MCA.

13. The proposed repeal of the existing rules and adoption by the Department of new rules governing the administration of the state supplemental payments to recipients of federal supplemental security income is necessitated by a change in administrative responsibility for the program from the economic assistance division to the community services division. The proposed rules reflect changes in the purposes and procedures of the state supplemental program. The state supplement will be available to individuals who are recipients of federal supplemental income and who reside in the facilities stated and defined in proposed Rule III. The structure of the proposed rules and the proposed payment standards for state supplement will implement the program's goals of providing for the basic living needs of dependent recipients while enhancing their ability to be as self-sufficient and integrated into the community as possible.

14. Interested parties may submit their data, views, or arguments, either orally or in writing at the hearing. Written data, views or arguments may also be submitted to the Office of Legal Affairs, Department of Social and Rehabilitation Services, P.O. Box 4210, Helena, Montana 59604, no later than June 16, 1982.

15. The Office of Legal Affairs, Social and Rehabilitation Services has been designated to preside over and conduct the hearing.



Director, Social and Rehabilitation Services

Certified to the Secretary of State April 30, 1982.

BEFORE THE DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES OF THE
STATE OF MONTANA

In the matter of the adoption of rules pertaining to refugee assistance.	))))	NOTICE OF PUBLIC HEARING ON THE PROPOSED ADOPTION OF RULES PERTAINING TO REFUGEE ASSISTANCE

TO: All Interested Persons.

1. On June 7, 1982, at 1:30 p.m., a public hearing will be held in the auditorium of the Social and Rehabilitation Services Building, 111 Sanders, Helena, Montana, to consider the adoption of rules pertaining to refugee assistance.

2. The rules proposed to be adopted provide as follows:

Rule I (46.15.101) DEFINITIONS (1) For the purpose of this chapter, the following definitions apply:

(a) Refugee means an individual who:

(i) is a national of Cambodia, Vietnam or Laos and entered the United States on or after April 8, 1975; or

(ii) is a national of Cuba or Haiti and is an entrant to the United States as verified by the immigration and naturalization service through INS form I-94.

(b) Assistance unit means all individuals who live in the same household and whose needs, income and resources are considered in determining the amount of assistance payments. Such individuals living together may consist of an individual, a couple, an intact family, or a combination of family members, such as aunt, uncle, niece and nephew.

The authority of the department to adopt the rule is based on Section 53-2-201, MCA and the rule implements Section 53-2-201, MCA.

Rule II (46.15.102) REFUGEE CASH ASSISTANCE (1) Refugee cash assistance (RCA) shall be provided to eligible refugees.

(a) An otherwise eligible recipient of RCA is eligible to receive assistance for 18 months from the date of entry into the United States or from the date the individual was first issued documentation by the immigration and naturalization service.

(i) Date of entry is the date that the individual entered the United States as certified by the immigration and naturalization service on INS form I-94.

(2) To be non-financially eligible for cash assistance, a refugee must meet the citizenship, residence and other non-financial criteria as described in this rule.

(a) A refugee must:

(i) have parole, voluntary departure or conditional entry status as verified by INS form I-94; or

(ii) have been admitted to the United States with permanent residence status on or after April 8, 1975, as verified by INS form I-151 or I-55I; or

(iii) be a dependent of a repatriated United States citizen and have been in the United States ninety (90) days and otherwise qualify as a refugee.

(b) A refugee must be a resident of Montana as defined in ARM 46.10.107.

(c) A recipient of RCA employed part time must be enrolled in English language or skill training, if appropriate and available; a RCA recipient employed full time may be enrolled in English language or skill training.

(d) A recipient of RCA must register for work with the employment office.

(i) Refusal to accept or continue employment or training will result in sanctions:

(A) the grant will be reduced by the amount included for the individual who failed to meet the employment requirement;

(B) assistance will be provided without interruption when employment is accepted within 30 days after refusal;

(C) reapplication for assistance can be made 30 days after termination of assistance.

(3) To be financially eligible for cash assistance, a refugee must meet all income and resource criteria of the AFDC program except that the $30 plus 1/3 disregard to earned income is not allowed. These AFDC criteria are found in ARM 46.10.401 through 404 and ARM 46.10.505 through 514.

(a) Title IV-A funded day care is not allowed.

The authority of the department to adopt the rule is based on Section 53-2-201, MCA and the rule implements Section 53-2-201, MCA.

Rule III (46.15.103) REFUGEE MEDICAL ASSISTANCE

(1) Medicaid will be provided to eligible refugees.

(a) All rules of the medicaid program as found in ARM 46.12.101 through 46.12.217 apply.

(i) For recipients of refugee cash assistance, the rules for AFDC - related categorically needy apply.

(ii) For individuals not eligible for refugee cash assistance due to excess income or resources, the rules for the medically needy apply.

The authority of the department to adopt the rule is based on Section 53-2-201, MCA and the rule implements Section 53-2-201, MCA.

3. The agency proposes to adopt these rules to comply with 45 CFR, Parts 400 and 401 found in the Federal Register, Vol. 46, No. 238 which were implemented February 1, 1982.

Those federal rules offer federally funded refugee assistance and criteria for that assistance with which the department must comply to run the program.

4. Interested parties may submit their data, views, or arguments either orally or in writing at the hearing. Written data, views or arguments may also be submitted to the Office of Legal Affairs, Department of Social and Rehabilitation Services, P.O. Box 4210, Helena, Montana 59604, no later than June 15, 1982.

5. The Office of Legal Affairs, Department of Social and Rehabilitation Services has been designated to preside over and conduct the hearing.

Director, Social and Rehabilitation Services

Certified to the Secretary of State May 3, 1982.

BEFORE THE DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES OF THE
STATE OF MONTANA

In the matter of the amendment of Rule 46.12.3803 pertaining to the medically needy income standards	)	NOTICE OF PUBLIC HEARING ON THE PROPOSED AMENDMENT OF RULE 46.12.3803 PERTAINING TO MEDICALLY NEEDY INCOME STANDARDS

To: All Interested Persons

1. On June 8, 1982, at 10:30 a.m., a public hearing will be held in the auditorium of the Social and Rehabilitation Services Building, 111 Sanders, Helena, Montana, to consider the amendment of Rule 46.12.3803 pertaining to the medically needy income standards.

2. The rule proposed to be amended provides as follows:

46.12.3803 MEDICALLY NEEDY INCOME STANDARDS (1) The first table applies to AFDC-related families and children, and the second to SSI-related individuals and couples.

(a) To arrive at quarterly medically needy income level, as used in ARM 46.12.3804, multiply the applicable monthly income level from the tables below by 3.

MEDICALLY NEEDY INCOME LEVELS
FOR AFDC-RELATED FAMILIES AND CHILDREN

Family Size	Monthly Income Level	
1	~~$ 195.00~~	$ 212.00
2	~~257.00~~	279.00
3	~~306.00~~	332.00
4	~~392.00~~	425.00
5	~~462.00~~	501.00
6	~~520.00~~	564.00
7	~~525.00~~	624.00
8	~~631.00~~	685.00
9	~~686.00~~	744.00
10	~~741.00~~	804.00
11	~~796.00~~	864.00
12	~~851.00~~	923.00
13	~~906.00~~	983.00
14	~~961.00~~	1,042.00
15	~~1,016.00~~	1,102.00
16	~~1,071.00~~	1,162.00

MEDICALLY NEEDY INCOME LEVELS
FOR SSI-RELATED INDIVIDUALS AND COUPLES

Family Size	Monthly Income Level	
1	~~$ 265.00~~	$ 285.00
2	~~342.00~~	371.00
3	~~375.00~~	442.00
4	~~475.00~~	565.00
5	~~567.00~~	666.00
6	~~633.00~~	750.00
7	~~700.00~~	830.00
8	~~767.00~~	911.00
9	~~833.00~~	990.00
10	~~900.00~~	1,069.00
11	~~967.00~~	1,149.00
12	~~1,033.00~~	1,228.00
13	~~1,100.00~~	1,307.00
14	~~1,167.00~~	1,386.00
15	~~1,233.00~~	1,466.00
16	~~1,300.00~~	1,545.00

(b) All families are assumed to have a shelter obligation, and no urban or rural differentials are recognized in establishing those amounts of net income protected for maintenance.

The authority of the department to amend the rule is based on Section 53-6-113, MCA and the rule implements Section 53-6-131, and 53-6-141, MCA.

3. The Department is proposing to amend this rule to increase the medically needy income levels. This proposal is based on a 8.5 percent cost of living increase. The medically needy income level for a single aged or disabled person may be adjusted pursuant to a pending change in supplemental security income payments which the Department is mandated to comply with pursuant to federal law.

4. Interested parties may submit their data, views or arguments, either orally or in writing at the hearing. Written data, views or arguments may also be submitted to the Office of Legal Affairs, Department of Social and Rehabilitation Services, P.O. Box 4210, Helena, Montana 59604, no later than June 16, 1982.

5. The Office of Legal Affairs, Social and Rehabilitation Services has been designated to preside over and conduct the hearing.

Director, Social and Rehabilitation Services

Certified to the Secretary of State May 3, 1982.

BEFORE THE DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES OF THE
STATE OF MONTANA

In the matter of the amendment of Rule 46.10.403 pertaining to the AFDC table of assistance standards	))))))	NOTICE OF PUBLIC HEARING ON THE PROPOSED AMENDMENT OF RULE 46.10.403 PERTAINING TO THE AFDC TABLE OF ASSISTANCE STANDARDS

TO: All Interested Persons

1. On June 8, 1982, at 9:30 a.m., a public hearing will be held in the auditorium of the Social and Rehabilitation Services Building, 111 Sanders, Helena, Montana, to consider the amendment of Rule 46.10.403 pertaining to the AFDC table of assistance standards.

2. The rule as proposed to be amended provides as follows:

46.10.403 TABLE OF ASSISTANCE STANDARDS

Subsection (1) remains the same.

(2) Monthly income as defined in ARM 46.10.505 is tested against the gross monthly income standard and, after specified exclusions and disregards, the net monthly income standard. These tests are applied using income reasonably expected to exist in the benefit month; however, if income is reported or discovered after the month of receipt, this income must be accounted for by applying the gross monthly income test retroactively in the second month after receipt. Monthly income is to be compared to the full standard for the size assistance unit even though the grant may only cover part of the month. If this monthly income exceeds the standard, the assistance unit is not eligible for any part of the benefit month. The assistance unit may be further ineligible as provided in ARM 46.10.403(3).

(a) Gross monthly income standards to be used when adults are included in the assistance unit are compared with gross monthly income defined in ARM 46.10.505.

GROSS MONTHLY INCOME STANDARDS TO BE USED WHEN ADULTS ARE INCLUDED IN THE ASSISTANCE UNIT

No. Of Persons in Household	With Shelter Obligation Per Month	Without Shelter Obligation Per Month
1	$ ~~354~~ 384	$ ~~128~~ 139
2	~~468~~ 508	~~206~~ 224
3	~~556~~ 603	~~280~~ 304
4	~~712~~ 773	~~364~~ 395
5	~~840~~ 911	~~432~~ 469
6	~~946~~ 1,026	~~486~~ 527
7	~~1,046~~ 1,135	~~536~~ 582
8	~~1,148~~ 1,246	~~588~~ 638
9	~~1,248~~ 1,354	~~640~~ 694
10	~~1,348~~ 1,463	~~692~~ 751
11	~~1,448~~ 1,571	~~744~~ 807
12	~~1,548~~ 1,680	~~796~~ 864
13	~~1,648~~ 1,788	~~848~~ 920
14	~~1,748~~ 1,897	~~900~~ 977
15	~~1,848~~ 2,005	~~952~~ 1,033
16	~~1,948~~ 2,114	~~1,004~~ 1,089

(b) Gross monthly income standards to be used when no adults are included in the assistance unit are compared with gross monthly income defined in ARM 46.10.505.

GROSS MONTHLY INCOME STANDARDS TO BE USED WHEN NO ADULTS ARE INCLUDED IN THE ASSISTANCE UNIT

No. of Children in Household	Amount Per Month
1	$ 106
2	~~172~~ 187
3	~~254~~ 276
4	~~336~~ 365
5	~~418~~ 454
6	~~504~~ 547
7	~~590~~ 640
8	~~676~~ 733
9	~~762~~ 827
10	~~848~~ 920
11	~~934~~ 1,013
12	~~1,020~~ 1,107
13	~~1,106~~ 1,200
14	~~1,192~~ 1,293
15	~~1,278~~ 1,387
16	~~1,364~~ 1,480

(c) Net monthly income standards to be used when adults are included in the assistance unit are compared with net monthly income defined in ARM 46.10.505.

NET MONTHLY INCOME STANDARDS TO BE USED WHEN ADULTS ARE INCLUDED IN THE ASSISTANCE UNIT

No. Of Persons in Household	With Shelter Obligation Per Month	Without Shelter Obligation Per Month
1	~~$ 236~~ 256	~~$ 85~~ 92
2	~~311~~ 337	~~137~~ 149
3	~~370~~ 401	~~186~~ 202
4	~~473~~ 513	~~242~~ 263
5	~~559~~ 607	~~287~~ 311
6	~~629~~ 682	~~323~~ 350
7	~~696~~ 755	~~356~~ 386
8	~~764~~ 829	~~391~~ 424
9	~~830~~ 901	~~426~~ 462
10	~~897~~ 973	~~461~~ 500
11	~~964~~ 1,046	~~496~~ 538
12	~~1,031~~ 1,119	~~531~~ 576
13	~~1,098~~ 1,191	~~566~~ 614
14	~~1,165~~ 1,264	~~601~~ 652
15	~~1,232~~ 1,337	~~636~~ 690
16	~~1,299~~ 1,409	~~671~~ 728

(d) Net monthly income standards to be used when no adults are included in the assistance unit are compared with net monthly income defined in ARM 46.10.505.

NET MONTHLY INCOME STANDARDS TO BE USED WHEN NO ADULTS ARE INCLUDED IN THE ASSISTANCE UNIT

No. of Children in Household	Amount Per Month
1	$ 70
2	~~114~~ 124
3	~~169~~ 183
4	~~223~~ 242
5	~~279~~ 303
6	~~335~~ 363
7	~~392~~ 425
8	~~449~~ 487
9	~~506~~ 549
10	~~563~~ 611
11	~~620~~ 673
12	~~677~~ 735
13	~~734~~ 796
14	~~791~~ 858
15	~~848~~ 920
16	~~905~~ 982

Subsection (3), (a), (b) remains the same.

(4) An assistance unit receives the full amount of the benefit standard less net monthly income which is prorated if eligibility is for less than a full month. From this amount recoveries will be taken for prior overpayments.

(a) Benefit standards to be used when adults are included in the assistance unit are compared with net monthly income defined in ARM 46.10.505.

BENEFIT STANDARDS TO BE USED WHEN ADULTS ARE INCLUDED IN THE ASSISTANCE UNIT

No. Of Persons in Household	With Shelter Obligation Per Month	With Shelter Obligation Per Day	Without Shelter Obligation Per Month	Without Shelter Obligation Per Day
1	~~$ 195~~ 212	~~$ 6.50~~ 7.07	~~$ 70~~ 76	~~$ 2.33~~ 2.53
2	~~257~~ 279	~~8.57~~ 9.30	~~113~~ 123	~~3.77~~ 4.10
3	~~306~~ 332	~~10.20~~ 11.07	~~154~~ 167	~~5.13~~ 5.57
4	~~392~~ 425	~~13.07~~ 14.17	~~200~~ 217	~~6.67~~ 7.23
5	~~462~~ 501	~~15.40~~ 16.70	~~238~~ 258	~~7.93~~ 8.60
6	~~520~~ 564	~~17.33~~ 18.80	~~267~~ 290	~~8.90~~ 9.67
7	~~575~~ 624	~~19.17~~ 20.80	~~295~~ 320	~~9.83~~ 10.67
8	~~631~~ 685	~~21.03~~ 22.83	~~323~~ 350	~~10.77~~ 11.67
9	~~686~~ 744	~~22.87~~ 24.80	~~352~~ 382	~~11.73~~ 12.73
10	~~741~~ 804	~~24.70~~ 26.80	~~381~~ 413	~~12.70~~ 13.77
11	~~796~~ 864	~~26.53~~ 28.80	~~410~~ 445	~~13.67~~ 14.83
12	~~851~~ 923	~~28.37~~ 30.77	~~439~~ 476	~~14.63~~ 15.87
13	~~906~~ 983	~~30.20~~ 32.77	~~468~~ 508	~~15.60~~ 16.93
14	~~961~~ 1042	~~32.03~~ 34.73	~~497~~ 539	~~16.57~~ 17.97
15	~~1016~~ 1102	~~33.87~~ 36.73	~~526~~ 571	~~17.53~~ 19.03
16	~~1071~~ 1162	~~35.70~~ 38.73	~~555~~ 602	~~18.50~~ 20.07

(b) Benefit standards to be used when no adults are included in the assistance unit are compared with net monthly income defined in ARM 46.10.505.

BENEFIT STANDARDS TO BE USED WHEN NO ADULTS ARE INCLUDED IN THE ASSISTANCE UNIT

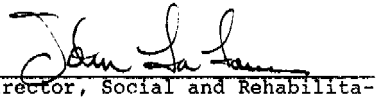
No. of Children in Household	Grant Amount Per Month	Grant Amount Per Day
1	$ 53	$ 1.77
2	~~95~~ 103	~~3.17~~ 3.43
3	~~140~~ 152	~~4.67~~ 5.07
4	~~185~~ 201	~~6.17~~ 6.70
5	~~230~~ 250	~~7.67~~ 8.33
6	~~277~~ 301	~~9.23~~ 10.03
7	~~324~~ 352	~~10.80~~ 11.73
8	~~371~~ 403	~~12.37~~ 13.43
9	~~418~~ 454	~~13.93~~ 15.13
10	~~465~~ 505	~~15.50~~ 16.83
11	~~512~~ 556	~~17.07~~ 18.53
12	~~559~~ 607	~~18.63~~ 20.23
13	~~606~~ 658	~~20.20~~ 21.93
14	~~653~~ 709	~~21.77~~ 23.63
15	~~700~~ 760	~~23.33~~ 25.33
16	~~747~~ 811	~~24.90~~ 27.03

The authority of the department to amend the rule is based on 53-4-212, MCA and the rule implements 53-4-211 and 53-4-241, MCA.

3. The department is proposing to amend these rules to give an annual cost of living increase to recipients of aid to families with dependent children in order to keep the grants at 55% of the census bureau poverty index level as authorized by the 1981 legislature.

4. Interested parties may submit their data, views, or arguments either orally or in writing at the hearing. Written data, views or arguments may also be submitted to the Office of Legal Affairs, Department of Social and Rehabilitation Services, P.O. Box 4210, Helena, Montana 59604, no later than June 16, 1982.

5. The Office of Legal Affairs, Department of Social and Rehabilitation Services has been designated to preside over and conduct the hearing.



Director, Social and Rehabilitation Services

Certified to the Secretary of State May 3, 1982.

BEFORE THE DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES OF THE
STATE OF MONTANA

In the matter of the adoption of rules pertaining to the low income weatherization assistance program	) NOTICE OF PUBLIC HEARING ON THE PROPOSED ADOPTION OF RULES PERTAINING TO THE LOW INCOME WEATHERIZATION ASSISTANCE PROGRAM

TO: All Interested Persons

1. On June 4, 1982, at 9:30 a.m., a public hearing will be held in the auditorium of the Social and Rehabilitation Services' Building, 111 Sanders, Helena, Montana, to consider the adoption of rules pertaining to the low income weatherization assistance program.

2. The rules proposed to be adopted are as follows:

RULE I (46.14.101) SAFEGUARDING/SHARING INFORMATION

(1) Disclosure of information concerning applicants for or recipients of weatherization assistance for low income persons is restricted to purposes directly connected with the administration of such aid. Such purposes include establishing eligibility, determining amount of assistance, and providing benefits to or on behalf of applicants and recipients.

(a) When information is released, such information will be accompanied with a notification of the confidentiality of the information and the penalty for misuse of such information. Whenever possible, the department will attempt to obtain prior consent from the applicant or recipient, except in emergency situations where notification will be given after the release of information and in cases where the information is released for legal and investigative actions concerning fraud, collection of support and third party medical recovery.

The authority of the department to adopt the rule is based on Section 53-2-201, MCA and the rule implements Sections 90-4-201 and 90-4-202, MCA.

RULE II (46.14.102) ROLE OF THE LOCAL CONTRACTOR

(1) The department will contract with appropriate community-based organizations in the state to provide outreach and to receive and process applications for the low income weatherization assistance program.

(a) In providing outreach, the local contractor performs activities, as specified in the contract, designed to inform all potentially-eligible households of the existence of and the benefits available under the low income weatherization assistance program.

(b) In receiving and processing applications, the local contractor determines household eligibility under the rules

contained in this chapter.

(c) The local contractor shall see that priority is given to identifying and providing weatherization assistance to elderly and handicapped low income persons provided by Rule XVIII (46.14.401).

(2) The local contractor provides weatherization service for eligible low income persons according to the rules and regulations of the United States department of energy (DOE) as found in 10 CFR 440 and the provisions of the contract for weatherization for low income persons. The department hereby adopts and incorporates by reference 10 CFR 440 which sets forth the specifications, weatherization techniques and material standards for weatherizing low income dwellings. A copy of 10 CFR 440 may be obtained from the Department of Social and Rehabilitation Services, P.O. Box 4210, 111 Sanders, Helena, Montana 59604.

The authority of the department to adopt the rule is based on Section 53-2-201, MCA and the rule implements Sections 90-4-201 and 90-4-202, MCA.

RULE III (46.14.104) FAIR HEARINGS (1) Any person who is dissatisfied with action taken on his application, benefit status, form or condition of services, may request a fair hearing as provided in ARM 46.2.202.

(2) It is the responsibility of the department through the local contractor to inform every applicant/recipient in writing at the time of application and at the time any action affects his benefits of the right to request a fair hearing.

The authority of the department to adopt the rule is based on Section 53-2-201, MCA and the rule implements Sections 90-4-201 and 90-4-202, MCA.

RULE IV (46.14.105) REFERRALS TO THE DEPARTMENT OF REVENUE (1) When requested by the department, the department of revenue shall have the power and duty to:

(a) investigate matters relating to weatherization assistance including, but not limited to, the claim for an acceptance of benefits by recipients and the receipt and disbursal of funds by the department or the local contractor; and

(b) institute civil and criminal actions in the appropriate courts to enforce the welfare laws with respect to low income weatherization assistance and violations thereof.

(2) The program integrity bureau is the liaison between the department and the department of revenue. Referrals of fraud and requests for investigation must be sent to the Program Integrity Bureau, Department of Social and Rehabilitation Services, P.O. Box 4210, Helena, Montana 59604, before

they are referred to the department of revenue. When the department of revenue makes a direct request to the local contractor for case information, the information may be sent directly to the department of revenue.

The authority of the department to adopt the rule is based on Section 53-2-201, MCA and the rule implements Sections 90-4-201 and 90-4-202, MCA.

RULE V (46.14.106) FRAUD (1) Whoever knowingly obtains by means of a willfully false statement, representation, or impersonation or other fraudulent device low income weatherization assistance to which he/she is not entitled is guilty of theft as provided in 45-6-301, MCA.

(2) If an individual appears to have received assistance fraudulently, the local contractor must report all facts of the matter to the program integrity bureau. The bureau may in turn refer the matter to the department of revenue or the county attorney of the county in which the recipient resides for further action.

The authority of the department to adopt the rule is based on Section 53-2-201, MCA and the rule implements Sections 90-4-201 and 90-4-202, MCA.

RULE VI (46.14.201) INTERVIEWS REQUIRED AND CONTENT OF INTERVIEWS (1) Rights and responsibilities explained.

(a) A staff member of the local contractor shall interview all applicants or persons authorized to act responsibly on behalf of applicants who contact the offices of the local contractor to apply for low income weatherization assistance. During the first interview, the staff member shall explain the person's rights, outline his responsibilities and describe the process in the system which may affect the client.

(2) The staff member shall explain to the person applying all factors of eligibility which must be substantiated and assist the person to understand the regulations governing his eligibility and receipt of benefits. The staff member shall inform the client of the availability of the regulations affecting eligibility as found in the Administrative Rules of Montana, copies of which are available and may be inspected in the offices of the clerk and recorder and the clerk of court in each county.

(3) No person shall be excluded from participation in, be denied benefits, or be subject to discrimination under the low income weatherization assistance program on the grounds of race, color, religion, sex, culture, age, creed, marital status, physical or mental handicap, political beliefs, or national origin.

The authority of the department to adopt the rule is

based on Section 53-2-201, MCA and the rule implements Sections 90-4-201 and 90-4-202, MCA.

RULE VII (46.14.202) APPLICATIONS TO BE VOLUNTARY (1) Applications must be voluntary and initiated by the person in need. There shall be no requirement of pre-application proof of eligibility; however, the applicant shall have the burden of proving eligibility at the time of application. The authority to proceed with a determination of eligibility for low income weatherization assistance is the signed application of the person who applies. When a case has been closed, application must be made for reinstatement of benefits. An application may be made by a third party when the physical or mental condition of the needy person precludes his ability to make application himself.

The authority of the department to adopt the rule is based on Section 53-2-201, MCA and the rule implements Sections 90-4-201 and 90-4-202, MCA.

RULE VIII (46.14.203) PLACE OF APPLICATION (1) The place of application shall not be closed for any portion of the working day or working week.

(2) Applications are to be made at the office of the local contractor in the area where the person lives. When conditions preclude a person from visiting the local contractor's office to make application, he shall have an opportunity to make application through the mail, at a mutually agreed place, by telephone with the staff-completed application mailed to the applicant for signature, or through a home visit by a member of the local contractor's staff.

The authority of the department to adopt the rule is based on Section 53-2-201, MCA and the rule implements Sections 90-4-201 and 90-4-202, MCA.

RULE IX (46.14.204) INVESTIGATION OF ELIGIBILITY (1) Investigations of eligibility will include securing information from the person applying for or receiving benefits and such other investigation as may be determined necessary by the department.

(a) Each application for assistance will be promptly and thoroughly investigated by a staff member of the local contractor. If a case is picked for quality control review, the client must cooperate.

The authority of the department to adopt the rule is based on Section 53-2-201, MCA and the rule implements Sections 90-4-201 and 90-4-202, MCA.

RULE X (46.14.205) PROCEDURES FOLLOWED IN PROCESSING APPLICATIONS (1) Procedures followed in determining eligibility for low income weatherization assistance are:

(a) Application is filed by applicant together with all necessary verification for determining financial eligibility and priority for service. The staff member of the local contractor accepts the application and determines financial eligibility and priority for service. The client is notified of the reasons for approval or disapproval of his application.

(b) Financial eligibility requirements that must be verified are:

(i) current receipt of benefits under supplemental security income or aid to families with dependent children;

(ii) income;

(iii) lack of tax dependency status for individuals enrolled at least half time in an institution of higher education.

(c) If reasonable doubt exists as to the accuracy of the information provided by the client, the type of dwelling, (including the number of bedrooms and/or the primary heating fuel/vendor) must also be verified.

The authority of the department to adopt the rule is based on Section 53-2-201, MCA and the rule implements Sections 90-4-201 and 90-4-202, MCA.

RULE XI (46.14.206) NOTIFICATION OF ELIGIBILITY DETERMINATION (1) An individual who makes application for low income weatherization assistance will receive written notice of eligibility including priority for service within 45 days of the date of application. If the applicant is determined ineligible, notification shall include the reasons for nonapproval. The notice of decision shall be made by the local contractor immediately following final decision on the application.

The authority of the department to adopt the rule is based on Section 53-2-201, MCA and the rule implements Sections 90-4-201 and 90-4-202, MCA.

RULE XII (46.14.207) NOTICE OF ADVERSE ACTION (1) Each person determined eligible for weatherization assistance must be notified ten days in advance of any action that terminates or reduces his benefits. Notification must be in writing and contain information about the amount of decrease or the closure, the reason and legal basis for the action, and must advise the client of the date on which the action will take effect. The notice must inform the client of his right to a fair hearing.

The authority of the department to adopt the rule is

based on Section 53-2-201, MCA and the rule implements Sections 90-4-201 and 90-4-202, MCA.

RULE XIII (46.14.301) DEFINITION OF HOUSEHOLD (1) Financial eligibility standards are implemented throughout the state and are applied to applicants on the basis of households.

(2) A household consists of all individuals who share a single primary heating source and who live in a single shelter or rental unit.

(3) An unborn child may not be counted as a member of the household.

The authority of the department to adopt the rule is based on Section 53-2-201, MCA and the rule implements Sections 90-4-201 and 90-4-202, MCA.

RULE XIV (46.14.302) ELIGIBILITY REQUIREMENTS FOR CERTAIN TYPES OF INDIVIDUALS AND HOUSEHOLDS (1) Except as provided below, households which consist solely of members receiving supplemental security income, aid to families with dependent children, or general assistance are automatically financially eligible for low income weatherization assistance. "Members receiving SSI, AFDC, or general assistance" includes any financially responsible relative or individual whose income and resources were considered in determining eligibility for these programs.

(2) Households which consist of members receiving SSI, AFDC, or general assistance and other individuals whose income and resources were not considered in determining eligibility for SSI, AFDC, or general assistance are not automatically eligible for low income weatherization assistance but must meet the financial requirements set forth in this sub-chapter.

(3) Individuals living in licensed group-living situations including recipients of SSI, AFDC, or general assistance, are not eligible for low income weatherization assistance.

(4) Households which contain a member who is enrolled at least half time in an institution of higher education and who was claimed for the previous tax year as a dependent child for federal income tax purposes by a taxpayer who is not a member of an eligible household are ineligible for low income weatherization assistance.

(a) An institution of higher education means a college, university, or vocational or technical school at the post-high school level.

(5) Prior to weatherizing multi-family housing, a specific eligibility test will be applied. Not less than 66 percent of the household units must be eligible household units.

The authority of the department to adopt the rule is

based on Section 53-2-201, MCA and the rule implements Sections 90-4-201 and 90-4-202, MCA.

RULE XV (46.14.303) INCOME STANDARDS (1) The gross receipts standards in the table in (2) below are 250% of the 1982 U.S. Government Office of Management and Budget poverty level for households of different sizes. This table applies to households with income from self-employment. Self-employed households with annual gross receipts at or below 250% of the 1982 poverty level are financially eligible for low income weatherization assistance only if they further meet the adjusted gross income test as set forth in (3) and (4) below.

(2) Gross receipts standards for households with self-employment income:

Number of individuals in household	Annual gross receipts for self-employed households
1	$11,700
2	15,550
3	19,400
4	23,250
5	27,100
6	30,950
Each additional member	3,850

(3) The income standards in the table in (4) below are 125% of the 1982 U.S. Government Office of Management and Budget poverty level for households of different sizes. This table applies to all households, including self-employed households that meet the gross receipts test set forth in (1) and (2) above. Households with adjusted gross income at or below 125% of the 1982 poverty level are financially eligible for low income weatherization assistance.

(4) Adjusted gross income standards for all households:

Number of individuals in household	Annual adjusted gross income for all households
1	$ 5,850
2	7,775
3	9,700
4	11,625
5	13,550
6	15,475
Each additional member	1,925

The authority of the department to adopt the rule is based on Section 53-2-201, MCA and the rule implements Sections 90-4-201 and 90-4-202, MCA.

RULE XVI (46.14.304) INCOME (1) Definitions:
(a) Annual gross income applies to households with

income from all non-excluded income before deductions, including but not limited to wages, salaries, commissions, tips, profits, gifts, interest or dividends, retirement pay, worker's compensation, unemployment compensation, and capital gains received by the members of the household in the twelve months immediately preceding the month of application.

(b) Annual gross receipts apply to households with income from self-employment and mean all income before any deductions, including any non-excluded income not from self-employment, which was received by members of the household in the twelve months immediately preceding the month of application.

(c) Self-employment deductions means all costs, excluding depreciation costs, necessary for the creation of any income from self-employment.

(d) For households with self-employment income, annual adjusted gross income means annual gross receipts minus self-employment deductions.

(2) Excluded from income are the following types of unearned income:

(a) complementary assistance from other agencies and organizations which consists of goods and services not included in or duplicated by the low income weatherization assistance benefit award;

(b) home produce utilized for household consumption;

(c) undergraduate student loans and grants for educational purposes made or insured under any program administered by the commissioner of education;

(d) extension of OASDI benefits for 18 to 22 year olds who are full time students;

(e) the value of the food stamp coupon allotment;

(f) the value of U.S. department of agriculture donated foods;

(g) any benefits received under Title III of the Nutrition Program for the Elderly of the Older Americans Act of 1965 as amended;

(h) the value of supplemental food assistance received under the Child Nutrition Act of 1966, and the special food services program for children under the National School Lunch Act (P.L. 92-433 and P.L. 93-150);

(i) all monies awarded to Indian tribes by the Indian claims commission or court of claims shall be excluded as authorized by P.L. 93-134, 92-254, 94-540 and 94-114;

(j) payments received under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970;

(k) the tax exempt portions of payments made pursuant to P.L. 92-203, the Alaska Native Claims Settlement Act;

(l) all payments under Title I of the Elementary and Secondary Education Act;

(m) all weekly incentive allowances paid under P.L. 93-203, the Comprehensive Employment and Training Act of 1973;

(n) incentive payments or reimbursement of training-related expenses made to work incentive program participants by the manpower agency;

(o) payment for supportive services or reimbursement of out-of-pocket expenses made to individual volunteers serving as senior health aides, or senior companions, and to persons serving in service corps of the retired executives and active corps of executives, and any other program under Titles II and III of P.L. 93-113; and

(p) payments to individual volunteers under Title I (VISTA) of P.L. 93-113, pursuant to section 404(g) of that law.

(q) any benefits received from the low income energy assistance program.

(3) Also excluded from income are one-time insurance payments or compensation for injury not to exceed $10,000.

The authority of the department to adopt the rule is based on Section 53-2-201, MCA and the rule implements Sections 90-4-201 and 90-4-202, MCA.

RULE XVII (46.14.305) RESOURCES (1) Financial eligibility for the low income weatherization assistance program will be determined without consideration of real or personal, tangible or intangible assets owned by members of the household.

The authority of the department to adopt the rule is based on Section 53-2-201, MCA and the rule implements Sections 90-4-201 and 90-4-202, MCA.

RULE XVIII (46.14.401) PRIORITIZATION FOR SERVICE (1) The department has established a priority formula in (2) below, for low income weatherization assistance.

(2) The applicable benefit award matrices amount from the low income energy assistance program found in ARM 46.13.401 is multiplied by;

(a) either 25 for eligible applicants 60 years or older who own their place of residence or 25 for eligible applicants who are disabled as defined by 20 CFR 416.901 who own their place of residence. The department hereby adopts and incorporates by reference the definition of a disabled person found in 20 CFR 416.901. A copy of these federal regulations may be obtained from the Department of Social and Rehabilitation Services, P.O. Box 4210, 111 Sanders, Helena, Montana 59604;

(b) either 7 for eligible applicants 60 years or older who rent their place of residence or for applicants who are disabled as defined by 20 CFR 416.901 who rent their place of residence;

(c) 3.5 for all other eligible applicants who own their place of residence;

(d) 1 for all other eligible applicants who rent their place of residence.

The authority of the department to adopt the rule is based on Section 53-2-201, MCA and the rule implements Sections 90-4-201 and 90-4-202, MCA.

RULE XIX (46.14.402) DETERMINING LOW INCOME WEATHERIZATION ASSISTANCE (1) Weatherization assistance will be made to eligible households in accordance with the state standard of prioritized measures for sample dwellings as established in (3) below.

(2) The local contractors may reorder a standard for any of the following reasons:

(a) A local contractor completes a job inspection book and the inspection reveals the cost-benefit ratio would be higher by reordering the standards as prioritized in (3) below. It must be noted on the inspection sheet that the reordering is the most appropriate cost-effective measure in this case and signed off by the local contractor.

(b) Material to complete the prioritized standard is not commercially available or fails to meet the materials standards as prescribed by DOE.

(3) STATE STANDARDS FOR WEATHERIZATION BY STANDARD DWELLING TYPE

PRIORITY	SOURCE OF HEAT LOSS	WEATHERIZATION MEASURE REQUIRED
Single Story Homes		
1	General Heat Waste	Stop Infiltration/Adjust Heating Source
2	Uninsulated Ceilings	Insulate Ceilings to R19
3	Partially Insulated Ceiling	Insulate Ceilings to R19
4	Windows	Storm Windows
5	Perimeter of Basement Uninsulated	Insulate Perimeter
6	Uninsulated Floor	Insulate Floor to R11
7	Uninsulated Walls	Insulate Walls
Mobile homes - all sizes, all heat types		
1	General Heat Waste	Stop Infiltration/Adjust Heating Source
2	Single Glass	Storm Windows/Thermal
3 or 4	Dead Air Locks	Construct Air Lock
4 or 3	Uninsulated Perimeter	Skirt Trailer

Two or more story homes - all heat types

1	General Heat Waste	Stop Infiltration/Adjust Heat Source
2	Single Glass	Storm Windows
3	Uninsulated Ceilings	Insulate Ceilings R19
4	Partially Insulated Ceilings	Insulate Ceilings R19
5	Uninsulated Perimeter	Insulate Perimeter
6	Uninsulated Floors	Insulate Floors to R11
7	Uninsulated Walls	Insulate Walls

The authority of the department to adopt the rule is based on Section 53-2-201, MCA and the rule implements Sections 90-4-201 and 90-4-202, MCA.

3. The State of Montana has administered a weatherization assistance program for low income people through its Department of Community Affairs to implement Title 90, Chapter 4, Part 2 of the MCA. With the transfer of that weatherization program to the Department of Social and Rehabilitation Services, rule drafting was initiated culminating in these proposed rules.

The low income weatherization assistance program has been administered to date through contracts with 10 local contractors. This system of administration will continue in the immediate future, but it was felt that the Montana Administrative Procedures Act required the adoption of rules.

The proposed rules slightly change the low income weatherization assistance program by formulating a different list of priorities to insure that limited funds can be utilized by the most needy first.

4. Interested parties may submit their data, views, or arguments either orally or in writing at the hearing. Written data, views or arguments may also be submitted to the Office of Legal Affairs, Department of Social and Rehabilitation Services, P.O. Box 4210, Helena, Montana 59604, no later than June 14, 1982.

5. The Office of Legal Affairs, Department of Social and Rehabilitation Services has been designated to preside over and conduct the hearing.

Director, Social and Rehabilitation Services

Certified to the Secretary of State May 3, 1982.

BEFORE THE DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES OF THE
STATE OF MONTANA

In the matter of the adoption of rules pertaining to the end stage renal program.	))))	NOTICE OF PUBLIC HEARING ON THE PROPOSED ADOPTION OF RULES PERTAINING TO THE END STAGE RENAL PROGRAM.

TO: All Interested Persons

1. On June 4, 1982, at 1:30 p.m., a public hearing will be held in the auditorium of the Social and Rehabilitation Services Building, 111 Sanders, Helena, Montana to consider the adoption of rules pertaining to the End Stage Renal Program.

2. The rules proposed to be adopted provide as follows:

RULE I PURPOSE (1) The purpose of the end stage renal program is to provide care and treatment of person's suffering from chronic renal disease, who require lifesaving care and treatment for such renal disease but who are unable to pay for the service on a continuing basis.

The authority of the department to adopt the rule is based on Section 53-2-201, MCA, and the rule implements Sections 53-6-201 and 53-6-202, MCA.

RULE II DEFINITIONS (1) End stage renal disease (ESRD) means that state of renal impairment which is virtually always irreversible and permanent, and requires dialysis or kidney transplantation to ameliorate uremic symptoms and maintain life.

(2) Family unit means the following individuals who are living together:

(a) the claimant,
(b) the claimant's spouse,
(c) the claimant's children, and
(d) the claimant's parents.

(3) Responsible relative means the claimant's spouse, the claimant's natural or adoptive parents, and the claimant's natural or adoptive children.

(4) Severe economic imbalance results when payment of expenses for the treatment of renal disease causes the family unit to deprive itself of the necessities of life.

(5) A homestead means the dwelling occupied by the family unit as their home. It shall include a garage, other out buildings, and as much land surrounding it as is reasonably necessary for the use as a home.

(6) Equity value means the market value of the property minus the amount of any enforceable lien, encumbrances, or security interest.

(7) Gross annual income means any money derived from any source (excluding borrowed money or loans obtained for specific uses) available to the family unit. Income includes, but is not limited to:

(a) money, wages or salary;
(b) net income from self-employment;
(c) royalties;
(d) dividends;
(e) interest;
(f) income from estates or trusts;
(g) lease and per-capita payments from the bureau of indian affairs or tribal governments;
(h) net rental income;
(i) public assistance or welfare payments such as aid to children and supplemental security income;
(j) pensions (disability or retirement) and annuities, (including regular insurance payments).

The authority of the department to adopt the rule is based on Section 53-2-201, MCA, and the rule implements Sections 53-6-201 and 53-6-202, MCA.

RULE III APPLICATION PROCEDURES (1) The application must be submitted in writing;

(a) on the form and in the manner prescribed by the department; and
(b) at the office of the county welfare department in the county in which the person presently resides.

(2) Application forms may be obtained at kidney dialysis centers in the state or from county welfare departments.

(3) As a part of the application process the county welfare department shall verify the information on an application concerning income and other financial and medical resources. Applicants shall take any steps necessary to provide verification of the information on their application.

(4) Application shall be processed within thirty (30) days of the date the application is received by the county office.

(5) Claimants will be notified of the approval or denial of their application. If approved, the period of approval shall be for the remaining portion of the state's fiscal year or less if the claimant becomes ineligible during the approved period. The claimant must make a new application for the continuation of program benefits after the end of the state's fiscal year.

(6) Any claimant who is dissatisfied with the action on an application, their benefit status, or condition of benefits, may request a fair hearing as provided in ARM 46.2.202.

(7) Claimants shall be responsible for notifying the county welfare department about changes in their source of

income and in their medical resources such as health insurance coverage.

The authority of the department to adopt the rule is based on Section 53-2-201, MCA, and the rule implements Sections 53-6-201 and 53-6-202, MCA.

RULE IV NONFINANCIAL ELIGIBILITY REQUIREMENTS (1) In order to participate in the Montana end stage renal program, the claimant applying for benefits must meet the following requirements;

(a) he must have a diagnosis of end stage renal disease from a licensed physician; and

(b) he must be a resident of the state of Montana. Once acquired, residence in Montana will continue until abandonment or acquisition of a residence elsewhere.

The authority of the department to adopt the rule is based on Section 53-2-201, MCA, and the rule implements Sections 53-6-201 and 53-6-202, MCA.

RULE V FINANCIAL ELIGIBILITY REQUIREMENTS (1) In order to participate in the Montana end stage renal program, the claimant must meet the following requirements:

(a) He must not be able to pay the total cost of such needed care and treatment without depriving himself or those legally dependent upon him for their necessities of life. When the claimant is either a minor child or an adult dependent on others for his support, the responsible relatives living with him must be unable to provide for his care without depriving themselves of the necessities of life.

(b) He shall not have relatives who are living apart from him and who are legally responsible to provide such care and treatment, but who refuse or neglect to provide such care and treatment in whole or in part without having demonstrated and documented their inability to support their dependent.

(c) He shall not have deprived himself directly or indirectly, of any property for the purpose of qualifying for assistance. The rule governing such fraudulent transfers of property is found in ARM 46.12.3207.

(d) He must take all steps necessary to apply for and, if entitled, pursue and accept any financial or medical resources for which he may qualify. Medical resources include public or private agencies which are or may be liable to pay all or a part of the medical costs of a claimant. Such resources include but are not limited to: medicare (Title XVIII); medicaid (Title XIX); insurance policies (including private health, group health or family health insurance carried by an absent parent if applicable); the veteran's administration; CHAMPUS (civilian health and medical program of the uniformed services); and vocational rehabilitation.

(2) The following property resources are exempt from consideration as a property resource for the program:

(a) a homestead;

(i) When a claimant is temporarily confined in a nursing home, extended-care facility or hospital, the claimant shall be considered to be occupying or living on the homestead. If the claimant lends or leases, rents or otherwise receives profits for the homestead, the homestead will be treated as commercial property and an amount equal to the value that the property could be rented for, if more than the actual rental, shall be counted as income.

(b) household goods and personal effects;

(c) face value of life insurance policies;

(d) the equity values of one vehicle and additional vehicles if needed to transport family members to work or to school;

(i) The equity value of a vehicle used to transport a family member to school shall only be exempt when a school bus or other public transportation is not available.

(e) burial plots for family members;

(f) funeral contracts or burial trusts;

(g) the balance due on a sales contract when real or personal property is sold on contract. Payments received on the contract, however, shall be considered income when received;

(h) the equity value of commercial or farm property or of a business excluding the family homestead, which does not exceed $100,000 in value;

(i) a trust which is established by a third party to pay the medical or educational expenses of a family member; and

(j) the principle and interest accrued in a public or private pension plan when the family unit does not have access to the principle and interest or is drawing retirement or disability income from the plan.

(3) The following property resources are non-exempt resources for purposes of the program and shall make a family unit ineligible when in total they exceed $1,500 for a single person, $2,250 for a couple, and $100 for each additional member:

(a) cash on hand;

(b) certificate of deposits;

(c) savings accounts;

(d) cash value of life insurance;

(e) market value of stocks or bonds;

(f) the equity value of commercial or farm property or of a business which exceeds $100,000;

(g) real property other than the family's homestead or business; and

(h) any other property not excluded in (2)(a) through (2)(j) of this rule.

The authority of the department to adopt the rule is based on Section 53-2-201, MCA, and the rule implements Sections 53-6-201 and 53-6-202, MCA.

RULE VI PROCEDURES FOR DETERMINING ELIGIBILITY

(1) Upon receipt, applications will be reviewed by the county welfare department for completeness. When necessary claimants will be interviewed and/or requests will be made for additional information. Claimants will be informed about other prior financial and medical resources which are available and to which they must avail themselves.

(2) The family unit's non-exempt financial resources shall be evaluated in accordance with Rule V.

(3) If the claimant is found eligible with respect to resources, the family unit's gross annual income for the previous calendar year shall be evaluated in accordance with the provisions below.

(a) Eligibility shall be based on the family unit's documented gross annual income for the previous calendar year, except that the earned income of a child not to exceed $2,000 annually and twenty-five (25) percent of the remaining gross annual earned income of the family unit shall be exempt from consideration, and medical expenses in the state fiscal year for which the claimant makes application for benefits. However, when the family unit's gross annual income for the previous calendar year is not an accurate indicator of the current year's income, the current year's income shall be estimated.

(b) Claimants shall participate in the medical expenses of their family unit according to the guidelines given below. All medical expenses which are reasonably related to the health care of the family unit will be recognized. Financial services under the ESRD will not be authorized until the family unit has reached its level of participation.

(i) The effective date of the claimant's eligibility shall start when the family unit's level of participation for the current fiscal year has been reached.

(ii) The guidelines for participation based on family size are as follows:

Number in Family	1	2	3
Total Annual Income of no more than (Standard Budget Allowance):	$6,900	$9,100	$10,900
(For families of more than 6, add $1,320 for each additional member.)	4	5	6
	$13,900	$16,400	$18,500

STANDARD BUDGET ALLOWANCE

Amount over Adjusted Needs	Amount of Patient Participation
$ 0 - 99	$ 00.00
100 - 199	20.00
200 - 299	40.00
300 - 399	60.00
400 - 499	80.00
500 - 599	105.00
600 - 699	130.00
700 - 799	160.00
800 - 899	190.00
900 - 999	220.00
1,000 - 1,099	250.00
1,100 - 1,199	290.00
1,200 - 1,299	325.00
1,300 - 1,399	365.00
1,400 - 1,499	410.00
1,500 - 1,599	450.00
1,600 - 1,699	495.00
1,700 - 1,799	530.00
1,800 - 1,899	595.00
1,900 - 1,999	645.00
2,000 - 2,099	700.00
2,100 - 2,199	755.00
2,200 - 2,299	810.00
2,300 - 2,399	870.00
2,400 - 2,499	935.00
2,500 - 2,599	995.00
2,600 - 2,699	1,060.00
2,700 - 2,799	1,130.00
2,800 - 2,899	1,200.00
2,900 - 2,999	1,270.00
3,000 - 3,099	1,345.00
3,100 - 3,199	1,420.00
3,200 - 3,299	1,495.00
3,300 - 3,399	1,575.00
3,400 - 3,499	1,660.00
3,500 - 3,599	1,740.00
3,600 and over	Fifty percent (50%)

The authority of the department to adopt the rule is based on Section 53-2-201, MCA, and the rule implements Sections 53-6-201 and 53-6-202, MCA.

RULE VII MEDICAL SERVICES (1) After the family unit's eligibility and level of participation has been determined, each family unit shall be classified into one of the following categories based on its net income.

(a) category "A" which includes those claimants who are eligible for medicaid;

(b) category "B" which includes claimants whose family unit's income is over medicaid eligibility standards, but below 300% of the poverty index; and

(c) category "C" which includes those claimants whose family units income is over 300% of the poverty index.

(2) The following are income levels of 300% of the poverty index according to family size effective July 1, 1982:

1	2	3
$13,800	$18,300	$21,700

4	5	6
$27,800	$32,800	$36,900

(3) Financial assistance under the ESRD program will have the following limitations on services:

(a) category "A" shall receive only authorized services for ESRD which are not covered by medicaid such as nonlegend drugs;

(b) category "B" shall receive all authorized services under the ESRD program;

(c) category "C" shall receive all authorized services except for travel, lodging, and pharmaceuticals.

(4) Subject to an evaluation of reasonableness and appropriateness by the department, and as long as these expenses are directly related to end stage renal disease if the service is medically necessary, and if the claimant remains eligible, the program will reimburse the following services:

(a) physician services;

(b) home dialysis services;

(i) training at a certified center including transportation, room and board;

(ii) rental or purchase of dialysis machine, supplies and repairs;

(iii) modification of existing plumbing and wiring necessary for operation of dialysis equipment;

(iv) other adaptive equipment and supplies.

(c) attendant or "back-up" person at actual reasonable costs up to a maximum of $6.00 per hour when the recipient household member(s) are unable to provide "regular" service because of unusual circumstances as certified by the department's social worker;

(d) center dialysis when justified;

(e) prescribed medications, nonlegend drugs specifically ordered by a physician, and medical supplies for treatment of end stage renal disease;

(f) surgery (fistula, etc);

(g) kidney transplantation will only be authorized when a special budget fund for this purpose is available;

(i) Transportation to a kidney transplant center for the claimant and donor shall be authorized by the department when it is necessary to maintain life.

(h) psychological treatment;

(i) transportation for emergency services only and when other financial and medical resources have been exhausted;

(j) health insurance premiums may be reimbursed when the claimant is unable to pay them and when the insurance will conserve ESRD program funds.

The authority of the department to adopt the rule is based on Section 53-2-201, MCA, and the rule implements Sections 53-6-201 and 53-6-202, MCA.

RULE VIII REIMBURSEMENT (1) Reimbursement for medical supplies and durable equipment will be the lower of the amount allowable by medicare or 90% of the usual and customary (billed) charges.

(2) Reimbursement for other services shall be made in accordance with ARM 46.12.503 and 506, "Hospital Services", ARM 46.12.562 "Home Dialysis for End Stage Renal Disease, Reimbursement", and ARM 46.12.2003 to 2008 "Physicians Services, Reimbursement".

(3) Members of a recipient's family shall not be reimbursed for providing "back-up" services.

(4) Only amounts specifically appropriated for this program may be used for this program. When all appropriated funds are spent for services, the program shall cease until further appropriations are received.

(5) All services shall be billed in accordance with ARM 46.12.303 "Billing, Reimbursement, Claim Processing, and Payment" and ARM 46.12.304, "Third Party Liability".

(6) All providers providing services under this program must agree to accept the conditions of provider participation found in ARM 46.12.301 "Provider Participation," ARM 46.12.302, "Contracts", ARM 46.12.307, "Provider Rights," and ARM 46.12.308, "Maintenance of Records and Auditing."

The authority of the department to adopt the rule is based on Section 53-2-201, MCA, and the rule implements Sections 53-6-201 and 53-6-202, MCA.

3. The department proposes these rules to set out a more objective eligibility criteria for the End Stage Renal Disease Program and to streamline program administration. The program has previously been administered by the department's Vocational Rehabilitation Division but is now being transferred to the more appropriate Economic Assistance Division. That transfer will improve service to the claimant by requiring that he only visit one office upon application. By utilizing the various county welfare department offices, the

claimant will be relieved of the burden of traveling out of his county to complete part of the application process. Further, the staff of the county offices have knowledge of and ready access to other programs that may be a prior resource to this program thereby effecting a better utilization of limited program funds. Besides ease of application to claimants, better staff utilization and a possible reduction is the result of the added efficiencies. The proposed rules set out objective criteria for eligibility so that limited funds will serve the group intended by the legislature. The eligibility criteria will insure that services are available to only those who will experience a severe economic imbalance. By setting out objective eligibility criteria, it is estimated that funds should be available to the eligible group throughout the entire program year rather than only a portion due to lack of funds as has happened on past occasions. By insuring that the eligible group is served all year, the department has reduced the severe hardships that can occur when the program is out of funds for the latter portion of a year.

4. Interested parties may submit their data, views, or arguments either orally or in writing at the hearing. Written data, views, or arguments may also be submitted to the Office of Legal Affairs, Department of Social and Rehabilitation Services, P.O. Box 4210, Helena, Montana, 59604, no later than June 14, 1982.

5. The Office of Legal Affairs, Department of Social and Rehabilitation Services has been designated to preside over and conduct the hearing.

Director, Social and Rehabilitation Services

Certified to the Secretary of State May 3, 1982.

BEFORE THE DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES OF THE
STATE OF MONTANA

In the matter of the adoption of rules, the amendment of Rules 46.6.201, 46.6.501, 46.6.502, 46.6.503, 46.6.504, 46.6.505, 46.6.506, 46.6.507, 46.6.508, 46.6.509, 46.6.510, 46.6.511, 46.6.512, 46.6.513 and 46.6.515 and the repeal of Rules 46.6.101, 46.6.301, 46.6.401, 46.6.402, 46.6.403, 46.6.404 and 46.6.514 pertaining to the nature and scope of vocational rehabilitation services and eligibility for those services.	NOTICE OF PUBLIC HEARING ON THE PROPOSED ADOPTION OF RULES, THE AMENDMENT OF RULES 46.6.201, 46.6.501, 46.6.502, 46.6.503, 46.6.504, 46.6.505, 46.6.506, 46.6.507, 46.6.508, 46.6.509, 46.6.510, 46.6.511, 46.6.512, 46.6.513 AND 46.6.515 AND THE REPEAL OF RULES 46.6.101, 46.6.301, 46.6.401, 46.6.402, 46.6.403, 46.6.404 AND 46.6.514 PERTAINING TO THE NATURE AND SCOPE OF VOCATIONAL REHABILITATION SERVICES AND ELIGIBILITY FOR THOSE SERVICES.

TO: All Interested Persons

1. On June 7, 1982, at 9:30 a.m., a public hearing will be held in the auditorium of the Social and Rehabilitation Services Building, 111 Sanders, Helena, Montana to consider the adoption of rules, the amendment of Rules 46.6.201, 46.6.501, 46.6.502, 46.6.503, 46.6.504, 46.6.505, 46.6.506, 46.6.507, 46.6.508, 46.6.509, 46.6.510, 46.6.511, 46.6.512, 46.6.513 and 46.6.515 and the repeal of Rules 46.6.101, 46.6.301, 46.6.401, 46.6.402, 46.6.403, 46.6.404 and 46.6.514 pertaining to the nature and scope of vocational rehabilitation services and eligibility for those services.

2. The rules as proposed to be adopted provide as follows:

RULE I (46.6.102) DEFINITIONS (1) "Applicant" means a person who has made formal application to the department to receive vocational rehabilitation services through the vocational rehabilitation program administered by the department.

(2) "Client" means an applicant who has been determined by the department to be eligible for the vocational rehabilitation services provided through the vocational rehabilitation program administered by the department and who has agreed to accept such services as the department may determine are appropriate for that person's vocational rehabilitation.

(3) "Department" means the department of social and rehabilitation services.

(4) "Dependent" means any relative to an individual by blood or marriage or anyone living in the same household with whom an individual has a close interpersonal relationship and for whom an individual provides a majority of their financial support.

(5) "Disabled individual" means a person with a physical

or mental disability that can be diagnosed by a physician or appropriate specialist having recognized credentials.

(6) "Employability" means that the provision of vocational rehabilitation services is likely to enable an individual to begin or continue in employment consistent with his abilities. The employment may be in the competitive labor market, self-employment, homemaking, farm or family work (including work for which payment is in kind rather than cash), sheltered or homebound employment, or gainful work of any other form.

(7) "Extended evaluation" means an evaluation of an applicant which necessitates the receipt, for an extended period of time, of vocational services otherwise not available to applicants in order to determine the eligibility of the applicant for the vocational rehabilitation services provided through the vocational rehabilitation program administered by the department.

(8) "Physical or mental disability" means an existing physical or mental impairment which significantly limits, or, if not corrected, may significantly limit an individual's activities or ability to function in a normal manner.

(9) "Vocational rehabilitation plan" means the Individualized Written Rehabilitation Program (I.W.R.P.) prepared by the department. This plan specifies the vocational rehabilitation goals and needs of the client and the services the department may provide to the client in order to assist the vocational rehabilitation of the client.

(10) "Severely handicapped individual" means an individual with a physical or mental disability which seriously limits his employability skills including mobility, communication, self-care, self-direction, work tolerance, or work skills and for whom vocational rehabilitation would require multiple vocational rehabilitation services over an extended period of time.

(11) "Substantial handicap to employment" means a physical or mental disability which severely limits an individual's ability to prepare for, obtain or retain employment appropriate to his disabilities, background and potential for rehabilitation.

(12) "Vocational rehabilitation services" means those services provided through the vocational rehabilitation program administered by the department under the authority of part 1 of Title 53, chapter 7 of the Montana Code Annotated and as defined in sub-chapter 5 of this Title of the ARM.

The authority of the department to adopt the rule is based on Section 53-7-102, MCA and the rule implements Sections 53-7-101, 53-7-102 and 53-7-105, MCA.

RULE II (46.6.302) PURPOSE (1) Vocational rehabilitation services provided through the department, except those necessary for determining the eligibility of an applicant for

services, may be provided by the department to any person who, after applying for services, has been determined by the department, in accordance with rule V (46.6.305), the criteria of this sub-chapter and that of sub-chapter 4, to be a disabled individual who is eligible for such services and who has agreed to accept such services as an applicant or a client of the department.

The authority of the department to adopt the rule is based on Section 53-7-102, MCA and the rule implements Sections 53-7-102 and 53-7-105, MCA.

RULE III (46.6.303) APPLICATION (1) In order to be considered for status as a vocational rehabilitation client, an individual shall make application to the department.

(2) The department shall consider all applications by individuals seeking vocational rehabilitation services offered through the department.

(3) The department shall process all applications for vocational services as expeditiously as possible.

The authority of the department to adopt the rule is based on Section 53-7-102, MCA and the rule implements Sections 53-7-102 and 53-7-105, MCA.

RULE IV (46.6.304) DETERMINATION OF ELIGIBILITY (1) The department will determine if an applicant, in accordance with the criteria of this sub-chapter and sub-chapters 4 and 5, policies and standards adopted by the department to govern eligibility, and applicable federal law and regulations, is a disabled individual, has a substantial handicap to employment and may be reasonably expected to benefit significantly as to employability from vocational rehabilitation services.

(2) The determination of an applicant's eligibility will be based on a preliminary diagnostic assessment of the applicant, inclusive of medical, psychological, social and vocational assessments and upon an assessment of financial need, if necessary. The assessments will be prepared and conducted by the department in the manner chosen by the department.

(3) The department shall make available to an applicant those services determined by the department to be necessary and appropriate for assessing the applicant's eligibility.

The authority of the department to adopt the rule is based on Section 53-7-102, MCA and the rule implements Sections 53-7-102 and 53-7-105, MCA.

RULE V (46.6.305) CLIENT ELIGIBILITY CRITERIA (1) Vocational rehabilitation services, except those necessary for determining the eligibility of an applicant to be a client,

will be provided by the department only to a person who is a client.

(2) Eligibility to be a client is based on the following basic criteria:

(a) the presence of a physical or mental disability which for the individual constitutes or results in a substantial handicap to employment; and

(b) a reasonable expectation that vocational rehabilitation services may substantially benefit the individual in terms of employability.

(3) Eligibility to be a client will not be determined:

(a) with regard to sex, race, age, religion, creed, color, or national origin;

(b) solely on the basis of type of disability;

(c) upon an age limit which will, of itself, result in a finding of ineligibility for any individual who otherwise meets the basic eligibility requirements;

(d) upon a residence requirement, durational or other, which excludes from services any individual who is in the state and who would be eligible for vocational rehabilitation services otherwise.

(4) An individual will not be eligible to be a client unless the department determines that he is utilizing all public and private benefits and services to which he may be otherwise entitled and which are of a similar nature to those available through the vocational rehabilitation program of the department.

(5) An applicant must agree to accept such vocational rehabilitation services as the department determines in accordance with the objectives of his vocational rehabilitation plan are appropriate for his vocational rehabilitation.

The authority of the department to adopt the rule is based on Section 53-7-102, MCA and the rule implements Sections 53-7-102 and 53-7-105, MCA.

RULE VI (46.6.306) SPECIFIC CRITERIA FOR RECEIPT OF CERTAIN SERVICES (1) Receipt of certain vocational rehabilitation services will be subject to the following specific criteria:

(a) rehabilitation vocational training services as defined in ARM 46.6.502 will be available only to an individual who the department has in its discretion determined has a mental or physical disability which is a substantial handicap to employment, has the capacity to develop his employability by such training and for whom the training is necessary to his vocational rehabilitation.

(b) physical and mental restoration services as defined in ARM 46.6.503 will be available only to an individual if the following criteria are met:

(i) the clinical status of the individual's physical or mental condition is stable or of slow progression. If the individual is under an extended evaluation plan, the condition need not be stable or of slow progression; and

(ii) that condition constitutes a substantial handicap to employment, and

(iii) physical restoration services may be reasonably expected to eliminate or substantially reduce the disabling condition within 6 months.

(c) demonstrated financial need is a requirement for the receipt of certain services as provided for in subsection (2)(c) of this rule.

(2) Financial need will be a criteria for the receipt of certain services as follows:

(a) The department will provide, without charge, the following services to applicants:

(i) evaluation of vocational rehabilitation potential, including diagnostic and related services and the transportation necessary in order to be evaluated.

(b) The department will provide, without charge, in accordance with their vocational rehabilitation plans, the following vocational rehabilitation services to clients:

(i) counseling, guidance and referral services;

(ii) placement in suitable employment;

(iii) post-placement services which are of no cost to the department.

(c) The department will provide to clients determined as provided for in sub-chapter 4 to be in financial need the following vocational rehabilitation services when it is determined, in accordance with their vocational rehabilitation plan, that such services are necessary:

(i) vocational training and training materials;

(ii) physical and mental restoration services;

(iii) income maintenance;

(iv) vocational and other training services;

(v) transportation and travel expenses;

(vi) vocational training books and supplies;

(vii) occupation related fees;

(viii) vocationally related tools, equipment and initial stocks and supplies;

(ix) interpreter services for the deaf;

(x) reader services for the blind;

(xi) telecommunications, sensory, and other technological aids and devices;

(xii) other goods and services;

(xiii) post-employment services.

The authority of the department to adopt the rule is based on Section 53-7-102, MCA and the rule implements Sections 53-7-102 and 53-7-105, MCA.

RULE VII (46.6.307) EXTENDED EVALUATIONS (1) The provision of vocational rehabilitation services to an applicant under an extended evaluation is based only on the following criteria:

(a) the presence of a physical or mental disability which for an individual constitutes or results in a substantial handicap to employment; and

(b) the inability, unless there is an extended evaluation, to determine whether vocational rehabilitation services might benefit an individual in terms of employability.

(2) Vocational rehabilitation services will be provided during extended evaluation of an applicant for no longer than 18 months.

(3) The vocational rehabilitation services provided during extended evaluations should be short-term and remedial in nature.

The authority of the department to adopt the rule is based on Section 53-7-102, MCA and the rule implements Sections 53-7-102 and 53-7-105, MCA.

RULE VIII (46.6.405) PURPOSE OF FINANCIAL NEED STANDARD (1) The financial need standard provides a formula and certain values by which the department may determine the existence and extent of an individual's financial need.

(2) The department will use the financial need standard in determining the eligibility of an individual for any of those vocational rehabilitation services listed in rule VI (2)(c), (46.6.306), and for calculating in rule XIV, (46.6.411), the amount of financial supplementation to be provided by the department to a client for maintenance.

The authority of the department to adopt the rule is based on Section 53-7-102, MCA and the rule implements Sections 53-7-102 and 53-7-105, MCA.

RULE IX (46.6.406) ADAPTATIONS OF FINANCIAL NEED STANDARD (1) The department may, within its discretion, use adaptations of the financial need standard where the situation of an individual is one of special circumstances which are subject to objective definition by documentation. These objectively defined circumstances include: variations in need due to special needs accompanying designated types of disabilities; variations in need based on the nature of living requirements in different localities; variations in need based on the nature of living requirements caused by particular rehabilitative services to be provided; and variations in need due to short periods of medical care for acute physical conditions arising during the course of vocational rehabilitation. The department will, by written policies, direct the exercise

of this discretion and determine the circumstances in which it may be utilized.

The authority of the department to adopt the rule is based on Section 53-7-102, MCA and the rule implements Sections 53-7-102 and 53-7-105, MCA.

RULE X (46.6.407) DETERMINATION OF FINANCIAL NEED PRIOR TO SERVICE (1) The financial need of an individual will be determined within a reasonable time and will be determined prior to the provision to an individual of any of those services listed in rule VI(2)(c), (46.6.306).

The authority of the department to adopt the rule is based on Section 53-7-102, MCA and the rule implements Sections 53-7-102 and 53-7-105, MCA.

RULE XI (46.6.408) INFORMATION FOR DETERMINATION OF FINANCIAL NEED (1) The individual will be the primary source of the financial information necessary for the determination by the department of his financial need. The department, within its discretion, may obtain information about an individual's financial resources and requirements from any reliable source. All sources of financial information must be documented.

(2) An individual's consent will be necessary for the department to obtain any personal financial information concerning him. If an individual is an unemancipated minor, the consent of his parents or guardian will be necessary for the department to obtain any personal financial information concerning him or his parents.

(3) Failure of an individual to consent to the release of pertinent financial information to the department necessary for determining his financial resources or financial requirements will be considered to be a withdrawal of his application or client status for vocational services.

(4) In accordance with departmental policies, any financial or other information obtained with an individual's consent or the consent of his parents shall be confidential.

(5) Any financial information relied upon by the department in determining an individual's financial resources or financial requirements shall be available to him.

The authority of the department to adopt the rule is based on Section 53-7-102, MCA and the rule implements Sections 53-7-102 and 53-7-105, MCA.

RULE XII (46.6.409) FINANCIAL NEED STANDARD (1) An individual will be considered to have financial need for the purposes of determining eligibility for those services listed in rule VI (2)(c), (46.6.306), if he has insufficient

financial resources by which to meet the estimated cost of subsistence and the cost of necessary vocational rehabilitation services conditioned on financial need.

(2) The department will use, in calculating the estimated cost of subsistence for an individual, the cost of living standards adopted by the economic assistance division of the department and provided in the AFDC table of assistance standards (see ARM 46.10.403).

The authority of the department to adopt the rule is based on Section 53-7-102, MCA and the rule implements Sections 53-7-102 and 53-7-105, MCA.

RULE XIII (46.6.410) RESOURCES (1) The department, in calculating the financial need of an individual will, except as provided otherwise in this rule, identify and consider all consequential financial resources actually available to him; including all financial resources, however derived, of the individual, of the individual's spouse, and, if the individual is an unemancipated minor, the financial resources of his parents.

(2) The department, in determining the financial resources of an individual, will rely upon only those financial resources of the individual which will actually be available to him during the period that he is receiving the vocational rehabilitation services provided by the department.

(3) The department, in determining the financial resources of an individual, will utilize the following financial resources:

(a) current income; including any benefit to which an individual may be entitled by way of pension, compensation for injury or other work loss, or insurance; as well as any in-kind service or renumeration in the case of on-the-job training actually available to him;

(b) capital assets as defined by departmental policy, including both real and personal property;

(c) similar benefits under any program available to an individual or members of his family that may be utilized, in whole or in part, to meet the costs of any vocational rehabilitation services or the costs of physical and mental restoration services and maintenance. Consideration need not be given to similar benefits for the costs of physical and mental restoration services and maintenance, if it would significantly delay the provision of services to an individual. When an individual is or would be eligible for similar benefits, those benefits must be utilized to the extent that they are adequate and do not interfere with achieving the vocational rehabilitation objectives for the individual;

(d) any other resources which the department within its discretion considers to be significant.

(4) The department, in determining the financial resources of an individual, will not utilize the following resources:

(a) an individual's or his parent's home;

(b) a small business or farm owned by an individual's parents in the case of a minor if that business or farm is determined by the department to be the primary source of income for the parents or is their major asset;

(c) resources necessary for the support of dependents in accordance with the financial need standard. Dependents are those for whom an individual has assumed financial responsibility or is legally responsible;

(d) obligations which the individual is required by legal process to pay;

(e) obligations which, in the discretion of the department, if recognized, would constitute a substantial obstacle to the achievement of the individual's vocational objective.

The authority of the department to adopt the rule is based on Section 53-7-102, MCA and the rule implements Sections 53-7-102 and 53-7-105, MCA.

RULE XIV (46.6.411) CALCULATION OF FINANCIAL SUPPLEMENTATION (1) The amount of financial supplementation for income maintenance as defined in ARM 46.6.505, to be provided to a client by the department, will be the amount by which a client's estimated cost of subsistence, plus the cost of services to be purchased, exceed all of his financial resources available subject to the limitations as provided for in subsections (4) and (5) of this rule.

(2) A client's financial requirements are determined as provided for in rule XII (1) and (2), (46.6.409).

(3) A client's financial resources available are determined as provided for in rule XIII, (46.6.410).

(4) The amount of financial supplementation to be made available to a client will be subject at the discretion of the department to such limitations as are necessary due to budgetary constraints upon the department.

(5) The maximum amount of financial supplementation that may be made available to the client shall not exceed the limit imposed in rule XVI (46.6.517).

The authority of the department to adopt the rule is based on Section 53-7-102, MCA and the rule implements Sections 53-7-102 and 53-7-105, MCA.

RULE XV (46.6.516) GUIDELINES AND STANDARDS FOR SERVICES PROVIDED BY CLIENTS (1) The department, in consultation with appropriate professional, trade, business, training and other organizations and institutions, may develop standards to serve as guidelines for the quality of services an individual

may provide as an employee, contractor, tradesman, professional, or businessman while that person is a client of the department.

The authority of the department to adopt the rule is based on Section 53-7-102, MCA and the rule implements Sections 53-7-102 and 53-7-105, MCA.

RULE XVI (46.6.517) FINANCIAL LIMITATIONS (1) The provision of vocational services by the department is subject to the following financial limitations.

(a) services subject to rates of payment are as follows:

(i) the rates of payment for physical and mental restoration services listed in ARM 46.6.503 will be those rates provided in the medical assistance rates of Title 46, chapter 6, subchapter 12 of the Administrative Rules of Montana.

(b) The maximum financial contributions for certain services during the period of client status will be as follows:

(i) $50 a week for income maintenance;

(ii) $200 total for tools;

(iii) $2,000 total for equipment.

(c) The maximum financial contributions for services to an individual considered to be industrially injured will be that established in accordance with the authority of 39-71-1003, MCA.

The authority of the department to adopt the rule is based on Section 53-7-102, MCA and the rule implements Sections 53-7-102 and 53-7-105, MCA.

3. The rules proposed to be amended provide as follows:

46.6.201 ORDER OF SELECTION (1) ~~Definitions:~~

~~(a) "Severely handicapped individual" means an individual whose physical or mental disability seriously limits his employability skills which include mobility, communication, self-care, self-direction, work tolerance, or work skills; and~~

~~(b) whose vocational rehabilitation can be expected to require multiple vocational rehabilitation services over an extended period of time;~~

~~(2) The department furnishes and is furnishing vocational rehabilitation services to all individuals who apply and have been determined to be eligible or to be in need of an extended evaluation of rehabilitation potential to determine eligibility;~~

~~(3) When no longer able to provide service to all, the following order of selection will be maintained:~~

~~(a) the severely handicapped, then,~~

~~(b) the industrially injured~~ When the department is

unable to provide services to all clients due to budgetary or other constraints, the following order of selection will be utilized in determining which clients will receive such services as remain available through the vocational rehabilitation program of the department:

(a) the severely handicapped; then,

(b) the industrially injured as determined in accordance with Title 39, chapter 71 of the Montana Code Annotated.

The authority of the department to amend the rule is based on Section 53-7-102, MCA and the rule implements Sections 53-7-102, MCA.

46.6.501 SERVICES (1) ~~The services enumerated below are contingent on two factors:~~ Availability of Services:

~~(a) the preliminary medical diagnostic workup to determine medical eligibility for the program;~~

~~(b) the thorough diagnostic workup which is the combination of medical, psychological, social, and vocational factors that are essential for plan development.~~

(a) The department may provide to a client, directly or by contract, recruitment services, training and training materials, physical and mental restoration services, transportation, maintenance, equipment and supplies for vocational effort, reader and interpretative services, support services for family members, other goods and services, placement services, and post employment services as are determined by the department in accordance with his vocational rehabilitation plan to be necessary to the client's vocational rehabilitation.

(b) The department will provide, directly or by contract, only those services authorized by a counselor in accordance with an applicant's extended evaluation or with a client's vocational rehabilitation plan.

(c) The department will not provide services for which there is no prior written authorization for the services in accordance with these rules and departmental procedures.

(d) The provision of vocational rehabilitation services by the department will be subject to financial limitations as provided in rule XVI (46.6.517).

(e) The department will not make available to an individual those vocational rehabilitation services that the individual is entitled to receive under any other state or federal program unless such services are contracted for by the other program from the department.

(f) The following services will not be available to an individual whose status is that of extended evaluation:

(i) placement services;

(ii) tools, equipment, and initial stocks and supplies;

(iii) business licenses and professional fees;

(iv) post-employment services.

(2) Discretion of department to determine services:
(a) Vocational rehabilitation should eliminate or reduce an individual's disability within a reasonable period of time. Rehabilitation will not be undertaken if the condition of disability is medically diagnosed to be continuing in nature with little or no prospect of rehabilitation.
(b) Vocational training should provide an individual with the skills and knowledge as are sufficient to provide an individual with a reasonable opportunity to find suitable employment given his condition. Vocational training will not be undertaken if this is not likely to result.
(c) Post-program and post-employment services will be offered to assist an individual in maintaining his employment status or in reobtaining employment. Post-program and post-employment services shall not be provided if this will not result.
(d) The department shall develop a vocational rehabilitation plan for each client. The department shall have the discretion to determine what will constitute the most appropriate services to be provided to an individual under this plan.

The authority of the department to amend the rule is based on Section 53-7-102, MCA and the rule implements Section 53-7-102, MCA.

46.6.502 VOCATIONAL TRAINING AND TRAINING MATERIALS

(1) The ~~State Division~~ department ~~will~~ may furnish training and training materials to ~~eligible individuals~~ an applicant in order to determine his vocational rehabilitation potential or to a client to the extent necessary to ~~achieve their~~ adequately develop his vocational rehabilitation. Such training ~~will~~ may include vocational, pre-vocational, personal adjustment training, and other rehabilitation training which contributes to the determination of the vocational rehabilitation potential or to ~~the individual's~~ vocational adjustment~~;~~. ~~and it covers t~~Training provided directly by the ~~State Division~~ department or procured from other public or private training facilities~~;~~ is included.

~~(2) A client is eligible for rehabilitation training when he has the mental and physical qualifications and capacity to profit by such training and it is necessary to his satisfactory rehabilitation.~~

~~(3) Training materials and books will be provided to eligible clients when their financial need for such assistance has been established; and to handicapped individuals accepted for evaluation of rehabilitation potential.~~

The authority of the department to amend the rule is based on Section 53-7-102, MCA and the rule implements Section 53-7-102, MCA.

46.6.503 PHYSICAL AND MENTAL RESTORATION SERVICES (1) Physical and mental restoration services ~~will~~ may be ~~furnished~~ provided to ~~eligible individuals~~ an applicant to the extent needed to determine ~~their~~ his vocational rehabilitation potential or to a client in order to ~~achieve their~~ facilitate his vocational rehabilitation in accordance with his vocational rehabilitation plan, and ~~will~~ may include the following:

(a) medical or surgical treatment and related costs;
(b) psychological and psychiatric treatment;
(c) dentistry;
(d) nursing services;
(e) hospitalization;
(f) convalescent or rest home care;
(g) drugs and supplies;
(h) prosthetic ~~appliances~~ and orthotic ~~or other~~ devices;
(i) physical therapy;
(j) occupational therapy;
(k) speech or hearing therapy;
(l) physical rehabilitation in a rehabilitation facility;
(m) eyeglasses and visual services~~,~~, if authorized by a physician skilled in the diseases of the eye or by an optometrist.
(n) podiatry;
(o) treatment of either acute or chronic medical complications and emergencies which are associated with or arise out of the provision of physical and mental restoration services; or are inherent in the condition under treatment;
(p) other medical or medically-related rehabilitation services.

~~(2) Such services will be furnished only if the following criteria are met:~~

~~(a) The clinical status of the individual's condition is stable or slowly progressive;~~

~~(b) Physical restoration services may be expected to eliminate or substantially reduce the handicapping condition within a reasonable period of time;~~

~~(3) To clarify eligibility and feasibility for Rehabilitative Services on clients requiring physical restoration, the existence of a disability, including catastrophic disability, does not necessarily imply that the individual is feasible for services as there are or may be factors which render it inadvisable for the division to attempt rehabilitation. Rehabilitation should eliminate or reduce disability within a reason able period of time, generally 6 months; and if the condition will take longer, or if it is chronic, indefinitely prolonged, or has a medical prognosis of poor or guarded, rehabilitation should probably not be attempted.~~

~~(4) Rehabilitative Services is a prior authorization service program which precludes retroactivity. Eligibility for the program should be postponed until the clinical status of the client is defined and a tentative medical treatment plan is suggested. Then is the moment for rehabilitation to become involved to determine potential for employability.~~

~~(5) In provision of physical restoration services to determine the rehabilitation potential of a handicapped individual under an extended evaluation plan, the provision that the condition is stable or slowly progressive does not apply.~~

~~(6) Eyeglasses and visual services may be prescribed and provided to a client by a physician skilled in diseases of the eye, or by an optometrist, as authorized under State law.~~

(2) The department may furnish short periods of medical care for acute conditions arising in the course of vocational rehabilitation, which, if not cared for, would constitute a hazard to the achievement of the vocational rehabilitation objective, or the completion of the extended evaluation to determine rehabilitation potential.

The authority of the department to amend the rule is based on Section 53-7-102, MCA and the rule implements Section 53-7-102, MCA.

46.6.504 TRANSPORTATION (1) The ~~State Division~~ department ~~will~~ may furnish transportation to ~~handicapped individuals~~ an individual and, where necessary, family members ~~of their family~~ to secure diagnosis, treatment, training, or other vocational rehabilitation services.

(2) Such transportation will include the cost of travel and subsistence during travel for ~~handicapped individuals~~ an individual and ~~their~~ his attendants or escorts, where such financial assistance is needed.

(3) Such transportation includes relocation and moving expenses necessary for the achievement of a vocational rehabilitation objective.

The authority of the department to amend the rule is based on Section 53-7-102, MCA and the rule implements Section 53-7-102, MCA.

46.6.505 INCOME MAINTENANCE (1) Income Mmaintenance aid is a supplementation to other rehabilitation services being provided, and ~~is~~ may be granted in special instances to enable ~~an individual~~ a client to derive the full benefit of other vocational rehabilitation services he is receiving.

~~(2) Major types of living expenses covered by maintenance grants include: food, shelter, clothing, laundry, and incidentals.~~

~~(3) Federal financial participation will not be available except as noted below, in payments for maintenance made in connection with the placement of a handicapped person after he actually receives sufficient remuneration for his employment to support him, or, in the case of a handicapped person placed in self-employment, after 30 days from the time the person is so placed. In certain unusual instances, when deemed necessary to accomplish a rehabilitation, maintenance for as much as 60 days may be provided a client following placement. This applies particularly to clients removed from a state or federal institution and placed on try-out jobs in new localities, thus giving them a better chance to become established economically until such time as they may be able to assume total maintenance costs themselves.~~

~~(4) Payment of maintenance to disability beneficiaries from trust funds will be subject to the conditions in Sections 10 and 11 of the Montana State Plan for Rehabilitative Services Division.~~

(2) Maintenance will be provided by the department at its discretion in accordance with rule XVI (46.6.517).

(3) Maintenance will be provided to a client for no more than 30 days after he has been placed in appropriate employment.

The authority of the department to amend the rule is based on Section 53-7-102, MCA and the rule implements Section 53-7-102, MCA.

46.6.506 PLACEMENT (1) The ~~State Division~~ department, either directly or through the services of other public and private placement agencies, will assume responsibility for ~~the~~ developing a placement ~~of all~~ for a ~~handicapped individuals~~ client ~~accepted for vocational rehabilitation services,~~ which is appropriate in accordance with the goals of his vocational rehabilitation plan.

(2) Following placement of a client and before case closure, several follow-up visits will be made by a ~~Division~~ department representative to ~~determine~~ assess the success ~~that~~ of the placement ~~has been fully achieved,~~ and ~~that~~ to determine whether the client is again able to meet his normal needs without further outside assistance. Once it is determined that a client is suitably placed, his case will be closed.

(3) The standards for determining that a client is suitably placed are:

(a) that the work performed is consistent with the client's physical and mental capacities, interests, and personal characteristics.

(b) that the client possesses or has acquired necessary skills to perform the work successfully.

(c) that the work has reasonable permanency.

(d) that working conditions will neither aggravate the client's disability nor jeopardize the health or safety of others.

(e) that the employment provides adequate income for the client and his family.

(f) that, if not employed full-time, the job is consistent with client's capacity to work and produce.

(g) that the wage and working conditions conform with the state and federal statutory requirements.

(4) ~~In each case~~ After placement there will be a minimum 60-day ~~follow-up~~ period ~~after placement,~~ prior to case closure, ~~to assure that~~ during which support for the vocational rehabilitation objective of the client ~~has been successfully achieved.~~ will be available.

The authority of the department to amend the rule is based on Section 53-7-102, MCA and the rule implements Section 53-7-102, MCA.

46.6.507 ~~TOOLS, EQUIPMENT, INITIAL STOCKS AND SUPPLIES~~ VOCATIONAL ASSISTANCE (1) Customary ~~T~~tools, equipment, initial stocks and supplies, including livestock, may be provided ~~as needed in the individual case~~ to a client for the operation of a business or agricultural enterprise or the pursuit of a trade, occupation, or profession ~~by eligible clients.~~ if these are determined by the department in accordance with the client's vocational rehabilitation plan to be appropriate for the client's vocational rehabilitation.

~~(2) Guides and standards governing quality and quantity are developed, as necessary, with appropriate professional, trade, business, training, and other organizations and institutions. Occupational licenses will be supplied, as required, in the individual case.~~

(2) The department may provide advice and assistance to a client in obtaining appropriate occupational licenses.

The authority of the department to amend the rule is based on Section 53-7-102, MCA and the rule implements Section 53-7-102, MCA.

46.6.508 READER AND INTERPRETER SERVICE (1) The department may provide reader services or interpreter services to a blind or deaf applicant to the extent needed to determine his vocational rehabilitation potential or to a blind or deaf client in order to facilitate his vocational rehabilitation in accordance with his vocational rehabilitation plan. ~~The Division will provide reader services for the blind and interpreter services for the deaf.~~ For these services the ~~Division~~ department will pay a reasonable fee which will not exceed what other state, private or federal agencies pay for similar services.

The authority of the department to amend the rule is based on Section 53-7-102, MCA and the rule implements Section 53-7-102, MCA.

46.6.509 SERVICES TO ~~FAMILY-MEMBERS~~ DEPENDENTS

~~(1) Family member means any relative by blood or marriage of a handicapped individual and also means other individuals living in the same household with whom the handicapped individual has a close interpersonal relationship.~~

~~(2)~~ (1) The ~~State Division~~ department ~~will~~ may furnish a necessary service to any ~~family-member~~ dependent of ~~the handicapped~~ an individual where the service is required as part of the ~~overall~~ extended evaluation or vocational rehabilitation plan of the ~~handicapped~~ individual and can be provided through no other resource.

~~(3)~~ (2) Such services will include only those services which may be expected to contribute substantially to the determination of rehabilitation potential or to the rehabilitation of ~~the~~ an ~~handicapped~~ individual.

~~(4) The State Division will furnish (directly or by contract) recruitment and training services to provide eligible individuals, or groups thereof, new employment opportunities in the fields of rehabilitation, health, welfare, public safety, law enforcement and other appropriate service employment.~~

The authority of the department to amend the rule is based on Section 53-7-102, MCA and the rule implements Section 53-7-102, MCA.

46.6.510 OTHER GOODS AND SERVICES (1) ~~When such services are found necessary, t~~The ~~Division~~ department may furnish an attendant for a severely disabled individual on extended evaluation or for a client to be an escort ~~him~~ to and from school, shop or other institutions where services are provided. Such services may be available to a client only when found to be necessary and the individual is unable to pay the cost himself. The ~~Division~~ department may pay for a client's business licenses and professional fees when such are required and the client is unable to pay the cost himself. ~~The same policy will apply to o~~Other necessary goods or supplies not otherwise covered in this chapter deemed necessary to determine the rehabilitation potential of ~~the~~ an ~~handicapped individual~~ applicant or necessary to render ~~him~~ a client fit to engage in a gainful occupation, may be furnished when the individual is unable to pay the cost himself.

~~(2) The State Division will furnish short periods of medical care for acute conditions arising in the course of vocational rehabilitation, which, if not cared for, would constitute a hazard to the achievement of the vocational~~

~~rehabilitation objective, or the completion of the extended evaluation to determine rehabilitation potential.~~

The authority of the department to amend the rule is based on Section 53-7-102, MCA and the rule implements Section 53-7-102, MCA.

46.6.511 POST EMPLOYMENT SERVICES (1) The ~~State Division~~ department ~~will~~ may in its discretion provide post employment services ~~after~~ upon placement and after case closure to assist former clients who are in need of such services to maintain themselves in employment.

(2) Post employment services may be ~~necessary~~ provided where ~~some~~ the department determines that assistance is needed following case closure in order to prevent the ~~breakdown~~ failure of otherwise ~~good~~ successful rehabilitation results~~.~~. ~~s~~Such services are supportive and supplemental to the ~~original~~ vocational rehabilitation plan for that individual. ~~and are of such a nature and scope as to be an extension of the individual's plan.~~

(3) All services of this ~~Division~~ department ~~will~~ may be available through post employment service where it is required to maintain the client in gainful employment or enable him to become employable.

The authority of the department to amend the rule is based on Section 53-7-102, MCA and the rule implements Section 53-7-102, MCA.

46.6.512 COUNSELING SERVICES (1) Systematic and adequate counseling and guidance for the benefit of ~~each client~~ an individual will be provided from referral to completion of all services included in ~~the individual's~~ his vocational rehabilitation plan.

(a) During plan development, sufficient personal counseling ~~is accomplished with~~ will be provided to ~~the client~~ an individual in order to develop a suitable vocational rehabilitation plan.

(b) ~~Clients~~ Individuals in service are to be contacted at least quarterly to ~~establish~~ determine if additional counseling is required.

(c) Counseling ~~is~~ shall continued through completion of services and of job placement.

(d) Sufficient counseling ~~is~~ shall be provided by post employment service to insure that the former client ~~is on~~ has a suitable job and will be able to continue in gainful employment.

The authority of the department to amend the rule is based on Section 53-7-102, MCA and the rule implements Section 53-7-102, MCA.

46.6.513 WORK ACTIVITY CENTER SERVICES (1) Services can be purchased from work activity centers only for ~~Rehabilitative Services Division~~ clients who are ~~defined as~~ severely handicapped individuals ~~disabled~~ and whose current vocational rehabilitation needs~~, at this point in their rehabilitation plans,~~ can be satisfied only with the purchase of vocational rehabilitation services as defined in this sub-chapter from a work activity center.

The authority of the department to amend the rule is based on Section 53-7-102, MCA and the rule implements Section 53-7-102, MCA.

46.6.515 OUT-OF-STATE SERVICES (1) Transportation and per diem will not be authorized for out-of-state services if the ~~needed~~ department determines that similar services are reasonably available in the state.

The authority of the department to amend the rule is based on Section 53-7-102, MCA and the rule implements Section 53-7-102, MCA.

4. The rules proposed to be repealed are:

Rule 46.6.101 on page 46-349 of Administrative Rules of Montana.

The authority of the department to repeal the rule is based on Section 53-7-102, MCA.

Rule 46.6.301 on page 46-357 of Administrative Rules of Montana.

The authority of the department to repeal the rule is based on Section 53-7-102, MCA.

Rule 46.6.401 on page 46-357 of Administrative Rules of Montana.

The authority of the department to repeal the rule is based on Section 53-7-102, MCA.

Rule 46.6.402 on page 46-361 of Administrative Rules of Montana.

The authority of the department to repeal the rule is based on Section 53-7-102, MCA.

Rule 46.6.403 on page 46-361 of Administrative Rules of Montana.

The authority of the department to repeal the rule is based on Section 53-7-102, MCA.

Rule 46.6.404 on page 46-362 of Administrative Rules of Montana.

The authority of the department to repeal the rule is based on Section 53-7-102, MCA.

Rule 46.6.514 on page 46-374 of Administrative Rules of Montana.

The authority of the department to repeal the rule is based on Section 53-7-102, MCA.

5. The department is proposing these rules in order to provide more appropriate procedures and criteria governing eligibility of persons for those vocational rehabilitation services available under the vocational rehabilitation program administered by the department through the Vocational Rehabilitation Division and statutorily mandated in Chapter 7, Part 1 of Title 53, MCA. The proposed amendments clarify the nature and scope of services.

6. Interested parties may submit their data, views, or arguments, either orally or in writing at the hearing. Written data, views, or arguments may also be submitted to the Office of Legal Affairs, Department of Social and Rehabilitation Services, P. O. Box 4210, Helena, Montana, no later than June 15, 1982.

7. The Office of Legal Affairs, Department of Social and Rehabilitation Services has been designated to preside over and conduct the hearing.

Director, Social and Rehabilitation Services

Certified to the Secretary of State May 3, 1982.

BEFORE THE DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES OF THE
STATE OF MONTANA

In the matter of the amendment of Rules 46.12.1201, 46.12.1202, 46.12.1203, 46.12.1204, 46.12.1205, and 46.12.1206 and the adoption of rules pertaining to nursing home reimbursement under the state medicaid program	)))))))	NOTICE OF PUBLIC HEARING ON THE AMENDMENT OF RULES 46.12.1201, 46.12.1202, 46.12.1203, 46.12.1204, 46.12.1205, AND 46.12.1206, AND THE ADOPTION OF RULES PERTAINING TO NURSING HOME REIMBURSEMENT

TO: All Interested Persons

1. On June 3, 1982, at 1:00 p.m., a public hearing will be held in the auditorium of the Social and Rehabilitation Services Building, 111 Sanders, Helena, Montana to consider the amendment of Rules 46.12.1201, 46.12.1202, 46.12.1203, 46.12.1204, 46.12.1205 and 46.12.1206 and the adoption of rules pertaining to nursing home reimbursement under the State Medicaid Program.

2. The agency has amended the rules with the following changes:

46.12.1201 TRANSITION FROM RULES IN EFFECT SINCE ~~APRIL 1, 1979~~ JANUARY 1, 1981 ~~(1) The rules in effect between April 1, 1979 and December 31, 1980 provide for determining a prospective rate based on prior fiscal year's costs. These rules further provide for determining rates under an alternative rate review process.~~

~~(2) A facility which has entered into an agreement for rate review prior to December 31, 1980, will continue under that agreement for the period covered by the agreement. A facility which has not requested a rate review by December 31, 1980, shall receive a rate determined under the rules that follow.~~

~~(3)~~ (1) These rules shall be effective ~~January 1, 1981~~ July 1, 1982.

(2) Includable costs for cost reports with ending dates before July 1, 1982, will be determined in accordance with rules for allowable costs then in effect.

(3) Each facility shall be required to submit a cost report for the period from the first day of their 1982 fiscal year through June 30, 1982. Administrative rules in effect on June 30, 1982, shall govern the preparation, submission and audit of this cost report as well as settlement for this period.

(4) Operating and property rates determined in accordance with ARM 46.12.1204 shall be subject to a phase-in

process to yield a payment rate. The payment rate is the result of computing the formula:

R=S+((A+M-S) divided by 3), if A+M-S is greater than zero, for the period July 1, 1982, through June 30, 1983, or

R=S+(2 times ((A+M-S) divided by 3)), if A+M-S is greater than zero, for the period July 1, 1983 through June 30, 1984, or

R=A+M, if A+M-S is greater than zero, for the period July 1, 1984 through June 30, 1985, or

R=S, if A+M-S is equal to or less than zero, for the period July 1, 1982 through June 30, 1985,

where:

R is the payment rate for the respective periods,

S is the interim rate in effect on June 30, 1982,

A is the operating rate effective July 1, 1984, in accordance with ARM 46.12.1204(2), and revised annually in accordance with ARM 46.12.1204(5),

M is the property rate effective July 1, 1984, in accordance with ARM 46.12.1204(3), and revised annually in accordance with ARM 46.12.1204(5).

The authority of the agency to amend the rule is based on Sections 53-6-113 and 53-2-201(h), MCA; and the rule implements Sections 53-6-111, 53-6-141, and 53-2-201(a), MCA.

46.12.1202 PURPOSE AND DEFINITIONS (1) ~~Reasonable-cost related-reimbursement--for--skilled--nursing-and--intermediate care-facility-services--is-mandated--by-section--249-of-Public law-92-603,-the-1972-amendment-to-the-Social-Security-Act.~~

~~(a)--The-purpose-of--the-following--rules-is--to-meet-the requirements-of-Title--XIX-including-section-249-of-Public-law 92-603-and-42-CFR--447--et-seq,-while--treating--the--eligible recipient,-the-provider-of-services,-and-the-department-fairly and-equitably.~~

~~(b)--The--rates--determined--under--the--following--rules exclude-costs-estimated-to-be-in-excess-of-those--necessary-in the-efficient-delivery-of--needed-health--services,--but-shall not-be-set-lower-than-the--level-which--the-department-reasonably-finds-to-be-adequate-to-reimburse--in-full--actual-allowable--costs--of-a--provider--operating--economically-and-efficiently--and-having--no-deficiencies--which--would--result--in decertification.--A-provider-will-be--defined-to-be--operating efficiently--if-he-is-a-prudent-and--cost--conscious-buyer.--A prudent-and--cost-conscious-buyer-not-only-refuses-to-pay-more than-the-going--price-for-a--service-or-item,-he-also-seeks-to minimize--costs.---The-department--defines--a-provider--to--be operating-economically--if-the-actual--allowable--costs-for--a rate-year-have-increased-from-the-applicable-prior-fiscal-year at-a-rate-which-is--no-more--than-the--rate-of--change-in--the trend-factor-(see-ARM--46.12.1204(3)(d))--for-the-same-period,-

~~The department defines a provider to have no deficiencies if that provider holds a current certification for participation in the medicaid program issued by the Montana department of health and environmental sciences.~~

~~(c) The rules for determining rates and the rate setting methodology may be amended or revised from time to time, but such amendments or revisions will become effective only after members of the public have had adequate opportunity to review and comment according to procedures established under Montana state law.~~

~~(d) The department will pay providers the amounts determined under these rules on a monthly basis upon receipt of an appropriate billing representing the determined rates applied to eligible recipients.~~

~~(2) As used in these rules governing nursing home care reimbursement the following definitions apply.~~

~~(a) "CPI" means the consumer price index for all urban consumers published monthly by the bureau of labor statistics, U.S. department of labor. CPI all means the all items figure. CPI food means the food at home item. CPI other means the CPI all items figure excluding the food item and the shelter item.~~

~~(b) "labor index" means the average hourly earnings of production or nonsupervisory workers of nursing and personal care facilities published by the bureau of labor statistics, U.S. department of labor. Such earnings amount shall be utilized as an index.~~

(1) The purpose of the following rules is to define the basis and procedures the department will use to pay for long-term care facility services provided to medicaid recipients from July 1, 1982 forward.

(a) These rules meet the requirements of Title XIX of the Social Security Act including 42 CFR 447 et seq and allow the department to pay for long-term care facility services through the use of rates that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable Montana and federal laws, regulations, and quality and safety standards.

(b) Efficiently and economically operated providers are those providers who provide adequate long-term care facility services at a cost that is less than or equal to the payment rate determined in ARM 46.12.1204.

(c) Adequate long-term care facility services are those provided in conformity with applicable Montana and federal laws, regulations, quality and safety standards, by providers having no deficiencies as determined in ARM 46.12.1206(9).

(d) The rules for determining rates and the rate-setting methodology may be amended or revised from time to time, but such amendments or revisions will become effective only after members of the public have had adequate opportunity to review and comment according to procedures established

under Montana state law. The department reviews provider cost report data, patient assessment data, and inflation indicators periodically. Should any of this information indicate a material change in the assumptions used to develop these rules, the department, at its discretion, will amend these rules accordingly.

(2) As used in these rules governing long-term care facility services, the following definitions apply:

(a) "Long-term care facility services" means skilled nursing facility services provided in accordance with 42 CFR 405 Subpart K, intermediate care facility services provided in accordance with 42 CFR 442 Subpart F, and intermediate care facility services for the mentally retarded provided in accordance with 42 CFR 442 Subpart G. The department hereby adopts and incorporates herein by reference 42 CFR 405 Subpart K, and 42 CFR 442 Subparts F and G, which define the participation standards for providers, copies of which may be obtained through the Department of Social and Rehabilitation Services, P. O. Box 4210, 111 Sanders, Helena, Montana 59604. These services include, but are not limited to, a regular medically necessary room, dietary services, nursing services, minor medical and surgical supplies, and the use of equipment and facilities. Examples of long term care facility services are:

(i) all general nursing services including but not limited to administration of oxygen and related medications, hand-feeding, incontinent care, tray service, and enemas;

(ii) items furnished routinely and relatively uniformly to all patients without charge, such as patient gowns, water pitchers, basins and bed pans;

(iii) items stocked at nursing stations or on the floor in gross supply and distributed or used individually in small quantities without charge, such as alcohol, applicators, cotton balls, bandaids, antacids, aspirin (and other non-legend drugs ordinarily kept on hand), suppositories, and tongue depressors;

(iv) items which are used by individual patients which are reusable and expected to be available, such as ice bags, bed rails, canes, crutches, walkers, wheelchairs, traction equipment, and other durable medical equipment;

(v) special dietary supplements used for tube feeding or oral feeding such as elemental high nitrogen diet; and

(vi) laundry services whether provided by the facility or by a hired firm, except for patients' personal clothing which is dry cleaned outside of the facility.

(b) "Provider" means any person, agency, corporation, partnership or other entity that furnishes long-term care facility services and has entered into an agreement with the department for providing those services.

(c) "Department" means the Montana department of social and rehabilitation services.

(d) ~~"Facility"--means-a--long-term-care--facility--which provides-skilled-nursing-or-intermediate-care,--or-both-to-two or-more--persons-and-which-is-licensed-as-such-by--the-Montana department--of-health--and-environmental--sciences.~~ "Medicaid recipient" means a person who is eligible and receiving assistance through Title XIX of the Social Security Act for long-term care facility services.

(e) "Patient day" means ~~an-individual~~ a whole 24-hour period that a person is present and receiving long term care facility services. ~~in-a--nursing--home--facility--for-a--whole 24-hour-period.~~ Even though ~~an-individual~~ a person may not be present for a whole 24-hour period on day of admission, or day of death, such day will be considered a patient day. When department rules provide for the reservation of a bed for a patient who takes a temporary leave from a ~~facility~~ provider to be hospitalized or make a home visit, such whole 24-hour periods of absence will be considered patient days.

(f) ~~"Routine--nursing-care--services"-means--skilled--or intermediate-nursing-care-as-defined-in-rules-for-nursing-home care-in-ANM-46.12.1103-and-46.12.1104.~~ "Average nursing care hourly wage" means the weighted sum of the hourly wages, including benefits, for registered nurses, licensed practical nurses, and nursing aides employed by providers, identified by the department in its most recent survey of providers, divided by the total number of personnel surveyed.

(g) ~~"ICF/MR"-means-a-facility-certified--by-the--Montana department-of--health-and--environmental--sciences-to--provide intermediate--care--for--patients-who--are-mentally--retarded.~~ "Average nursing care time" means the sum of management hours of care for medicaid recipients identified by the department in its most recent patient assessment survey, divided by the total number of medicaid recipients surveyed.

(h) "Average wage" means the sum of starting salaries for job openings in the 300-series in the dictionary of occupational titles identified by the department in its most recent survey of jobs opened in Montana's job service offices during a twelve-month-or-more period, divided by the number of job openings surveyed.

~~(i)--"Provider"-means--any-person,--agency,--corporation, partnership-or-other-entity-which--has-entered--into-an-agreement-with--the--department--for-the--providing-of-nursing-care services.~~

(i) "Wage area" means the geographic area serviced by the Montana job service office in which a provider is located.

(j) "Extensive remodeling" means a renovation or refurbishing of all or part of a provider's physical facility, in accordance with certificate of need requirements, when the project's total cost depreciable under generally accepted accounting principles exceeds, in a twelve-month period, $2,400 times the number of licensed beds in the facility.

"Extensive remodeling" does not include the construction of additional beds.

(k) "Age of facility" means the number of whole years from the year of construction to the rate year.

(l) "Wood frame construction" means the use of wood or steel studs in most bearing walls, with an exterior covering of wood siding, shingles, stucco, brick, or stone veneer, or other materials. "Wood frame construction" is defined to include all pre-engineered steel or aluminum buildings.

(m) "Non-wood frame construction" means all types of construction not included as wood-frame construction.

~~(h)~~ (n) "Owner" means any person, agency, corporation, partnership or other entity which has an ownership interest, including a leasehold or rental interest, in assets used to provide ~~nursing~~ long-term care facility services pursuant to an agreement with the department.

~~(i)~~ (o) "Administrator" means the person, including an owner, salaried employee, or other provider, with day-to-day responsibility for the operation of the facility. In the case of a facility with a central management group, the administrator, for the purpose of these rules, may be some person (other than the titled administrator of the facility), with day-to-day responsibility for the long-term care portion of the facility. In such cases, this other person must also be a licensed nursing home administrator.

~~(k)~~ (p) "Related parties" for purposes of interpretation hereunder, shall include the following:

(i) ~~An individual~~ A person or entity shall be deemed a related party to his spouse, ancestors, descendants, brothers and sisters, or the spouses of any of the above, and also to any corporation, partnership, estate, trust, or other entity in which he or a related party has a substantial interest or in which there is common ownership.

(ii) A substantial interest shall be deemed an interest directly or indirectly, in excess of ~~ten~~ five percent ~~(10%)~~ (5%) of the control, voting power, equity, or other beneficial interest of the entity concerned.

(iii) Interests owned by a corporation, partnership, estate, trust, or other entity shall be deemed as owned by the stockholders, partners, or beneficiaries.

(iv) Control exists when ~~an individual~~ a person or entity has the power, directly or indirectly, whether legally enforceable or not, to significantly influence or direct the actions or policies of another ~~individual~~ person or entity, whether or not such power is exercised.

(v) Common ownership exists when ~~an individual~~ a person has substantial interests in two or more providers or entities serving providers.

~~(l)~~ (q) "Fiscal year" and "fiscal reporting period" both mean the ~~facility's~~ provider's internal revenue tax year.

~~(m)--"Property-Costs"-are-amounts-allowable-for--facility or-equipment-depreciation,-interest-on-loans-for-a-facility-or equipment,-and-leases-or-rental-of-a-facility-or-equipment.~~

~~(n)--"Operating-costs"--are-the--difference-between-total allowable-cost-and-property-costs.~~

~~(o)--"Certificate-of--Need"-is-the--authorization-to-proceed-with--the-making-of--capital--expenditures-under--Section 1122,-Title-XI-of-the-Social-Security-Act,-and--sections-50-5-101-through-50-5-307-MCA.~~

~~(p)--"New-facility"--means-an-entirely--newly-constructed facility--which-has--not-provided-nursing--care-services--long enough-to-have-a-cost-report-with-a-complete-audit-as-provided under---ARM--46.12.1205(6)--covering---a--twelve-month--fiscal reporting-period.~~

~~(q)--"New-provider"-means-a-provider--who-acquires-ownership--or--control-of-a--skilled-nursing--or-intermediate--care facility-whether-by-purchase,-lease,--rental-agreement,--or-in any-other-way,-subsequent-to-the-effective-date-of-this-rule.~~

~~(r)--"Rate--year"-means-the-provider's--fiscal--year--for which-an-interim-rate-is-being-issued.~~

~~(s)---Nominal--charge--means-a--charge--by--a--government facility-to-a-private-patient-which-amounts-to--less-than-half of-the-actual-allowable-costs-per-day-for-the-rate-year.~~

(r) "Department audit staff" and "audit staff" mean personnel directly employed by the department or any of the department's contracted audit personnel or organizations.

~~(t)~~ (s) "Estimated economic life" means the estimated remaining period during which the property is expected to be economically usable by one or more users, with normal repairs and maintenance, for the purpose for which it was intended when built.

(t) "Rate year" means a 12-month period beginning July 1.

(u) The laws and regulations and federal policies cited in this sub-chapter shall mean those laws and regulations which are in effect as of ~~October 22, 1980~~ March 31, 1982.

The authority of the agency to amend the rule is based on Sections 53-6-113 and 53-2-201(h), MCA; and the rule implements Sections 53-6-111, 53-6-141, and 53-2-201(a), MCA.

46.12.1203 PARTICIPATION REQUIREMENTS The ~~skilled-nursing-and-intermediate-care-facilities~~ providers participating in the Montana medicaid program shall meet the following basic requirements to receive payments for services:

(1) maintain a current license under the rules of the department of health and environmental sciences for the category of care being provided;

(2) maintain a current certification for Montana medicaid under the rules of the department for the category of care being provided;

(3) maintain a current agreement with the department to provide the care for which payment is being made;

(4) have a licensed nursing home administrator or other qualified supervisor for the facility as statutes or regulations may require;

(5) accept, as payment in full for all operating and property costs, the amounts calculated and paid in accordance with the reimbursement method set forth in these rules~~.~~; and

(6) a provider maintaining patient trust accounts must insure that any funds maintained in those accounts are used only for those purposes for which the patient or legal guardian has given written delegation. A provider may not borrow funds from these accounts for any purpose.

The authority of the agency to amend the rule is based on Sections 53-6-113 and 53-2-201(h), MCA; and the rule implements Sections 53-6-111, 53-6-141, and 53-2-201(a), MCA.

46.12.1204 ~~REIMBURSEMENT METHOD~~ PAYMENT RATE ~~AND PROCEDURES~~

Subsections 1 through 8 are deleted in their entirety.

(1) Except as provided under ARM 46.12.1204(4), a provider's payment rate is the sum of an operating rate and a property rate, adjusted by the phase-in procedure provided in ARM 46.12.1201(4).

(2) The operating rate is the result of computing the formula:

A=B times ((C times (($27.43 + ($54,627 divided by D)) divided by .9)) + E),
where:
A is the operating rate per day of service,
B is the area wage adjustment for a provider,
C is 1.0 effective July 1, 1982, 1.09 effective July 1, 1983, and 1.1881 effective July 1, 1984,
D is the number of licensed beds for a provider times 366 days,
E is the patient care adjustment for a provider.

(a) The area wage adjustment for a provider is the result of computing the following formula:

B=1 + (((F-G) divided by G) times .71) if F is equal to or greater than one standard deviation from the average wage, or
B=1.0 if F is less than one standard deviation from the average wage,
where:
B is the area wage adjustment for a provider,
F is the average wage for a provider's wage area,

G is the average wage for all wage areas plus one standard deviation, if F is more than one standard deviation above the average wage, or
G is the average wage for all wage areas minus one standard deviation, if F is more than one standard deviation below the average wage.

(b) The patient care adjustment for a provider is the result of computing the following formula:

E=((J divided by K) times L times K) - (L times K)
where:
E is the patient care adjustment for a provider.
J is the provider's average nursing care time,
K is the average nursing care time for all providers.
L is the average nursing care hourly wage including benefits.

(3) The property rate is the result of computing the formula:

(a) M = (((N divided by Z) times $5.82) times (O - (P times Q))) divided by .9
where:
M is the property rate per day of service,
N is 25 years minus the age of the facility (limited to 20 years) as of 1982 (or as of licensure, for entire facilities built after July 1, 1982), if the facility is of wood-frame construction, or, 30 years minus the age of the facility (limited to 22 years) as of 1982 (or as of licensure, for entire facilities built after July 1, 1982), if the facility is of non-wood-frame construction.
O is 1.0 effective July 1, 1982, 1.06 effective July 1, 1983 and 1.1236 effective July 1, 1984,
P is .0400 if facility is of wood-frame construction, or .0333 if facility is of non-wood-frame construction,
Q is the rate year minus 1983 (number of years the building has aged since 1983), or the rate year minus the year of licensure for facilities built after July 1, 1982.
Z is 25 years if the facility is of wood-frame construction, or 30 years if the facility is of non-wood-frame construction.

(b) For facilities with additions built subsequent to the initial construction, the age of the facility shall be determined by pro-rating on a square-foot basis.

(c) For facilities extensively remodeled after July 1, 1982, the actual age of the facility shall be reduced by one year for each $1,200 per bed of remodeling, to a maximum total reduction for remodeling of ten years. If the facility was at the maximum age of 20 years for wood-frame construction or 22 years for non-wood-frame construction at the time of

remodeling, then the reduction for remodeling shall be made to that maximum age, rather than to actual age.

(4) The payment rate to providers of intermediate care facility services for the mentally retarded is the actual includable cost incurred by the provider as determined in ARM 46.12.1207 divided by the total patient days of service during the provider's fiscal year, except that the payment rate will not exceed the interim rate in effect on June 30, 1982, as indexed to the mid-point of the rate year by 9% per 12-month year.

(a) One month prior to the beginning of the provider's fiscal year, an interim payment rate which is the department's estimate of actual includable cost divided by estimated patient days will be determined.

(b) The difference between actual includable cost prorated for services to medicaid patients as limited in ARM 46.12.1204(4) and the amount paid through the interim payment rate will be settled through the overpayment and underpayment procedures set forth in ARM 46.12.1209.

(5) The averages, standard deviations, prorating for additions, and remodeling factors used in the patient care adjustment, area wage adjustment, or property rate are recalculated once a year, using the most currently available data prior to June 1. Revised rates based on the new calculations are issued by July 1 of each year.

The authority of the agency to amend the rule is based on Sections 53-6-113 and 53-2-201(h), MCA; and the rule implements Sections 53-6-111, 53-6-141, and 53-2-201(a), MCA.

46.12.1205 ~~COST-REPORTING~~ PAYMENT PROCEDURES

Subsections 1 through 8 are deleted in their entirety.

(1) The department pays providers amounts determined under these rules on a monthly basis upon receipt of an appropriate billing which represents the number of patient days of long-term care facility services provided to medicaid recipients times the payment rate minus the amount each medicaid recipient participates in the cost of care.

(2) The payments made according to ARM 46.12.1205(1) represent full payment for the patient days of long term care facility services represented on a billing. A provider shall not bill or collect any additional amount from medicaid recipients or the department for these services, except that the department may be billed additionally as allowed below:

(a) A provider may bill additionally at direct cost, with no indirect charges added, on a per-patient basis, for the following: oxygen, including those disposable items associated with the administration of oxygen such as cannulas, tubing and masks (however, the administration of oxygen is a routine service which is included in the payment rate for

long-term care facility services and may not be billed additionally); catheters, disposable colostomy and ileostomy appliances, and bedside drainage bags; and routine nursing supplies used in extraordinary amounts and prescribed by a physician on an individualized basis for specialized care related to a specific diagnosis and prior-authorized by the department or its designee.

(b) Physical, occupational, and speech therapies may be billed additionally by the licensed therapist providing the service. If the therapist is employed by the provider, the provider shall bill under a separate therapy provider number. Department rules related to physical therapy (ARM 46.12.527), occupational therapy (ARM 46.12.547), and speech pathology (ARM 46.12.532) shall apply.

(c) Medically necessary motorized or customized wheelchairs with special design for a unique condition; helmets; shoulder braces, sacroiliac, lumbro sacral, and dorso-lumbral supports; hinged joint steel knee cap; wrist supports; orthopedic braces; elastic stockings; and oxygen may be billed additionally by the provider of medical supplies or equipment in accordance with ARM 46.12.1801-1802 and ARM 46.12.1805-1806.

(d) All prescribed medication may be billed additionally by the pharmacy providing the medication including flu shots and tine tests in accordance with ARM 46.12.701.

(e) Non-emergency transportation may not be billed additionally. Emergency transportation may be billed additionally by an ambulance service in accordance with ARM 46.12.1021-1022 and ARM 46.12.1025.

(f) Providers may contract with any qualified person or agency, including home health agencies, to provide required long term care facility services. However, except as allowed in this subsection, none of the contracted services may be billed additionally.

(3) If a provider has any deficiency as determined in ARM 42.12.1206(9), the department will conduct an audit of the provider's costs for the fiscal year in which the deficiency occurred and collect any difference between the amount the department paid during the fiscal year and actual includable cost prorated for services to medicaid recipients as determined in ARM 46.12.1207. Recovery will be in accordance with ARM 46.12.1209. If there are no deficiencies as defined in ARM 46.12.1206(9), the provider retains the full amount the department pays during the fiscal year.

(4) Any medical services and supplies for medicaid recipients in long-term care facilities not included under long-term care facility services may be billed by the provider of those services according to applicable department rules.

(5) No payment or subsidy will be made to a provider for holding a bed while the recipient is receiving medical services elsewhere, such as in a hospital, except in a situation

where a provider is full and has a waiting list of potential residents. A provider will be considered full if all beds are occupied or being held for a patient temporarily in a hospital. In this exceptional instance, a payment may be made for holding a bed while the resident is temporarily receiving care in a hospital, is expected to return to the provider, and the cost of holding the bed will evidently be less costly than the possible cost of extending the hospital stay until an appropriate bed would otherwise become available. Furthermore, payment in this exceptional instance may be made only upon approval from the director of the department or his designee.

(6) Reimbursement will be made to a provider for reserving a bed while the recipient is temporarily absent if the recipient's plan of care provides for therapeutic home visits. A total of 24 days annually will be allowed for therapeutic home visits. The provider is responsible for notifying the department on a form provided by the department when a resident leaves the facility for a therapeutic home visit. Reimbursement for therapeutic home visits will not be allowed unless the form is filed with the department. Absences are restricted to no more than 72 consecutive hours per absence. Longer hours per absence may be allowed if determined medically appropriate and prior authorized by the director of the department or his designee.

The authority of the agency to amend the rule is based on Sections 53-6-113 and 53-2-201(h), MCA; and the rule implements Sections 53-6-111, 53-6-141, and 53-2-201(a), MCA.

46.12.1206 ~~ADMINISTRATIVE REVIEW AND FAIR HEARING PROCEDURES~~ PATIENT ASSESSMENTS, STAFFING REPORTS AND DEFICIENCIES

Subsections 1 through 3 are deleted in their entirety.

(1) Each provider will report to the department each month the care requirements for each medicaid patient in the facility on forms specified and provided by the department.

(2) Each provider will report to the department each month the staffing provided at the facility on forms specified and provided by the department.

(3) Completed patient assessment forms and staffing report forms must be received by the department within ten days following the end of each calendar month, and must be certified as accurate and complete by the administrator or his designee. If the complete, accurate and certified forms are not received within the ten-day period, the first available payment for long term care facility services will be withheld until such time as the forms are received. The use of the department's forms is mandatory. The reports as submitted shall be complete and accurate. Incomplete reports or reports

containing inconsistent data will be returned to the provider for completion or correction.

(4) At least twice annually, patient assessment and staffing review teams will validate the monthly patient assessment and staffing reports for accuracy and consistency with medical and financial records maintained at the facility.

(5) Upon admission and as frequently thereafter as the department may deem necessary, the department will evaluate the necessity of nursing home care for each medicaid patient, in accordance with 42 CFR 456.250 through 456.522, which specify utilization review criteria for long-term care facilities and which are federal regulations which the department hereby adopts and incorporates by reference. A copy of the cited regulations may be obtained from the Department of Social and Rehabilitation Services, P. O. Box 4210, 111 Sanders, Helena, Montana 59604.

(6) As frequently as the department deems necessary, the quality of medical care that each medicaid patient is receiving shall be evaluated by the department, in accordance with 42 CFR 456.600 through 456.614, which specify medical review criteria for long-term care facilities and which are federal regulations which the department hereby adopts and incorporates by reference. A copy of the cited regulations may be obtained from the Department of Social and Rehabilitation Services, P. O. Box 4210, 111 Sanders, Helena, Montana 59604.

(7) Review teams designated by the department will submit written reports to the medicaid financing bureau relative to findings and recommendations based upon the evaluations conducted in accordance with ARM 46.12.1206(4), (5) and (6). The medicaid financing bureau will respond to these reports by:

(a) Informing the provider that the three areas of review have been successfully completed with no significant deficiencies; or,

(b) informing the provider that corrective action is necessary and that a corrective action plan approved jointly by the department and the state department of health and environmental sciences must be implemented within a period of time specified by the department; or,

(c) informing the provider that deficiencies are major and constitute a danger to the patients' well-being and necessitate the filing of a formal complaint with the state department of health and environmental sciences.

(8) In addition to the actions specified in ARM 46.12.1206(7), for any provider with an identified deficiency, the department will:

(a) Schedule and conduct an audit of the provider's cost report within 180 days of receipt of the cost report covering the fiscal year in which the deficiency occurred.

(b) Determine includable costs as specified in ARM 46.12.1207 through audit procedures and recover, in accordance

with ARM 46.12.1209, all amounts paid in excess of includable costs. Amounts recovered will be not less than 10% of amounts paid to the facility for the period for long-term care facility services.

(9) Deficiencies referred to in ARM 46.12.1206(8) shall be deemed to have occurred if:

(a) There are any findings initiated by the department review teams resulting in necessary corrective action in accordance with ARM 46.12.1206(7)(b); or,

(b) there are any findings initiated by the department review teams which result in confirmation by the state department of health and environmental sciences that a condition existed in the facility which constituted a danger to the patients' well-being, in accordance with ARM 46.12.1206(7)(c); or,

(c) there is a loss of certification for participation in the medicaid program in accordance with rules established by the department of health and environmental sciences; or,

(d) there is a determination by the medicaid financing bureau that a facility's average patient assessment care requirement was 25% or more in excess of actual facility nursing care staffing for two or more consecutive months.

The authority of the agency to amend the rule is based on Sections 53-6-113 and 53-2-201(h), MCA; and the rule implements Sections 53-6-111, 53-6-141, and 53-2-201(a), MCA.

RULE I (46.12.1207) INCLUDABLE COSTS (1) For purposes of reporting includable costs, the department hereby adopts and incorporates herein by reference the health insurance manual HIM-15, which is a manual published by the United States department of health and human services, social security administration, which provides guidelines and policies to implement medicare regulations which set forth principles for determining the reasonable cost of provider services furnished under the Health Insurance for Aged Act of 1965, as amended. A copy of the HIM-15 may be obtained through the Department of Social and Rehabilitation Services, P.O. Box 4210, 111 Sanders, Helena, Montana 59604. For the purpose of reporting costs as required in ARM 46.12.1208(4) includable costs for cost reports with ending dates subsequent to July 1, 1982, will be determined in accordance with HIM 15 subject to the exceptions and clarifications herein provided, including the following:

(a) Return on net invested equity will be an includable cost for providers of intermediate care facility services to the mentally retarded if they provide those services with the intention of earning a profit.

(b) Cost incurred in the provision of long-term care facility services to the extent such costs are reasonable and necessary are includable.

(c) Includable property costs shall be limited in the following manner:

(i) The capitalized cost of a facility including the building, leasehold improvements, and all equipment shall not exceed property costs determined under ARM 46.12.1204(3).

(ii) Lease costs shall not exceed the property costs determined under ARM 46.12.1204(3).

(d) Administrators' compensation:

(i) Administrators' compensation includable is limited to the amounts determined according to HIM-15 which has been incorporated by reference into this rule.

(ii) Administrators' compensation and the reporting of administrators' compensation shall include:

(A) salary amounts paid to the administrator for managerial, administrative, professional and other services;

(B) employee benefits excluding employer contributions required by state or federal law--FICA, WCI, FUI, SUI. For a self-employed administrator, an amount equal to what would have been the employer's contribution for FICA and WCI may be excluded from such employee benefits;

(C) deferred compensation either accrued or paid;

(D) supplies, services, special merchandise, and the cost of assets paid or provided for the personal use or benefit of the administrator;

(E) wages of a domestic or other employee who works in the home of the administrator;

(F) personal use of a car owned by the business;

(G) personal life, health, or disability insurance premiums paid;

(H) a portion of the physical plant occupied as a personal residence;

(I) other types of remuneration, compensation, fringe benefits or other benefits whether paid, accrued, or contingent.

(e) Employee benefits:

(i) Employee benefits are defined as amounts paid to or on behalf of an employee, in addition to direct salary or wages, and from which the employee or his beneficiary derives a personal benefit before or after the employee's retirement or death.

(ii) All employer contributions which are required by state or federal law, including FICA, WCI, FUI, SUI are includable employee benefits. In addition, employee benefits which are uniformly applicable to all employees are includable. A bona fide employee benefit must directly benefit the individual employee, and shall not directly benefit the owner, provider or related parties.

(iii) Costs of activities or facilities which are available to employees as a group, such as condominiums, swimming pools or other recreational activities, are not includable.

(iv) For purposes of this subsection, an employee is one

from whose salary or wages the employer is required to withhold FICA. Stockholders who are related parties to the corporate providers, officers of a corporate provider, and partners owning or operating a facility are not employees even if FICA is withheld for them.

(v) Paid vacation and sick leave shall be considered employee benefits to the extent that the facility has in effect a written policy which is uniformly applicable to all employees within a given class of employees, and paid vacation and sick leave are reasonable in amount.

(f) Bad debts, charity and courtesy allowances are deductions from revenue and shall not be includable as costs.

(g) Revenues received for services or items provided to employees and guests are recoveries of cost and shall be deducted from the related cost.

(h) Dues, membership fees or subscriptions to organizations unrelated to the provider's provision of nursing care services are not includable costs.

(i) Charges for services of a chaplain are not an includable cost.

(j) Fees for management or professional services (e.g., management, legal, accounting or consulting services) are includable to the extent they are identified to specific services, and the hourly rate charged is reasonable in amount. In lieu of compensation on the basis of an hourly rate, the provider may compensate for professional services on the basis of a reasonable retainer agreement which specifies in detail the services to be performed. Documentation that such services were in fact performed shall be provided by the provider. No cost in excess of the agreed upon retainer fee shall be includable for services specified under the fee.

(k) Travel costs related to patient care are includable to the extent that such costs are allowable under Sections 162 and 274 of the internal revenue codes and section 1.162-2 of the income tax regulations, which are federal statutes and regulations dealing with allowable travel expenses and transportation costs. The above-cited sections of the internal revenue code and income tax regulations are hereby adopted and incorporated herein by reference. A copy of the statutes and regulations may be obtained from the Department of Social and Rehabilitation Services, P.O. Box 4210, 111 Sanders, Helena, Montana 59604. Vehicle operating costs will be prorated between business and personal use based on mileage logs or a prior approved percentage derived from a sample mileage log or other approved method acceptable to the department. For vehicles used primarily by the administrator any portion of vehicle costs disallowed on pro-ration shall be included as compensation subject to the limits specified in ARM 46.12.1207. Depreciation shall be included on a straight-line basis (subject to salvage value) with a minimum of 3 years. Depreciation and interest, or comparable lease costs may not

exceed $3200 per year. Other reasonable vehicle operating expenses may be included. Public transportation costs will be allowable at tourist or other available commercial rate (not first class).

(1) Purchases from related parties. Costs applicable to services, facilities and supplies furnished to a provider by parties related to that provider shall not exceed the lower of costs to the related party or the price of comparable services, facilities or supplies purchased elsewhere. Providers shall identify such related parties and costs in the annual cost report.

The authority of the agency to adopt the rule is based on Sections 53-6-113 and 53-2-201(h), MCA; and the rule implements Sections 53-6-111, 53-6-141, and 53-2-201(a), MCA.

RULE II (46.12.1208) COST REPORTING The procedures and forms for maintaining cost information and reporting are as follows:

(1) Accounting Principles. Generally accepted accounting principles shall be used by each provider to record and report costs. As part of the cost report these costs will be adjusted in accordance with these rules to determine includable costs.

(2) Method of Accounting. The accrual method of accounting shall be employed, except that, for governmental institutions that operate on a cash method or a modified accrual method, such methods of accounting will be acceptable.

(3) Cost Finding. Cost finding means the process of allocating and prorating the data derived from the accounts ordinarily kept by a provider to ascertain its costs of the various services provided. In preparing cost reports, all providers shall utilize the methods of cost finding described at 42 CFR 405.453 which the department hereby adopts and incorporates herein by reference. 42 CFR 405.453 is a federal regulation setting forth methods for allocating costs. A copy of the regulation may be obtained from the Department of Social and Rehabilitation Services, P.O. Box 4210, 111 Sanders, Helena, Montana 59604. Notwithstanding the above, distinctions between skilled nursing and intermediate care need not be made in cost finding.

(4) Uniform Financial and Statistical Report. Provider costs are to be reported based upon the provider's fiscal year using the financial and statistical report form provided by the department. The use of the department's financial and statistical report form is mandatory for participating facilities. These reports shall be complete and accurate; incomplete reports or reports containing inconsistent data will be returned to the provider for correction.

(a) Filing period -- Cost reports must be filed within 90 days after the end of the provider's fiscal year.

(b) Late filing -- In the event a provider does not file within 90 days of the closing date of its fiscal year, or files an incomplete cost report, an amount equal to 10 percent of the provider's total reimbursement for the following month shall be withheld by the department. If the report is overdue or incomplete a second month, 20 percent shall be withheld. For each succeeding month the report is overdue or incomplete, the provider's total reimbursement shall be withheld. All amounts so withheld will be payable to the provider upon submission of a complete and accurate cost report. Unavoidable delays may be reported with a full explanation and a request made for an extension of time limits prior to the filing deadline. However, there is a maximum limitation of one 30-day extension.

(c) Cost reports shall be executed by the individual provider, a partner of a partnership provider, the trustee of a trust provider, or an authorized officer of a corporate provider. The person executing the reports shall sign under penalties of false swearing, that he has examined the report including accompanying schedules and statements, and that to the best of his knowledge and belief, the report is true, correct, and complete, and prepared consistent with governing laws and regulations.

(5) Maintenance of Records. Records of financial and statistical information supporting cost reports shall be maintained by the provider and the department for three years after the date a cost report is filed, or the date the cost report is due, whichever is later.

(a) Each provider will maintain, as a minimum, a chart of accounts, a general ledger and the following supporting ledgers and journals: revenue, accounts receivable, cash receipts, accounts payable, cash disbursements, payroll, general journal, patient census records identifying the level of care of all patients individually, all records pertaining to private pay patients and patient trust funds.

(b) To support includable costs, all business records of any related party, including any parent or subsidiary firm, which relate to a provider under audit, shall be available at the facility for audit. To support includable costs, the owner's or related party's personal financial records relating to the facility shall be made available for audit. Any costs not so supported will not be includable.

(c) Cost information as developed by the provider shall be complete, accurate and in sufficient detail to support payments made for services rendered to recipients and recorded in such a manner to provide a record which is auditable through the application of reasonable audit procedure. This includes all ledgers, books, records and original evidence of cost (purchase requisitions, purchase orders, vouchers, checks,

invoices, requisitions for materials, inventories, labor time cards, payrolls, bases for apportioning costs, etc.) which pertain to the determination of reasonable cost.

(d) All of the above records and documents shall be available at the facility at all reasonable times after reasonable notice and subject to inspection, review or audit by the department, the federal department of health and human services, the Montana legislative auditor, and other appropriate governmental agencies. Upon refusal of the provider to make available and allow access to the above records and documents, all payments made by the department during the provider's fiscal year to which those records relate shall be recovered in full by the department. Failure to submit a cost report will result in recovery by the department of all amounts paid by the department for the fiscal period covered by the cost report.

(6) Audits. Department audit staff will perform a desk review of cost statements and may conduct on-site audits of provider records. Such audits shall be conducted in accordance with audit procedures developed by the department.

(a) Desk review of cost reports will determine the adjustments to be applied to reported costs. Incomplete reports, or inconsistency in reported costs will cause the return of the cost report to the facility for correction and may result in withholding payment as set forth in ARM 46.12.1208(4)(b). Department audit staff will conduct a desk review of each cost report within nine months of its receipt to verify, to the extent possible, that the provider has provided a complete and accurate report.

(b) On-site audits of provider detailed records shall be made to assure validity of reports, costs and statistical information. Audits will meet generally accepted auditing standards. Audits of providers' cost reports, financial records and other pertinent data will be adequate to verify that the provider has included only those expense items that are specified as includable costs under ARM 46.12.1207 in compiling the costs of services, and that the provider's includable costs are reasonable.

(c) On conclusion of a review of a cost report and not later than nine months after its receipt, the department shall send the provider the results of the review.

(d) Upon conclusion of each on site audit the department audit staff will submit an audit report to the medicaid financing bureau. The report will meet generally accepted auditing standards and will state the auditor's opinion as to whether, in all material respects, the cost report submitted by the provider has included only those expense items that are specified as includable costs under ARM 46.12.1207 in compiling the costs of services, and that the provider's includable costs are reasonable. The department will keep audit reports on file for at least 3 years after receipt.

(7) A provider may object to audit findings through the administrative review process according to ARM 46.12.1210.

The authority of the agency to adopt the rule is based on Sections 53-6-113 and 53-2-201(h), MCA; and the rule implements Sections 53-6-111, 53-6-141, and 53-2-201(a), MCA.

RULE III (46.12.1209) OVERPAYMENT AND UNDERPAYMENT

(1) Where the department finds that an overpayment has occurred, the department will notify the provider of the overpayment.

(2) In the event of an overpayment the department will, within 30 days after the day the department notifies the provider that an overpayment exists, arrange to recover the overpayment by set-off against amounts paid for long term care facility services or by repayments by the provider.

(3) If an arrangement for repayment cannot be worked out within 30 days after notification to the provider, the department will make deductions from rate payments with full recovery to be completed within 120 days from date of the initial request for payment. Recovery will be undertaken even though the provider disputes in whole or in part the department's determination of the overpayment. In the discretion of the department such recovery may be delayed in whole or in part if a request for fair hearing under ARM 46.12.1210 has been made.

(4) Errors in cost report data identified by the provider may be corrected if submitted within 30 days after receipt of the department's audit or desk review report.

(5) In the event an underpayment has occurred, the department will reimburse the provider promptly following the department's determination of error.

(6) Court or administrative proceeding for collection of overpayment or underpayment shall be commenced within five years following the due date of the original cost report or the date of receipt of a complete cost report whichever is later. In the case of a reimbursement or payment based on fraudulent information, recovery of overpayment may be undertaken at any time. Court costs, including attorneys' fees, in connection with court or administrative proceedings shall be deemed includable only when approved by the court or hearings officer.

(7) The amount of any overpayment constitutes a debt due the department as of the date of initial request for payment and may be recovered from any person, party, transferee, or fiduciary who has benefited from either the payment or from a transfer of assets.

The authority of the agency to adopt the rule is based on Sections 53-6-113 and 53-2-201(h), MCA; and the rule implements Sections 53-6-111, 53-6-141, and 53-2-201(a), MCA.

RULE IV (46.12.1210) ADMINISTRATIVE REVIEW AND FAIR HEARING PROCEDURES (1) Administrative Review. Within 15 days of receipt of the department's written findings, recommendations, or rate, the provider may detail in writing any objections or justifications concerning the findings and may also request an administrative conference. Within the 15 days a provider may request an extension of up to 30 days for submission of objections and justifications. The department may grant further extensions for good cause shown. The conference shall be held no later than 30 days after the department receives the provider's written objections and justifications and the request for a conference. The department's medicaid financing bureau shall conduct the conference based on it's findings and recommendations and the provider's written objections and justifications. No later than 60 days following receipt of the written objections and justifications, or the conference, whichever is later, the department's medicaid financing bureau, after consultation with the office of legal affairs, shall mail a written determination concerning the provider's objections and justifications and the position the department takes concerning the findings.

(2) Fair Hearing. In the event the provider does not agree with the department's determination following administrative review by the department, the following fair hearing procedures will apply.

(a) The written request for a fair hearing shall be mailed or delivered to the Department of Social and Rehabilitation Services, Hearings Officer, P.O. Box 4210, 111 Sanders, Helena, Montana, 59604.

(b) The request shall be signed by the provider or his designee.

(c) The fair hearing request must be received not later than the 30th calendar day following the date of receipt of the department's written administrative review determination.

(d) The fair hearing request shall identify the individual items and amounts in disagreement, give the reasons for the disagreement, and furnish substantiating materials and information.

(e) The hearings officer or board will provide copies of requests, notices and written decisions to the department's director, medicaid financing bureau and office of legal affairs.

(f) The hearing officer will conduct the fair hearing and may hold a pre-hearing conference and grant extensions of time as he deems necessary.

(g) The hearings officer will render a written proposed decision within fifteen calendar days of final submission of the matter to him.

(3) Appeal. In the event the provider or department disagrees with the hearings officer's proposed decision, a notice of appeals may be submitted to the hearings officer for

forwarding to the board of social and rehabilitation appeals within ten days of the hearings officer's decision. The notice of appeals shall set forth the specific grounds for appeal. If no notice of appeals is filed within ten days, the hearing officer's proposed decision shall become the final agency decision.

(a) All evidence in the record and offers of proof shall be transmitted to the board by the hearings officer. The decision of the board shall be based solely on the record transmitted by the hearings officer. A legal brief or a legal argument based on the record may be presented personally or through a representative of the provider or the department to the board.

(b) The board shall reduce its decision to writing and mail copies to the providers within ten days of completion of the hearing. The provider shall be notified of its right to judicial review under the provisions of title 2, chapter 4, part 7, MCA.

The authority of the agency to adopt the rule is based on Sections 53-6-113 and 53-2-201(h), MCA; and the rule implements Sections 53-6-111, 53-6-141, and 53-2-201(a), MCA.

3. The department's present reimbursement methodology indexes each provider's prior costs to produce future prospective rates. As a result, providers with high historic costs are rewarded with high prospective rates, while providers with lower historic costs are forced to remain artificially inexpensive. Although the present methodology allows for rate review adjustments, the reviews are ad hoc and limited in analytical scope, providing no real examination of the causes for the differences among higher and lower costing providers. Indexing has only served to compound the problem because the actual dollar disparity necessarily becomes larger each year.

The proposed reimbursement methodology is still based on providers' prior costs, but is not tied to each facility's own historical cost. Rather, the entire set of fiscal year 1980 cost data from all Montana providers is statistically averaged to determine operating rates for each provider, modified by three relevant factors: (1) size of facility, (2) level of patient care required, and (3) prevalent wage factors by geographic area. Further, indexed Montana nursing home construction costs between 1972 and 1981 for free-standing facilities are used as the basis for including the reasonable cost of property in the rate in the form of an imputed rent concept for each provider, modified by three relevant factors: (1) type of construction, (2) age of the facility, and (3) renovations and additions. The combination of the operating rate and the modified imputed rent is the total rate for a provider which is indexed each

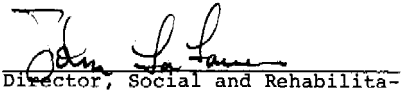
year for three years and adjusted for changes in patient care mix, the wage factor and any renovation or additions. Although few providers will have exactly the same reimbursement rate under the proposed methodology, exact reasons for the differences exist, unlike the present methodology.

The department recognizes that the change from facility-specific, cost-based reimbursement to the proposed basis would result in substantial reimbursement increases and decreases for many providers. Although the proposed methodology takes into account all of the identified relevant factors associated with the cost of operating an efficient and economic facility, it would be unrealistic to expect providers to adjust their operations overnight in response to the proposed rate changes. Therefore, the proposed rules incorporate a phase-in procedure which will allow providers to adjust to the new rates over a three-year period. No provider will receive a rate less than the rate being presently issued. Most providers will experience rate increases during each of the three years; the percentage varies depending upon how closely a provider's current operation matches the assumed efficiencies and economies inherent in the proposed rate methodology.

During the three-year phase-in period, the proposal will eliminate the present subsidy for inefficient operation which is built into the present system. Providers whose operation is necessarily more expensive (due to more difficult patients and/or substantial geographic wage differences and/or size of facility) will have those factors taken into consideration as rates are calculated. Providers whose operation is more expensive due to inefficiencies will have to make adjustments over the three-year period.

4. Interested parties may submit their data, views, or arguments either orally or in writing at the hearing. Written data, views or arguments may also be submitted to the Office of Legal Affairs, Department of Social and Rehabilitation Services, P.O. Box 4210, Helena, Montana 59604, no later than June 11, 1982.

5. The Office of Legal Affairs, Department of Social and Rehabilitation Services has been designated to preside over and conduct the hearing.



Director, Social and Rehabilitation Services

Certified to the Secretary of State May 3, 1982.

BEFORE THE DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES OF THE
STATE OF MONTANA

In the matter of the amendment of Rules 46.12.1201, 46.12.1202, 46.12.1203, 46.12.1204, 46.12.1205, and 46.12.1206 and the adoption of rules pertaining to nursing home reimbursement under the state medicaid program	))))))	NOTICE OF ECONOMIC IMPACT STATEMENT FOR THE AMENDMENT OF RULES 46.12.1201, 46.12.1202, 46.12.1203, 46.12.1204, 46.12.1205, AND 46.12.1206, AND THE ADOPTION OF RULES PERTAINING TO NURSING HOME REIMBURSEMENT RATES

TO: All Interested Persons

1. On June 3, 1982, at 1:00 p.m., a public hearing will be held in the auditorium of the Social and Rehabilitation Services Building, 111 Sanders, Helena, Montana to consider the amendment of Rules 46.12.1201, 46.12.1202, 46.12.1203, 46.12.1204, 46.12.1205 and 46.12.1206 and the adoption of rules pertaining to nursing home reimbursement under the State Medicaid program.

2. The following is an economic impact statement issued pursuant to section 2-4-405, MCA and for the adoption and amendment of rules set forth in MAR Notice No. 46-2-343.

(a) The cost to the state of administering and enforcing the rule: Department administrative costs will be reduced by approximately $110,000 per year from FY 1985 forward. This results from eliminating many cost report audits presently conducted by contract with private firms and conducting those audits through existing department audit staff. This will be possible because the proposed reimbursement rule reduces the volume of required audits and simplifies the range of cost issues that must be managed.

(b) The aggregate cost of compliance to all persons affected: Direct programmatic costs to the Medicaid program will be reduced by an estimated $850,000 for the period July 1, 1982 through June 30, 1985. For FY 1986 and FY 1987, the annual savings is estimated at approximately $2,540,000. Because the proposed rule involves a 3-year phase-in process, the savings to the Medicaid program is less during the phase-in period than it will be for later years. Since cost estimates for both the current and the proposed methodology are based upon the same inflation index projections, changes in the rate of inflation will not have a significant effect on estimated savings.

(c) Any economic benefit of compliance to all persons affected: The proposed rule will shift the reimbursement methodology from a direct "cost-based facility-specific" system to a formula rate based upon the size of each facility, the degree of difficulty of care for the patients in that

facility, and the geographic location of the facility. The basic operating rate formula was derived through the use of regression analysis techniques designed to determine the cost of operation of an "efficient and economically operated" long-term care facility, as modified by the three factors noted above. Although no facility in the State will experience an actual rate decrease as a result of this proposal, about half the facilities will receive smaller future increases than under current rules. The resultant savings to the Medicaid program will equal the larger increases to the other half of the facilities plus the net savings noted in (b) above.

John LaFaver

Director, Social and Rehabilitation Services

Certified to the Secretary of State May 3, 1982.

STATE OF MONTANA
DEPARTMENT OF COMMERCE
BEFORE THE BOARD OF VETERINARIANS

IN THE MATTER of the Amendments of ARM 8.64.402 fee schedule and 8.64.501 concerning application requirements; repeal of ARM 8.64.404 concerning disciplinary action and adoption of a new rule, 8.64.507 concerning immoral, unprofessional or dishonorable conduct	NOTICE OF AMENDMENT OF ARM 8.64.402 FEE SCHEDULE, ARM 8.64.501 APPLICATION REQUIREMENTS; REPEAL OF ARM 8.64.404 DISCIPLINARY ACTION, and ADOPTION OF 8.64.507 IMMORAL, UNPROFESSIONAL OR DISHONORABLE CONDUCT

TO: All Interested Persons:

1. On March 25, 1982, the Board of Veterinarians published a notice of proposed amendment, repeal and adoption of the above entitled rules at pages 525 through 529, 1982 Montana Administrative Register, issue number 6.

2. The board has amended, repealed and adopted the rules exactly as proposed.

3. No comments or testimony were received.

BOARD OF VETERINARIANS
WILLIAM A. ROGERS, D.V.M.
PRESIDENT

BY: _____
GARY BUCHANAN, DIRECTOR
DEPARTMENT OF COMMERCE

Certified to the Secretary of State, May 3, 1982.

BEFORE THE DEPARTMENT OF HEALTH AND ENVIRONMENTAL SCIENCES
OF THE STATE OF MONTANA

In the matter of the repeal of rules 16.10.601, 16.10.602, 16.10.603, 16.10.604, 16.10.605, 16.10.607, 16.10.608, 16.10.609, 16.10.611, 16.10.612, 16.10.614, 16.10.615, 16.10.616, 16.10.617, 16.10.618, 16.10.620, 16.10.622, 16.10.623, 16.10.624 and 16.10.625	NOTICE OF REPEAL OF RULE regulating hotels, motels, tourist homes and roominghouses

TO: All Interested Persons

1. On March 25, 1982, the Department of Health and Environmental Sciences published notice of a proposed repeal of rules 16.10.601, 16.10.602, 16.10.603, 16.10.604, 16.10.605, 16.10.607, 16.10.608, 16.10.609, 16.10.611, 16.10.612, 16.10.614, 16.10.615, 16.10.616, 16.10.617, 16.10.618, 16.10.620, 16.10.622, 16.10.623, 16.10.624 and 16.10.625 concerning the regulation of hotels, motels, tourist homes, and roominghouses at page 533 of the 1982 Montana Administrative Register, issue number 6.

2. The department has repealed the rules as proposed.

3. No comments or testimony were received.

4. The authority of the department to repeal the rules is based on section 50-51-103, MCA.

JOHN J. DRYNAN, M.D., Director

Certified to the Secretary of State May 3, 1982

BEFORE THE DEPARTMENT OF HEALTH AND ENVIRONMENTAL SCIENCES
OF THE STATE OF MONTANA

In the matter of the adoption of Rules I through XII establishing requirements for hotels, motels, tourist homes, roominghouses and retirement homes	)))))	NOTICE OF ADOPTION OF RULES (Hotels, Motels, Tourist Homes, Roominghouses and Retirement Homes)

To: All Interested Persons

1. On March 25, 1982, the Department of Health and Environmental Sciences published notice of proposed adoption of rules which establish requirements for the construction and operation of hotels, motels, tourist homes, roominghouses and retirement homes at pages 534-542 of the 1982 Montana Administrative Register, issue number 6.

2. The department has adopted the rules with the following changes:

RULE I [16.10.630] Same as proposed.

RULE II [16.10.631] (1)(a)-(j) Same as proposed.

(k) any other information requested by the department or the local health authority.

(2) Same as proposed.

(3) Approval will be granted for a period not to exceed 2 3 years, after which, if construction has not ~~commenced~~ been completed, plans must again be submitted to the department or local health authority for re-evaluation.

RULE III [16.10.632] (1)(a)(i) Same as proposed.

(ii) the building and fire authorities approve the building or waive approval.

RULE IV [16.10.633] Same as proposed.

RULE V [16.10.634] Same as proposed.

RULE VI [16.10.635] Same as proposed.

RULE VII [16.10.636] (1) - (4) Same as proposed.

(5) A sewage system design, other than the type described in this rule, may be utilized only if it is designed by an engineer registered in Montana and offers equivalent sanitary protection as determined by the department or local health authority.

(6)(i) - (iv) Same as proposed.

RULE VIII [16.10.637] Same as proposed.

RULE IX [16.10.638] Same as proposed.

RULE X [16.10.639] Same as proposed.

[NOTE: ARM 16.10.626, Food Service Requirements, will be renumbered 16.10.640, and is transferred concurrently with this notice.]

RULE XI [16.10.641] Same as proposed.

RULE XII (16.10.642] Same as proposed.

3. The department held a public hearing April 26, 1982, on these rules in response to a request filed to hold such public hearing from an organization representing more than 25 individuals who were directly affected by the proposed rules. Other than representatives of the department, no one attended the public hearing. The following comments were submitted in writing prior to April 26, 1982.

COMMENT: James Kembel, Administrator, Building Codes Division, Department of Administration, suggested that:

In Rule II(1), insert between "approval," and "Plans" a new sentence reading, "In addition, plans must be submitted to the applicable building and fire authorities for their review and approval." In Rule II(1), add new lettered subsection (1) reading "additional plans information may be needed in order for the applicable building and fire authorities to give their required approval."

RESPONSE: The department did not adopt these suggested changes to Rule II because the requirement for building code and fire code review and approval is clearly provided for in Rule II(1)(i) and (j), and if these authorities need additional plan information, the ability to obtain this information should be provided through their program rules.

COMMENT: Mr. Kembel suggested also that after "authority" in Rule III(1), add "and the applicable building and fire authorities." In Rule III(1)(a), after "local health authority" and before "for review and approval.", insert "applicable building and fire authorities." and after "local health authority" and before "may waive" insert ", applicable building and fire authorities."

RESPONSE: The department did not adopt the first two suggested changes to Rule III made by Mr. Kembel because Rule III already provides for the approval of fire and building authorities which Mr. Kembel is suggesting in his amendments. Rule III(1)(a) clearly indicates the need for fire and building authority approval by referring to Rule II(1). As for his last suggestion recognizing a waiver of approval by the building and fire authorities, the department concurred and so provided.

COMMENT: Mr. Kembel suggested also that Rule IV require notification to fire and building authorities of previously unlicensed establishments.

RESPONSE: The department did not adopt this suggestion because previously unlicensed establishments must undergo the review process in Rule II or Rule III which require prior approval of building and fire authorities.

COMMENT: The Montana Seniors' Advocacy Assistance (MSAA) through its attorney suggested adding "or the local health authority" to Rule II(1)(k).

RESPONSE: The department concurred and so provided.

COMMENT: In Rule II(3), MSAA suggested providing a maximum period of time for completion of construction and adding a definition of "commencement of construction."

RESPONSE: The department provided a maximum period for completion of construction. The department is reviewing the necessity for a definition of commencement of construction.

COMMENT: MSAA questioned what standards would be used to determine whether or not a water supply has an adequate capacity under Rule VI(4)(b).

RESPONSE: The department utilizes the best professional judgment of the design engineer and the technical reviewer employed by the department, considering the proposed use or uses of the system.

COMMENT: MSAA suggested that "as determined by the department or the local health authority" be added to Rule VII(5).

RESPONSE: The department concurred and so provided.

4. The authority for the rules is Section 50-51-103, MCA, and the rules implement Section 50-51-103, MCA.

JOHN J. DRYNAN, M.D., Director

Certified to the Secretary of State May 3, 1982

BEFORE THE DEPARTMENT OF REVENUE

OF THE STATE OF MONTANA

IN THE MATTER OF THE REVISION OF RULES relating to the Assessment of Furniture and Fixtures used in Commercial Establishments as defined in Title 42, Chapter 21, ARM.	)))))	NOTICE OF ADOPTION OF RULES relating to the Assessment of Furniture and Fixtures used in Commercial Establishments as as defined in Title 42, Chapter 21,ARM (42.21.154, 42.21.155, 42.21.156, 42.21.157).

TO: All Interested Persons:

1. On December 7, 1981, the Department of Revenue published notice of a public hearing on proposed revision of rules relating to the valuation of commercial furniture and fixtures, at pages 1724 through 1728, of the 1981 Montana Administrative Register, issue no. 23. On January 6, 1982, the public hearing was held.

2. Existing rule 42.21.134, ARM, is hereby repealed. The Department adopts Rule I (42.21.154), Rule II (42.21.155), Rule III (42.21.156) as originally noticed. Rule IV (42.21.157) is adopted with the following changes (old material interlined, new material underlined):

RULE IV.(42.21.147) PREPARATION OF TREND FACTOR SCHEDULES

(1) On or before January 1 of every year, the Department of Revenue shall prepare schedules of trend factors for each of the groups of equipment specified in subsections (2) through (8) of Rule III.

(2) The data used to compute the trend factors are the monthly values of the "Producer Price Indexes" (PPI) specified in subsections (2) through (8) of Rule III. The values shall be taken from the most recent publications received by the Montana State Library as of November 30.

(3) In order to compute the trend factors to be used in year Y for a given equipment group, it is first necessary to calculate average annual values of the appropriate PPI for as many years as are in the useful life attributed to the group. Average annual values of the PPI for year Y are calculated by adding together the 12 values of the PPI listed for the months ~~July~~ January of year Y-2 through ~~June~~ December of the year ~~Y-1~~ Y-2 and dividing the sum by 12. ~~Note that the most recent average annual PPI is based on a period which ends approximately 6 months before the actual computation is made. For example, in calculating trend factors for 1982, the most recent average annual PPI involved will be based on PPI's for the months of July, 1980 through June, 1981.~~

(4) The trend factors for a specific equipment group are quotients whose numerators are the most recent average annual

PPI for the group and whose denominators are, in succession, the most recent average annual PPI, the average annual PPI for the period immediately preceding the most recent one, and so on, until a number of factors equal to the number of years of useful life have been calculated. In general, the trend factor to be applied to equipment in the group which is X years old (where X is less than or equal to the useful life of the equipment) is the quotient of the most recent average annual PPI and the average annual PPI for the (S-1)st period preceding the most recent one. The trend factor to be applied to equipment in the group which is older than the specified useful life L for the group is the quotient of the most recent average annual PPI for the group and the average annual PPI for the (L-1)st period preceding the most recent one. The following example is presented in order to make the mechanics of the calculation clear.

Suppose that the trend factors to be used in year Y for an equipment group which has a ~~5-year~~ 3-year useful life are to be calculated. The calculation is to be based on the following hypothetical PPI data for the group:

~~MONTH~~

~~Year~~	~~J~~	~~F~~	~~M~~	~~A~~	~~M~~	~~J~~	~~J~~	~~A~~	~~S~~	~~O~~	~~N~~	~~D~~
~~Y-1~~	~~43.8~~	~~44.2~~	~~44.7~~	~~45.3~~	~~45.5~~	~~46.0~~	N/A	N/A	N/A	N/A	N/A	N/A
~~Y-2~~	~~39.6~~	~~39.9~~	~~40.4~~	~~40.7~~	~~41.1~~	~~41.3~~	~~41.6~~	~~41.9~~	~~42.2~~	~~42.5~~	~~43.1~~	~~43.4~~
~~Y-3~~	~~36.1~~	~~36.4~~	~~36.7~~	~~37.1~~	~~37.2~~	~~37.4~~	~~37.8~~	~~38.1~~	~~38.3~~	~~38.6~~	~~38.9~~	~~39.2~~
~~Y-4~~	~~30.9~~	~~31.4~~	~~31.8~~	~~32.7~~	~~33.1~~	~~33.3~~	~~33.8~~	~~34.2~~	~~34.6~~	~~35.0~~	~~35.2~~	~~35.6~~
~~Y-5~~	~~25.3~~	~~26.0~~	~~26.4~~	~~26.9~~	~~27.6~~	~~28.0~~	~~28.5~~	~~28.7~~	~~29.2~~	~~29.5~~	~~30.1~~	~~30.5~~
~~Y-6~~	~~N/A~~	~~N/A~~	~~N/A~~	~~N/A~~	~~N/A~~	~~N/A~~	~~23.6~~	~~24.0~~	~~24.5~~	~~24.7~~	~~24.9~~	~~25.2~~

~~The Average Annual PPI's are:~~

$$\frac{41.6+41.9+42.2+42.5+43.1+43.4+43.8+44.2+44.7+45.3+45.5+46.0}{12} = 43.7$$

$$\frac{37.8+38.1+38.3+38.6+38.9+39.2+39.6+39.9+40.4+40.7+41.1+41.3}{12} = 39.5$$

$$\frac{33.8+34.2+34.6+35.0+35.2+35.6+36.1+36.4+36.7+37.1+37.2+37.4}{12} = 35.8$$

$$\frac{28.5+28.7+29.2+29.5+30.1+30.5+30.9+31.4+31.8+32.7+33.1+33.3}{12} = 30.8$$

$$\frac{23.6+24.0+24.5+24.7+24.9+25.2+25.3+26.0+26.4+26.9+27.6+28.0}{12} = 25.6$$

Year	J	F	M	A	M	J	J	A	S	O	N	D
Y-1	91.1	90.8	91.3	91.2	90.6	90.1	N/A	N/A	N/A	N/A	N/A	N/A
Y-2	86.8	88.5	89.3	90.4	91.2	92.0	92.1	91.8	92.0	91.8	91.2	91.6
Y-3	84.1	84.2	84.4	84.7	84.7	84.7	84.2	84.3	84.7	85.1	85.6	86.4
Y-4	N/A	N/A	N/A	N/A	N/A	N/A	84.3	84.1	83.8	84.1	84.2	84.4

The July-June 12-month average values are:

$$\frac{92.1+91.8+92.0+91.8+91.2+91.6+91.1+90.8+91.3+91.2+90.6+90.1}{12} = 91.3$$

$$\frac{84.2+84.3+84.7+85.1+85.6+86.4+86.8+88.5+89.3+90.4+91.2+92.0}{12} = 87.4$$

$$\frac{84.3+84.1+83.8+84.1+84.2+84.4+84.1+84.2+84.4+84.7+84.7+84.7}{12} = 84.3$$

The trend factors ~~for the equipment group~~ are:

Age of Equip. in Years	Trend Factor
1	~~43.7/43.7 = 1.00~~ 91.3/91.3 = 1.000
2	~~43.7/39.5 = 1.11~~ 91.3/87.4 = 1.045
3 and older	~~43.7/35.8 = 1.22~~ 91.3/84.3 = 1.083
~~4~~	~~43.7/30.8 = 1.42~~
~~5~~	~~43.7/25.6 = 1.71~~

AUTH: 15-1-201(1); IMP: 15-6-139.

3. Four parties appeared at the hearing who testified in opposition to the revision of the rules. Two documents were also submitted by two of the above-referenced parties.

A representative of the Montana Taxpayers Association (MONTAX) explained the basis of the dispute between MONTAX and the Department of Revenue relating to the assessment of furniture and fixtures. The heart of that controversy centered upon the "trending" factors which are to be utilized in the assessment of this property. He mentioned that the MONTAX had instituted an action to compel the Department to commence rule-making pursuant to Senate Joint Resolution 26. Joint Resolution 26 directed the Department of Revenue to promulgate rules pertaining to the assessment of furniture and fixtures without utilizing a "trending" factor. On March 2, 1982, the District Court of the First Judicial District rendered judgment in that case. It found Senate Joint Resolution 26 to be an unconstitutional usurpation of executive authority and by implication, upheld the authority of the Department of Revenue to utilize "trending" during the assessment process.

Mr. George Anderson objected to the revision of the rules on three grounds. First, he contended that the indexes to be uti-

lized for computation of trend factor are not properly related to the category of property to which they will be applied. Second, he argued that certain computer components have exhibited a negative trend, yet the rule will provide for a positive trend. Finally, he asserted that the 20% residual value, as provided in the rule, does not bear any relationship to true market value.

Mr. Dennis Burr objected to the revision of the rule for three reasons: (1) failure of the Department of Revenue to publish valuation schedules; (2) the complexity of trend factor schedules, and (3) the application of data from the Producer Price Index in determining market value.

Mr. Philip Strope objected to the 20% residual value that the rule will provide for hotel and motel property.

4. After carefully reviewing the documents which were submitted by parties at the hearing and the Report of the Hearing Officer dated April 6, 1982, I have concluded that the rules will be revised.

The contention of MONTAX can easily be disposed of. The Judiciary has determined that the Department of Revenue is not bound by legislative rulemaking direction and that it may utilize "trending" as a part of its assessment procedures.

With respect to Mr. Anderson's comments, it is recognized that the Producer Price Index (PPI) is an accurate gauge of price changes for commodities purchased by businessmen. By applying the appropriate index within the PPI to the specific property being assessed, one is able to attain a true reflection of market value. There is, indeed, a logical nexus between the index utilized and the property to which it is applied. Moreover, the use of seven categories insures that property will be assessed through application of an index to which it closely relates. PPI is direct evidence of the trend factors in the market.

Computer components, according to the PPI, have reflected a positive trend. In the interest of promoting uniform assessment, the Department of Revenue must rely upon proven indexes of trend factors, such as the PPI. In the absence of any probative evidence to the contrary, I am convinced that a 20% residual value for this property is correct.

There is no need to publish general valuation schedules. The Department of Revenue will prepare trend factor schedules and make them available to taxpayers. Thus, the possibility that a taxpayer may be confused by the PPI is thereby foreclosed. Every effort has been made to insure that the computation of market value is readily apparent.

The argument that the Consumer Price Index more accurately reflects price changes pertaining to property than does the PPI, is without merit and is rejected. Because the CPI includes consumable items which are never utilized by businessmen and because it does not reflect price changes for most of the equipment and machinery used by businessmen, it is anything but an

accurate reflection of price changes in the business realm.

Finally, no probative evidence has been submitted which convinces me that the hotel and motel property do not have a 20% residual value. In the interest of promoting uniform assessment, that value will be accepted until I am convinced that it no longer reflects market value.

5. Authority to make the revisions is found in 15-1-201.

ELLEN FEAVER, Director
Department of Revenue

Certified to Secretary of State 5-3-82

BEFORE THE SECRETARY OF STATE
OF THE STATE OF MONTANA

In the matter of the amendment of rule 1.2.210, pertaining to format for an adoption by reference	)))	NOTICE OF THE AMENDMENT OF RULE 1.2.210 ADOPTION OF AN AGENCY RULE BY INCORPORATION BY REFERENCE

TO: All Interested Persons:

1. On March 25, 1982, the office of the Secretary of State published notice of an amendment to rule 1.2.210 concerning format for an adoption of a later federal regulation by reference, at page 549, 1982 Montana Administrative Register, issue number 6.

2. The office has amended the rule as proposed.

3. No comments or testimony were received.

JIM WALTERMIRE
Secretary of State

Dated this 3rd day of May, 1982

NOTICE OF FUNCTIONS OF ADMINISTRATIVE CODE COMMITTEE

The Administrative Code Committee reviews all proposals for adoption of new rules or amendment or repeal of existing rules filed with the Secretary of State. Proposals of the Department of Revenue are reviewed only in regard to the procedural requirements of the Montana Administrative Procedure Act. The Committee has the authority to make recommendations to an agency regarding the adoption, amendment, or repeal of a rule or to request that the agency prepare a statement of the estimated economic impact of a proposal. In addition, the Committee may poll the members of the Legislature to determine if a proposed rule is consistent with the intent of the Legislature or, during a legislative session, introduce a Joint Resolution directing an agency to adopt, amend or repeal a rule.

The Committee welcomes comments from the public and invites members of the public to appear before it or to send it written statements in order to bring to the Committee's attention any difficulties with existing or proposed rules. The address is Room 138, Montana State Capitol, Helena, Montana, 59620.

HOW TO USE THE ADMINISTRATIVE RULES OF MONTANA AND THE MONTANA ADMINISTRATIVE REGISTER

Definition: Administrative Rules of Montana (ARM) is a loose-leaf compilation by department of all rules of state departments and attached boards presently in effect, except rules adopted up to three months previously.

Montana Administrative Register (MAR) is a soft back, bound publication, issued twice-monthly, containing notices of rules proposed by agencies, notices of rules adopted by agencies, and interpretations of statute and rules by the attorney general (Attorney General's Opinions) and agencies' (Declaratory Rulings) issued since publication of the preceding register.

Use of the Administrative Rules of Montana (ARM):

Known Subject Matter	1.	Consult General Index, Montana Code Annotated to determine department or board associated with subject matter or statute number.
Department	2.	Refer to Chapter Table of Contents, Title 1 through 46, page i, Volume 1, ARM, to determine title number of department's or board's rules.
	3.	Locate volume and title.
Subject Matter and Title	4.	Refer to topical index, end of title, to locate rule number and catchphrase.
Title Number and Department	5.	Refer to table of contents, page 1 of title. Locate page number of chapter.
Title Number and Chapter	6.	Go to table of contents of Chapter, locate rule number by reading catchphrase (short phrase describing rule.)
Statute Number and Department	7.	Go to cross reference table at end of each title which lists each MCA section number and corresponding rules.
Rule in ARM	8.	Go to rule. Update by checking the accumulative table and the table of contents for the last register issued.

ACCUMULATIVE TABLE

The Administrative Rules of Montana (ARM) is a compilation of existing permanent rules of those executive agencies which have been designated by the Montana Procedure Act for inclusion in the ARM. The ARM is updated through March 31, 1982. This table includes those rules adopted during the period April 1, 1982 through June 30, 1982, and any proposed rule action that is pending during the past 6 month period. (A notice of adoption must be published within 6 months of the published notice of the proposed rule.) This table does not, however, include the contents of this issue of the Montana Administrative Register (MAR).

To be current on proposed and adopted rulemaking, it is necessary to check the ARM updated through March 31, 1982, this table and the table of contents of this issue of the MAR.

This table indicates the department name, title number, rule numbers in ascending order, catchphrase or the subject matter of the rule and the page number at which the action is published in the 1981 and 1982 Montana Administrative Registers.

ADMINISTRATION, Department of, Title 2

I-VI	Adoption of Personnel Policy, p.429, 843
I-VII	Education and Training, p. 435, 843
I-VII	Alternate Work Schedules, p.56, 681
2.11.103	Capitol Building Tour Guide Service, p. 623
2.21.4701	and other rules - New Employee Orientation, p. 439, 844
2.21.5101	and other rules - Exit Interviews, p. 433, 844
2.21.6501	and other rules - Discipline Handling, p. 60
2.21.6704	Creation of the State Incentive Awards Advisory Council, p. 624

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