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MONTANA ADMINISTRATIVE REGISTER

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MONTANA ADMINISTRATIVE REGISTER

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 The notice section contains state agencies' proposed new, amended or repealed rules, the rationale for the change, date and address of public hearing, and where written comments may be submitted.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. Special notices and tables are inserted at the back of each register.

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BEFORE THE DEPARTMENT OF ADMINISTRATION
OF THE STATE OF MONTANA

In the matter of the amendments of ARM 2.21.6706, 2.21.6707, 2.21.6713, and 2.21.6718 relating to the employee incentive award program	))))	NOTICE OF PUBLIC HEARING ON PROPOSED AMENDMENT OF ARM 2.21.6706, 2.21.6707, 2.21.6713, and 2.21.6718 RELATING TO THE EMPLOYEE INCENTIVE AWARD PROGRAM.

TO: All Interested Persons.

1. On June 4, 1987, at 12:15 p.m. in Room 136, Mitchell Building, Helena, Montana, a public hearing will be held to consider the amendment of ARM 2.21.6706, 2.21.6707, 2.21.6713, and 2.21.6718 relating to the employee incentive award program.

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

2.21.6706 COOPERATION REQUESTED OF AGENCIES (1) It is suggested that each agency head assume personal responsibility for the incentive awards program or assign such responsibility to a committee of agency employees or to an individual agency employee. The name, business address, and telephone number of the individual or committee chairman responsible for the incentive awards program in the agency shall be furnished to the incentive awards program administrator in the department of administration.

(2) It is suggested that the agency head through relevant employees or through an incentive awards committee shall:

(a) investigate and evaluate suggestions;

(b) recommend approval/disapproval of a suggestion being adopted or whether the decision to adopt should be delayed;

(c) send such recommendations to the program administrator in the department of administration within ~~30~~ 45 days after being assigned to evaluate a suggestion, or notify the program administrator that the evaluation will be delayed;

(d) include with such recommendations documentation of the expected cost savings or improved services and any arguments for and/or against adopting the suggestion;

(e) specify in a recommendation to delay the adoption decision, an estimate of the length of the delay and a list of the barriers to be overcome;

(f) encourage agency employees to participate in the state incentive awards program.

(3) A recommendation from an agency head for an award approval shall indicate to the program administrator that the agency has implemented or intends to implement the suggestion and to pay an award based on the agency's

anticipated cost savings or value of improved services. Awards ~~are~~ shall be set at 10% of the suggestion's first-year savings or value of improved services up to ~~$17,500~~ $3,000 for each suggestion.

(4) The agency head or his designee shall formally present relevant incentive awards or be present during such presentations made by the governor. A recognition certificate shall accompany the awarded compensation.

(Auth. 2-18-1103, MCA; Imp. 2-18-1103 and 2-18-1106, MCA)

2.21.6707 ELIGIBILITY OF SUGGESTIONS (1) Each suggestion initially shall be submitted to the program administrator in the department of administration who shall review the suggestion to determine if it is a duplicate, or similar to, a suggestion which has previously been submitted or adopted. If duplicate suggestions are received by the program administrator, the one bearing the earliest date of receipt shall be eligible for consideration and all others shall be ineligible. Similar suggestions may be eligible for consideration to the extent the second suggestion adds to the cost savings or value of improved services realized by the first suggestion.

(2) Formal suggestions shall be submitted on official forms prescribed by the department of administration specifically for the incentive awards program. Such forms shall be made available to employees through their agencies.

(3) Failure to complete the required form shall result in its return to the employee submitting the suggestion. No action shall be taken on a suggestion until a completed form is received by the program administrator, in addition to any other materials submitted with the suggestion.

(4) The program administrator shall review suggestions for compliance with the criteria listed in (5). Following this review, the program administrator shall assign the suggestions to be evaluated by potentially affected agencies.

(5) As provided in 2-18-1105 (2a), MCA, "an employee may not be eligible for an incentive award if his suggestion or invention directly relates to his assigned duties and responsibilities unless the proposal is so superior or meritorious as to warrant special recognition as determined by the department.

(b) Suggestions or inventions relating to the following matters may not be considered for awards:

(i) personnel grievances;

(ii) classification and pay of positions;

(iii) matters recommended for study or review; and

(iv) proposals resulting from assigned or contracted audits, studies, surveys, reviews, or research." Consideration will not be given to suggestions relating to a specific grievance as that term is defined in ARM 2.21.8002, or to the classification and pay of a specific position.

However, suggestions regarding such areas as the procedure used to hear grievances or systems used to manage classification and pay could be considered.

(6) If an agency modifies a suggestion that is subsequently approved by the program administrator, the employee is eligible for an award based only on the savings or value of improved services that directly result from the suggestion. Parts of a suggestion not used or modifications made by management shall not be used as a basis for calculating the amount of an employee's award. Parts of a suggestion may be considered ineligible. The remaining parts shall be sent to the relevant agencies for investigation and evaluation.

(7) Each suggestion shall be reviewed by the program administrator to determine if it has application to agencies other than the one for which it was proposed. If it is determined that a suggestion has interagency application, it shall be referred to each agency to which it applies.

(8) The amount of an award for a suggestion made by a group of employees shall be determined on the same basis as if the suggestion had been submitted by one employee. The amount awarded shall not exceed a total of ~~$17,500~~ $3,000 and shall be equally divided among the employees making the suggestion.

(9) Suggestions which involve patentable or nonpatentable inventions are eligible for awards. Awards for inventions shall be determined on the same basis as awards for other types of suggestions.

(10) If an employee's suggestion is not adopted, the employee may resubmit the suggestion to the program administrator in the department of administration. Resubmitted suggestions shall not be considered by the program administrator or the incentive awards advisory council unless the resubmittal includes specific and new evidence or documentation that sufficiently warrants reconsideration to adopt the suggestion.

(11) Employees are responsible for researching the cost savings of their suggestions and for providing data supporting their estimated savings.

(Auth. 2-18-1103, MCA; Imp. 2-18-1103, 2-18-1105, and 2-18-1106, MCA)

2.21.6713 TIME LIMITS ON IMPLEMENTED SUGGESTIONS (1) An employee who has made an oral or other informal suggestion that has already been implemented shall be eligible for an award only if the suggestion is formally submitted to the program administrator in the department of administration within ~~30~~ 90 days from the date the suggestion was implemented by an agency. Suggestions implemented before April 1, 1982, are not eligible for an award.

(2) A current or former employee shall be entitled to an award if his previously unadopted suggestion or

previously delayed suggestion, as defined by ARM 2.21.6702 (12) and (14), is adopted and implemented within three years of the suggestion being formally submitted under this program. If extenuating circumstances exist, a current employee may still receive an award for a suggestion submitted more than three years before being implemented. Employees shall be responsible for notifying the program administrator if their previously unadopted suggestion is adopted.
(Auth. 2-18-1103, MCA; Imp. 2-18-1103 and 2-18-1106, MCA)

2.21.6718 SUGGESTIONS REQUIRING LEGISLATIVE ACTION (1) Suggestions requiring legislative action shall be considered ineligible until the appropriate law is passed to enable feasible implementation of the suggestion. In these cases, the department may assist agencies in drafting the necessary legislation.

(2) Awards in excess of ~~$1,500~~ $3,000 may be proposed by the incentive awards advisory council to the legislature for possible action. If barriers to implementation such as legislative action are not present, the initial ~~$1,500~~ $3,000 may be awarded immediately by the program administrator, while the excess shall be awarded when authorized by the legislature.
(Auth. 2-18-1103, MCA; Imp. 2-18-1103 and 2-18-1106, MCA)

3. The amendments to the rules are proposed:

(a) to reflect statute changes made by the 1987 legislature raising the award amount from $1,500 to $3,000;

(b) to provide for an increased response time for agencies and employees; and to clarify employee's responsibilities.

The changes are requested by the Program Administrator and have been reviewed by the Incentive Awards Advisory Council who concurs with the changes.

4. Interested parties may submit their data, views or arguments concerning the proposed amendment in writing to:

Laurie Ekanger, Administrator
State Personnel Division
Department of Administration
Room 130, Mitchell Building
Helena, Montana 59620

no later than June 11, 1987.

5. Debra S. Flentie, Administrative Officer, Labor Relations and Employee Benefits Bureau, State Personnel Division, Department of Administration, Helena, Montana 59620, has been designated to preside over and conduct the hearing.

6. The authority of the agency to make the proposed amendments is based on 2-18-1103, MCA, and the rules implement 2-18-1101 through 1-18-1106, MCA.

Ellen Feaver

Ellen Feaver, Director
Department of Administration

Certified to the Secretary of State May 4, 1987.

BEFORE THE DEPARTMENT OF AGRICULTURE
OF THE STATE OF MONTANA

In the matter of the adoption of rules for implementation of a rodenticide grants program.	)))))	NOTICE OF PROPOSED ADOPTION OF RULES PROVIDING FOR THE IMPLEMENTATION OF A RODENTICIDE GRANTS PROGRAM AND THE COLLECTION FEES NO PUBLIC HEARING CONTEMPLATED

TO: All Interested Persons.

1. On June 15, 1987 the Montana Department of Agriculture proposes to adopt new rules implementing the Rodenticide Surcharge and Grant Program.

2. The proposed new rules read as follows:

RULE I DEFINITIONS When used in these rules, unless a different meaning clearly appears from the context:

(1) "Department" means the department of agriculture provided for in 2-15-3001, MCA.

(2) "Advisory council" or "council" means the advisory council provided for in Section 2 of SB 238.

(3) "Field Rodent" means Columbian ground squirrel (Spermophilus columbianus), Richardson ground squirrel (Spermophilus richardsonii), Armatus ground squirrel (Spermophilus armatus), thirteen-lined ground squirrel (Spermophilus tridecemlineatus), pocket gopher (Thomomys, various species), field mice (Microtus, various species), and black-tailed prairie dog (Cynomys ludovicianus).

(4) "Rodenticides" means pesticides registered for field rodent control.

AUTH: Section 6 SB 238 of the 1987 Session
IMP: Section 6 SB 238 of the 1987 Session

RULE II DEALER RECORDS (1) Dealers shall submit to the department records of the annual sale of all rodenticides registered for field rodent control. Products solely registered for home, yard, lawn and garden use or other domestic uses are exempted. The record shall include the total volume sold, the trade name, the company name, the EPA registration number and the total dollar sales of each individual product. The rodenticide record shall be submitted to the department by January 30 of the following year. The records shall be made on the standard forms provided by the department or on forms approved by the department.

AUTH: Section 6 SB 238 of the 1987 Session
IMP: Section 4 SB 238 of the 1987 Session

RULE III GRANT APPLICATION PROCEDURE (1) The department will specify funding cycles and application deadlines as necessary.

(2) Any person may submit to the department an application to accomplish the program objectives set forth in 80-7-1102, MCA. The department may, from time to time, establish the priorities for accomplishing these objectives, which will assist applicants in developing their application for a grant. The application shall be completed in compliance with Rules IV and V.

(3) The department may return an insufficient or incomplete proposal for correction or completion. The department may provide the applicant with reasons for the proposal's return and a brief description of the information required in order to make the proposal correct or complete, or both. If these corrections or completions, or both, are not made, the proposal will not be evaluated.

(4) The applicant may request assistance from the department in completing the application. The department will provide such assistance, the level of which will be determined by availability of staff and funds.

AUTH: Section 6 SB 238 of the 1987 Session
IMP: Section 1 SB 238 of the 1987 Session

RULE IV GRANT APPLICATION CONTENT AND FEASIBILITY (1) All applications for grants shall contain:

(a) Name, address, and telephone number of the project sponsor, project manager and liaison (if different than manager).

(b) Title or name of the proposed project.

(c) Location of proposed project.

(d) A brief description of the history and background of the project.

(e) Objectives of the project and projected accomplishments.

(f) A thorough discussion of the project including the purpose, location and schedule of major project phases.

(g) A description, if appropriate, of how the project will satisfy EPA registration standards, EPA laboratory or field protocols and related information.

(h) Amount of funding requested for a grant. A statement indicating the amount of funding available from other sources such as cost share monies. If no other funding is available, the applicant must give the reasons.

(i) Proof, where appropriate, the applicant has the cooperation of all landholders within the project area including federal, state, and private entities.

(2) Where appropriate, the applicant may include the following information:

(a) A listing of rodenticides, biological control agents, or cultural methods used for rodent control within the project area. This description may include prior field

investigations and research information to support the proposal.

(b) Educational programs that will be conducted in conjunction with the project to increase vertebrate pest awareness and control techniques.

(c) Maps, drawings, charts, tables, etc., used as a basis for project planning and implementation.

(d) Description of other management alternatives and applicant's consideration of those alternatives.

(3) An evaluation of the project as required in Rule VI.

AUTH: Section 6 SB 238 of the 1987 Session
IMP: Section 1 SB 238 of the 1987 Session

RULE V LEGAL REQUIREMENTS The applicant is required to follow all federal and state statutory and regulatory standards.

AUTH: Section 6 SB 238 of the 1987 Session
IMP: Section 1 SB 238 of the 1987 Session

RULE VI PROJECT EVALUATION (1) The department and council will evaluate the applications for a grant based upon the department's current vertebrate pest and rodenticide priorities and their relationship to the objective set forth in 80-7-1102 (2) through (11).

AUTH: Section 6 SB 238 of the 1987 Session
IMP: Section 1 SB 238 of the 1987 Session

RULE VII REPORTING AND MONITORING PROCEDURES (1) The project sponsor or project manager shall monitor the progress and results of the project and evaluate its overall effectiveness. The project sponsor shall submit to the department such program and fiscal reports as agreed to in the grant contract. The department may conduct fiscal and performance audits. If the department determines that unsatisfactory fiscal reports have been filed, the project sponsor shall initiate necessary corrective action. The department may terminate modified grants as agreed to in the grant contract.

AUTH: Section 6 SB 238 of the 1987 Session
IMP: Section 1 SB 238 of the 1987 Session

RULE VIII APPLICABILITY DATE (1) Rule II shall be applicable to sales of rodenticides registered for field rodent control sold on or after May 1, 1987.

AUTH: Section 6 SB 238 of the 1987 Session
IMP: Section 6 SB 238 of the 1987 Session

3. On March 22, 1987 the Rodenticide Grant Program became effective upon the passage of Senate Bill 238. The act

established a program designed to provide funds for projects that involve the control of vertebrate pests. It is therefore necessary to establish rules to properly implement the method of collection of the surcharge assessed against rodenticides. These rules are also necessary to establish the procedures for the orderly administration of grants given to persons conducting projects that control rodents. The department also found it necessary to establish an effective date of May 1, 1987 for the commencement of the collection of the surcharge funds. This date permits the department to provide the necessary notice to the interested persons and still begin the period of collection at the earliest date to insure sufficient funds for a viable grant program. Without a May 1 effective date there would be a noticeable loss of revenue for the program.

4. Interested persons may submit their data, views, or comments concerning the proposed rules to Gary Gingery, Montana Department of Agriculture, Agriculture/Livestock Building, Capitol Station, Helena, Montana, 59620, no later than June 12, 1987.

5. If a person who is directly affected by the proposed adoption wishes to express his data, views and arguments orally or in writing at a public hearing, he must make written request for a hearing and submit this request along with any written comments he has to Gary Gingery, Montana Department of Agriculture, Agriculture/Livestock Building, Capitol Station, Helena, Montana, 59620, no later June 12, 1987.

6. If the agency receives requests for a public hearing on the proposed adoption from either 10% or 25, whichever is less, of the persons who are directly affected by the proposed adoption, from the Administrative Code Committee of the legislature, from a governmental sub-division or agency, or from an association having not less than 25 members who will be directly affected, a hearing will be held at a later date. Notice of the hearing will be published in the Montana Administrative Register. Ten percent of those persons directly affected has been determined to be 50 persons based on 500 licensed pesticide dealers in Montana.

7. The authority of the department to make the proposed rule is based on section 6 SB 238 of the 1987 Legislature, and the rule implements sections 1, 4, 6 SB 238 of the 1987 Legislature.

Ralph Peck, Deputy Director
Department of Agriculture
for Keith Kelly, Director

Certified to the Secretary of State April 30, 1987

STATE OF MONTANA
DEPARTMENT OF COMMERCE
BEFORE THE BOARD OF HEARING AID DISPENSERS

In the matter of the proposed amendment of 8.20.401 concerning traineeship requirements and standards	))))	NOTICE OF PUBLIC HEARING ON PROPOSED AMENDMENT OF 8.20.401 TRAINEESHIP REQUIREMENTS AND STANDARDS

1. On Thursday, June 18, 1987, at 1:00 p.m., a public hearing will be held in the downstairs conference room at the Department of Commerce building, 1424 9th Avenue, Helena, Montana, to consider the amendment of the above-stated rule.

2. The proposed amendment of 8.20.401 will read as follows: (new matter underlined, deleted matter interlined) (full text of the rule is located at page 8-583, Administrative Rules of Montana)

"8.20.401 TRAINEESHIP REQUIREMENTS AND STANDARDS (1) through (6) will remain the same.

~~(7) Trainees shall affix the designation "trainee" after his or her name on all business cards, correspondence, advertising or any written material concerning the hearing aid field.~~"

Auth: 37-16-202, MCA Imp: 37-12-202, 301, 405, MCA

3. The board proposes to hold a hearing on this rule at the request of William Fowler, who contended in petition that this rule provision is an unlawful extension of legislative authority.

4. Interested persons may submit their data, views, or arguments, either orally or in writing, at the hearing. Written data, views and arguments may also be submitted to the Board of Hearing Aid Dispensers, 1424 9th Avenue, Helena, Montana, no later than June 18, 1987.

5. Geoffrey L. Brazier of Helena, Montana, will preside over and conduct the hearing.

BOARD OF HEARING AID DISPENSERS
DUDLEY ANDERSON, CHAIRMAN

BY: Geoffrey L. Brazier
GEOFFREY L. BRAZIER, ATTORNEY
DEPARTMENT OF COMMERCE

Certified to the Secretary of State, May 4, 1987.

BEFORE THE BOARD OF PUBLIC EDUCATION
OF THE STATE OF MONTANA

In the matter of the amendment of Request To Suspend Or Revoke A Teacher Or Specialist Certificate: Preliminary Action, Notice And Opportunity For Hearing Upon Determination That Substantial Reason Exists To Suspend Or Revoke Teacher Or Specialist Certificate, Hearing In Contested Cases, After Hearing By Member Of Board/Hearing Examiner/Board Of Public Education, Appeal From Denial Of A Teacher Or Specialist Certificate, Considerations Governing Acceptance of Appeal In Cases Arising Under 20-4-104(1)(c), MCA, Hearing On Appeal	NOTICE OF PUBLIC HEARING ON PROPOSED AMENDMENT OF ARM 10.57.601, REQUEST TO SUSPEND OR REVOKE A TEACHER OR SPECIALIST CERTIFICATE: PRELIMINARY ACTION, ARM 10.57.602, NOTICE AND OPPORTUNITY FOR HEARING UPON DETERMINATION THAT SUBSTANTIAL REASON EXISTS TO SUSPEND OR REVOKE TEACHER OR SPECIALIST CERTIFICATE, ARM 10.57.603, HEARING IN CONTESTED CASES, ARM 10.57.604, AFTER HEARING BY MEMBER OF BOARD/HEARING EXAMINER/BOARD OF PUBLIC EDUCATION; AND PROPOSED ADOPTION OF RULE I, APPEAL FROM DENIAL OF A TEACHER OR SPECIALIST CERTIFICATE, RULE II, CONSIDERATIONS GOVERNING ACCEPTANCE OF APPEAL IN CASES ARISING UNDER 20-4-104 (1)(c), MCA, RULE III, HEARING ON APPEAL

TO: All Interested Persons

1. On June 11, 1987, at 1:30 p.m., or as soon thereafter as it may be heard, a public hearing will be held in the Board of Regents' Conference Room, 33 South Last Chance Gulch, Helena, Montana, in the matter of the amendment of ARM 10.57.601, Request To Suspend Or Revoke A Teacher Or Specialist Certificate: Preliminary Action, ARM 10.57.602, Notice and Opportunity For Hearing Upon Determination That Substantial Reason Exists To Suspend Or Revoke Teacher Or Specialist Certificate, ARM 10.57.603, Hearing In Contested Cases, ARM 10.57.604, After Hearing By Member Of Board/Hearing Examiner/ Board of Public Education, and RULE I, Appeal From Denial Of A Teacher Or Specialist Certificate, RULE II, Considerations Governing Acceptance Of Appeal In Cases Arising Under 20-4-104(1)(c), MCA, and RULE III, Hearing On Appeal.

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

10.57.601 REQUEST TO SUSPEND OR REVOKE A TEACHER OR SPECIALIST CERTIFICATE: PRELIMINARY ACTION (1) through (1) (a) Remains the same.

(b) The superintendent of public instruction, ~~for any other teacher or specialist,~~

(2) Requests shall specify whether revocation or suspension is sought and shall include:

(a) The specific charge(s), against the teacher or specialist,

(b) The subsection of 20-4-110 MCA under which the charge(s) are brought,

(c) An outline of the facts and evidence related to the

charge(s), and

(d) A copy of the minutes documenting the trustees' decision to request revocation or suspension.

~~(2)~~ (3) Upon receipt of such request, the board of public education shall implement an investigation to determine whether or not a substantial reason for suspension or revocation of the teacher or specialist certificate exists. This investigation shall include notifying the affected teacher or specialist of the charges against him by certified mail and allowing him ten days to respond to those charges. After receiving response, the board may request further information from either party to ensure the preliminary investigation properly reflects the facts and position of each party.

(4) Immoral conduct related to the teaching profession, under section 20-4-110(1)(f), MCA, means:

(a) Sexual contact, as defined in section 45-2-101(6), MCA, or sexual intercourse as defined in section 45-2-101(61), MCA, between a teacher or specialist and a person the teacher or specialist knows or reasonably should know is a student at a public or private elementary or secondary school;

(b) Conduct, whether resulting in the filing of criminal charges or not, which would constitute an offense under any of the following statutes of this state:

(i) Section 45-5-502, MCA, (sexual assault);

(ii) Section 45-5-503, MCA, (sexual intercourse without consent);

(iii) Section 45-5-504, MCA, (indecent exposure);

(iv) Section 45-5-505, MCA, (deviate sexual conduct), if the conduct either was non-consensual or involved a person the teacher or specialist knew or reasonably should know is a student at a public or private elementary or secondary school;

(v) Section 45-5-507, MCA, (incest);

(vi) Sections 45-5-601, 45-5-602, or 45-5-603, MCA, (offenses involving prostitution);

(vii) Section 45-5-622(2), MCA, (endangering the welfare of children);

(viii) Section 45-5-623, MCA, (unlawful transactions with children);

(ix) Section 45-5-625, MCA, (sexual abuse of children);

(x) Section 45-8-201, MCA, (obscenity);

(xi) Section 45-8-202, MCA, (public display of offensive material);

(xii) Any statute in Title 45, Chapter 9, Part 1, MCA, (Dangerous Drugs), provided that a first offense under section 45-9-102(2), MCA, shall not fall within this definition;

(c) Repeated convictions for violations of any one or more of the criminal laws of this state, which violations are not otherwise grounds for suspension or revocation, if the repeated convictions, taken together, demonstrate that the teacher or specialist is unwilling to conform his conduct to the requirements of law.

AUTH: Sec. 20-4-102 MCA
IMP: Sec. 20-4-110 MCA

10.57.602 NOTICE AND OPPORTUNITY FOR HEARING UPON DETERMINATION THAT SUBSTANTIAL REASON EXISTS TO SUSPEND OR REVOKE TEACHER OR SPECIALIST CERTIFICATE (1) through (1) (a) Remains the same.

(b) If the board determines that there is substantial reason to suspend or revoke the teacher or specialist certificate, the board shall provide notice by certified mail of the pending action to the teacher or specialist, ~~and of the opportunity for the teacher or specialist to contest the pending action.~~ Such notice shall include:

(b)(i) through (b) (vi) Remains the same.

(c) The notice shall advise the teacher or specialist that he has the right to contest the proposed action of the board, and that he may do so by appearing at the hearing either personally or through counsel, or by requesting the board to consider the matter on the basis of the available evidence without an appearance by the teacher or specialist.

(d) The board shall enclose with the notice an election form on which the teacher or specialist shall be asked to indicate whether he intends to appear at the hearing and contest the board's proposed action, contest the board's proposed action without appearing at the hearing, or accept the proposed suspension or revocation without contesting it. The notice shall require the teacher or specialist to return the election form within twenty (20) days of the date on which the notice was mailed, and shall inform the teacher or specialist that failure to return the form in a timely manner will result in the suspension or revocation of the certificate by default.

(e) If the teacher or specialist does not return the completed election form within twenty (20) days or elects to accept the proposed suspension or revocation without contesting it, the board shall suspend or revoke the teacher or specialist certificate at its next meeting.

(f) If the teacher or specialist elects to contest the proposed suspension or revocation and complies with subsection (1)(d) of this rule, the board shall conduct a hearing.

~~(2) If the teacher does not notify the board of the teacher's or specialist's intention to contest pending action within 20 days of the service of notice, the board will suspend or revoke the teacher or specialist certificate at its next meeting.~~

~~(3) If the teacher or specialist does notify the board within 20 days of service of notice of the teacher's or specialist's intention to contest pending action, the matter will proceed to hearing.~~

AUTH: Sec. 20-4-102 MCA
IMP: Sec. 20-4-110 MCA

10.57.603 HEARING ~~IF TEACHER OR SPECIALIST INTENDS TO CONTEST PENDING ACTION~~ IN CONTESTED CASES (1) through (2) Remains the same.

10.57.604 AFTER HEARING BY MEMBER OF BOARD/HEARING EXAMINER/BOARD OF PUBLIC EDUCATION (1) After hearing by the

board of public education, the board adopts findings of fact, conclusion of law and an order either suspending or revoking the teacher or specialist certificate or not suspending or revoking the teacher or specialist certificate. ~~These are entered on the minutes of the board of public education and sent to the party adversely affected.~~ The board shall enter its decision on its minutes and shall serve a copy by certified mail on the party adversely affected and on any other involved party. When a certificate is suspended or revoked, the superintendent of public instruction shall notify certifying agencies in each of the other states.

AUTH: Sec. 20-4-102 MCA
IMP: Sec. 20-4-110 MCA

3. The rules as proposed to be adopted are as follows:

Procedures For Hearing Appeals
From Decisions Denying Issuance
Or Renewal Of Teacher Certificates

RULE I APPEAL FROM DENIAL OF A TEACHER OR SPECIALIST CERTIFICATE (1) Appeal from the decision of the superintendent of public instruction to deny issuance or renewal of a teacher or specialist certificate shall be brought before the board of public education by written request which:

(a) summarizes the appellant's response to the superintendent's denial of a certificate;

(b) states that the appellant meets the minimum qualifications for issuance of a license established by law; and

(c) if applicable, shows that the appeal satisfies the requirements of RULE II.

AUTH: Sec. 20-4-102 MCA
IMP: Sec. 20-4-110 MCA

RULE II CONSIDERATIONS GOVERNING ACCEPTANCE OF APPEAL IN CASES ARISING UNDER 20-4-104(1)(c), MCA (1) The board of public education will not consider an appeal from a denial by the superintendent of public instruction based on section 20-4-104(1)(c), MCA, if the appellant has made an appeal to the board from the denial of a teacher or specialist certificate within three (3) years prior to the application which is at issue, which appeal was denied by the board following a hearing, unless the appellant can show substantial changes in circumstances relating to his eligibility for a certificate.

AUTH: Sec. 20-4-102 MCA
IMP: Sec. 20-4-110 MCA

RULE III HEARING ON APPEAL (1) The board of public education shall conduct the hearing as provided in ARM 10.57.603 and in compliance with Title 2, chapter 4, part 6, MCA.

(2) On appeal the burden is on the appellant to establish by preponderance of the evidence that he satisfies the statutory criteria for issuance of a teacher or specialist

certificate.

(3) In cases in which the superintendent of public instruction has denied issuance or renewal of a teacher or specialist certificate under section 20-4-104(1)(c), MCA, the board of public education may require the appellant to undergo at his expense a mental or physical examination by a physician or health professional designated by the board. The report of examination shall be admissible evidence in the appeal proceedings before the board, subject to the appellant's right to cross-examine the maker of the report.

AUTH: Sec. 20-4-102 MCA
IMP: Sec. 20-4-110 MCA

4. The board is proposing these amendments to ensure that all teachers are of good moral and professional character, to provide rules which conform with the amendments to 20-4-110 MCA passed by the 50th Legislature and to clarify all procedures dealing with suspension, revocation or denial of a teacher certificate.

5. Interested persons may present their data, views or arguments either orally or in writing at the hearing. Written data, views or argument may also be submitted to Alan Nicholson, Chairman, Board of Public Education, 33 South Last Chance Gulch, Helena, Montana, 59620, no later than June 1, 1987.

6. Alan Nicholson, Chairman, and Claudette Morton, Executive Secretary to the Board of Public Education, 33 South Last Chance Gulch, Helena, Montana, have been designated to preside over and conduct the hearing.

Alan Nicholson
ALAN NICHOLSON, CHAIRMAN
BOARD OF PUBLIC EDUCATION

BY: Claudette Morton

Certified to the Secretary of State May 4, 1987.

BEFORE THE BOARD OF OIL
AND GAS CONSERVATION
OF THE STATE OF MONTANA

In the matter of the amendment of Rules 36.22.501 and 36.22.502 pertaining to location limitations and plugging and abandonment procedures for seismic shot holes.	NOTICE OF PROPOSED AMENDMENT OF RULES 36.22.501 SHOT LOCATION LIMITATIONS AND 36.22.502 PLUGGING AND ABANDONMENT. NO PUBLIC HEARING CONTEMPLATED

TO: All Interested Persons

1. On June 25, 1987, the Board of Oil and Gas Conservation (board) proposes to amend rules 36.22.501 and 36.22.502 pertaining to location limitations and proper plugging and abandonment procedures for seismic shot holes.

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

36.22.501 SHOT LOCATION LIMITATIONS No vibroseis shall be done closer than 330 feet, or seismic shot hole ~~shall be~~ drilled or surface charge set closer than 1320 feet (1/4 mile) to any building, structure, water well, or spring; nor closer than 660 feet (1/8 mile) to any reservoir dam without written permission of the surface owner.

AUTH: 82-1-101, MCA IMP: 82-1-101, MCA

36.22.502 PLUGGING AND ABANDONMENT Unless otherwise agreed to between the surface owner and, the company, firm, corporation, or individual responsible for the drilling of seismic shot holes, and the board's designated inspector, all such holes shall be plugged and abandoned as set forth below; provided, however, that before the surface owner agrees to a plugging method which deviates from this rule, he must be given a copy of this rule:

(1) The seismic company responsible for the plugging and abandonment of seismic shot holes shall notify the board in writing at its Billings office of its intent to plug and abandon, including the date and time such activities are expected to commence, the location by Section, Township and Range of the holes to be plugged, and the name and telephone number of the person in charge of the plugging operations. A copy of this notice shall be sent to the surface owner at the same time.

(2) All seismic shot holes shall be plugged before shooting. Exceptions may be granted after approval by the board's designated inspector. In the event the original plug does not hold, the hole shall be properly plugged as soon ~~after being utilized~~ as reasonably practicable; however, in no

event shall ~~they~~ any hole remain unplugged for a period of more than 30 days unless, upon application, the board or its staff grants an extension which may not exceed 90 days. All holes shall be temporarily capped during the period between drilling and final plugging.

(3) When drilling seismic shot holes, and non-artesian ~~flow~~ water is ~~not~~ encountered ~~at the surface,~~ or when water is used in conjunction with the drilling, plugging shall be accomplished by filling the hole with coarse ground bentonite from the bottom up to 5 feet above the static water level with a minimum of 100 pounds of bentonite. The hole shall be further filled and tamped with cuttings to a depth of three feet below ground level. All shot holes drilled in the glacial till area of Montana as shown on USGS Miscellaneous Geologic Investigations Map I-327 shall be filled with coarse ground bentonite from the bottom to 3 feet below the surface. A commercial plug shall be set at this depth with a permit number or the name of the contractor either imprinted on the plug or on a plastic or metallic tag securely attached to the plug. The remainder of the hole shall be filled with cuttings and soil, and a sufficient mound shall be left over the hole to allow for settling.

(a) With the approval of the board's designated inspector the shot hole ~~shall~~ may be ~~filled~~ plugged by filling the hole with bentonite-water slurry by hose injection and displacement upwards from the maximum depth attainable. The slurry mixture shall have a marsh funnel viscosity of 60 seconds or greater per quart (subject to field verification on site) and shall contain a minimum of 28 pounds of commercial plugging bentonite per 42 gallons of water. ~~Except where the addition of cuttings or other solid or coagulating additives to the slurry mixture is required to form an effective plug, cuttings shall not be added to the slurry mixture where the hole is drilled with air. A commercial plug shall be set on top of the bentonite at a sufficient depth below the surface of the land to allow cultivation with a permit number or the name of the contractor or plugging subcontractor either imprinted on the plug or on a plastic or metallic tag securely attached to the plug.~~ The hole shall be filled to a depth of 3 feet below ground level and the commercial plug shall be set at this depth. The remainder of the hole shall be filled with cuttings and soil, and a sufficient mound shall be left over the hole to allow for settling.

(b) Seismic holes that penetrate artesian water deposits shall be stabilized with a cement slurry to a level not higher than ~~four~~ three feet below the surface of the ground ~~level~~. The cement slurry shall be of sufficient density to contain the waters to their native strata. The remainder of the hole shall be filled with native surface material. When alkaline or saline waters are encountered, the hole shall be plugged immediately as set forth in (3) and (a) except, if the bentonite-water slurry method is used, ~~that~~ a

heavier slurry mix must be used with the addition of inorganic drying or stabilizing chemicals such as calcium chloride, sodium bicarbonate, or soda ash to assist in the effective plugging and stability of the bentonite column in the hole.

(c) In completely dry holes, plugging shall be accomplished by filling the hole with not less than 50 pounds of coarse ground bentonite followed by the cuttings. The returned cuttings shall be tamped to insure the hole is not bridged. The hole shall be filled to a depth of 3 feet below the surface and the commercial plug set and topped with cuttings and soil as prescribed by paragraph (3).

With approval of the board's designated inspector, the shot hole may be plugged by filling the hole with the bentonite-water slurry mixture as set forth in paragraph (a).

~~(3)(c)~~ (d) Seismic shot holes that ~~tend to~~ crater or slough at the surface after being shot shall be plugged as set forth in subsections (3), (a) and (b) insofar as those procedures are reasonably possible. However, deviations ~~for~~ from those procedures are permissible as circumstances may dictate, provided the procedures are designed to accomplish the primary objective of containing waters penetrated by the hole to their native strata and restoring the surface as near as practicable to its original conditions. The board and surface owner shall be notified of such deviations.

(4) The surface area around each seismic shot hole shall be restored to its original condition insofar as such restoration is practicable. Cuttings shall be spread no deeper than 1 inch thick and all stakes, markers, cables, ropes, wires, primacord, cement or mud stacks, and any other debris or material not native to the area shall be removed from the drill site and deposited in a convenient sanitary landfill or other approved site or disposed of by an approved disposal method. Appropriate seeds shall be planted when required to restore the surface to its original condition.

(5) A seismic shot hole may be left unplugged at the request of the surface owner for conversion to a fresh water well provided the surface owner executes a release on Form No. 19 relieving the party otherwise responsible for the plugging and abandonment of the hole from any liability for damages that may thereafter result from the hole remaining unplugged. This release will cite the date, location, surface elevation, depth to aquifer ~~or gas emitting strata~~, and any action taken. This information shall be furnished by the geophysical operator. The surface owner must also notify and file within 30 days appropriate forms with the Water Rights Bureau of the DNRC and the Board of Water Well Contractors to insure that the shot hole is properly constructed, cased, and developed into a water well.

AUTH: 82-1-104, MCA IMP: 82-1-104, MCA

3. The board is proposing these amendments to the rules

as a result of an extensive review of the existing rules by interested parties including land and mineral owners, geophysical contractors, the Montana Bureau of Mines and Geology, the Montana Department of State Lands and the board. The purpose of these amendments is to authorize a better and more economical method of plugging seismic shot holes. The proposed amendments provide (1) footage requirements for vibroseis and surface shooting, (2) use of coarse ground bentonite for plugging nonartesian shot holes, (3) requiring shot holes in the glacial till area as defined by a USGS map to be plugged from the bottom of the hole to three feet below the surface, (4) cuttings to be spread no deeper than one inch, and (5) requiring that the surface owner of shot hole left unplugged for conversion to a fresh water well must file the appropriate forms with the Water Rights Bureau of DNRC and the Board of Water Well Contractors within 30 days to insure that the shot hole is properly completed as a water well.

4. Interested parties may submit their data, views, or arguments concerning the proposed amendments to Dee Rickman, 1520 East Sixth Avenue, Helena, Montana 59620, no later than June 18, 1987.

5. If a person who is directly affected by the proposed amendments wishes to enter his data, views and arguments orally or in writing at a public hearing, he must make written request for a hearing and submit that request along with any written comments he has to Dee Rickman, 1520 East Sixth Avenue, Helena, Montana 59620, no later than June 18, 1987.

6. If the board receives requests for a public hearing on the proposed amendments from either 10% or 25, whichever is less, of the persons directly affected by the proposed amendments; from the Administrative Code Committee of the legislature; from a governmental subdivision or agency; or from an association having not less than 25 members who will be directly affected, a hearing will be held at a later date. Notice of the hearing will be published in the Montana Administrative Register. Ten percent of those persons directly affected has been determined to be at least 25 persons based on the board's determination that there are more than 250 persons whose operations are governed by this rule or persons who are affected by such operations.

James C. Nelson

James C. Nelson, Chairman
Board of Oil and Gas Conservation

BY: Dee Rickman

Certified to the Secretary of State May 4, 1987.

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

In the matter of the amendment of Rules 46.6.1501, 46.6.1502, 46.6.1503, and 46.6.1504 pertaining to the program for persons with severe disabilities	)))))	NOTICE OF PUBLIC HEARING ON THE PROPOSED AMENDMENT OF RULES 46.6.1501, 46.6.1502, 46.6.1503 AND 46.6.1504 PERTAINING TO THE PROGRAM FOR PERSONS WITH SEVERE DISABILITIES

TO: All Interested Persons

1. On June 10, 1987, 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 proposed amendment of rules as cited above pertaining to the program for persons with severe disabilities.

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

46.6.1501 ~~PHYSICAL~~ PROGRAM FOR PERSONS WITH SEVERE DISABILITIES ~~PROGRAM~~, PURPOSES

The purpose of the ~~physical disabilities~~ program for persons with severe disabilities is to provide for the needs of ~~physically~~ severely disabled persons who are in need of services generally not available to them. ~~due to their ineligibility for other assistance programs.~~ The program is to provide services in community settings that assist and supervise the client in meeting daily living needs.

AUTH: Sec. 53-19-112 MCA; AUTH Extension, Sec. 7, Ch. 713, L. 1985, Eff. 10/1/85; Sec. 8, Ch. 514, L. 1987, Eff. 4/16/87

IMP: Sec. 53-19-101 and 53-19-103 MCA; Sec. 3, Ch. 514, L. 1987, Eff. 4/16/87 (HB 462)

46.6.1502 ~~PHYSICAL~~ PROGRAM FOR PERSONS WITH SEVERE DISABILITIES ~~PROGRAM~~, SERVICES

(1) Services provided under the ~~physical disabilities~~ program for persons with severe disabilities shall be those services that assist a client in living independently in community settings.

Subsections (2) through (3) remain the same.

AUTH: Sec. 53-19-112 MCA; AUTH Extension, Sec. 7, Ch. 713, L. 1985, Eff. 10/1/85; Sec. 8, Ch. 514, L. 1987, Eff. 4/16/87

IMP: Sec. 53-19-101 and 53-19-103 MCA; Sec. 5, Ch. 514, L. 1987, Eff. 4/16/87 (HB 462)

46.6.1503 ~~PHYSICAL~~ PROGRAM FOR PERSONS WITH SEVERE DISABILITIES ~~PROGRAM~~, ELIGIBILITY REQUIREMENTS (1) A person is ~~physically~~ severely disabled if:

(a) the person is disabled with a permanent ~~impairment~~ disability that substantially limits major life activity such as walking, self-care, seeing, hearing, speaking, learning, reasoning, judgement or memory; and

(b) the disability can be diagnosed by a physician.

(2) A person is eligible for ~~physical disabilities~~ services for severely disabled persons if~~:~~ the department, in its discretion and in accordance with section 53-19-112, MCA, as amended, these rules, and Title VII, Part A, of the federal Rehabilitation Act of 1973 (29 U.S.C. 796, as amended), determines that the disability is of such severity that, to secure and maintain employment or to function independently, the person requires more intensive vocational or comprehensive rehabilitation services than are available through other state and federal programs.

~~(a) the person is physically disabled;~~

~~(b) the person is determined by the department to be in need of services;~~

~~(c) there are appropriate services available to the person under the program; and~~

~~(d) the person is not eligible for similar services provided under other programs including but not limited to programs for developmentally disabled persons, for vocational rehabilitation services or for medicaid home and community based services.~~

(3) Severely disabled persons not receiving other vocational and rehabilitation services provided by the department have priority for services provided under this program.

(4) A person who has a primary diagnosis of mental illness or who receives mental health services under title 53, chapter 21, MCA, is not eligible for placement in residential services for severely disabled persons unless he is eligible for and receiving services under this part and Title VII, Part A of the federal Rehabilitation Act of 1973.

(~~3~~5) The person's financial needs in relation to service needs will be determined as provided for in ARM 46.6.405 through 46.6.411.

AUTH: Sec. 53-19-112 MCA; AUTH Extension, Sec. 7, Ch. 713, L. 1985, Eff. 10/1/85; Sec. 8, Ch. 514, L. 1987, Eff. 4/16/87

IMP: Sec. 53-19-103 MCA; Sec. 1, Ch. 514, L. 1987, Eff. 4/16/87 (HB 462)

46.6.1504 ~~PHYSICAL~~ PROGRAM FOR PERSONS WITH SEVERE DISABILITIES ~~PROGRAM~~, CLIENT SERVICES, AND PLACEMENT A person found to be eligible for ~~physical~~ disabilities services to severely disabled persons may ~~only~~ receive only those available services which are identified as appropriate for that person through an independent living plan or contract.

AUTH: Sec. 53-19-112 MCA; AUTH Extension, Sec. 7, Ch. 713, L. 1985, Eff. 10/1/85; Sec. 8, Ch. 514, L. 1987, Eff. 4/16/87
IMP: Sec. 53-19-103 MCA; Sec. 5, Ch. 514, L. 1987, Eff. 4/16/87 (HB 462)

3. These rules are being changed to conform with state law as amended by HB 462. Upon passage of final federal regulations, it is anticipated that the rules for the severe disabilities and independent living will be rewritten to better conform for federal and state purposes.

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, 1987.

5. The Office of Legal Affairs, Department of Social and Rehabilitation Services has been designated to preside over and conduct the hearing.

Dave Lewis
Director, Social and Rehabilitation Services

Certified to the Secretary of State May 4, 1987.

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

In the matter of the amendment of Rule 46.25.728 pertaining to eligibility determinations for General Relief Assistance	)))))	NOTICE OF PUBLIC HEARING ON THE PROPOSED AMENDMENT OF RULE 46.25.728 PERTAINING TO ELIGIBILITY DETERMINATIONS FOR GENERAL RELIEF ASSISTANCE

TO: All Interested Persons

1. On June 8, 1987, at 3:00 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 proposed amendment of Rule 46.25.728 pertaining to eligibility determinations for General Relief Assistance.

2. The rule as proposed to be amended provides as follows:

46.25.728 INCOME AND RESOURCE COMPUTATION Subsections (1) through (1)(b) remain the same.

(c) The first fifty dollars ($50) of earned income for each household member shall be excluded in determining eligibility and assistance amounts.

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

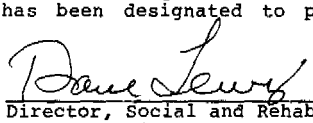
AUTH: Sec. 53-2-201, 53-2-803 and 53-3-114 MCA; AUTH Extension, Sec. 19, Ch. 670, L. 1985, Eff. 7/1/85; Sec. 6, Ch. 10, Sp. L. June, 1986, Eff. 6/30/86; Sec. 3, Ch. 614, L. 1987, Eff. 7/1/87

IMP: Sec. 53-3-205, 53-3-209 and 53-3-311 MCA; Sec. 1, Ch. 614, L. 1987, Eff. 7/1/87

3. This rule change implements House Bill (HB) 581 as enacted by the Fiftieth Legislative Session by providing an exclusion of the first fifty dollars ($50) of earned income for each household member in determining eligibility and calculating assistance amounts for the general relief assistance 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 11, 1987.

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 4, 1987.

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

In the matter of the amendment of Rule 46.25.731 pertaining to the Structured Job Search and Training Program	))))	NOTICE OF PUBLIC HEARING ON THE PROPOSED AMENDMENT OF RULE 46.25.731 PERTAINING TO THE STRUCTURED JOB SEARCH AND TRAINING PROGRAM

TO: All Interested Persons

1. On June 8, 1987, at 2:00 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 proposed amendment of Rule 46.25.731 pertaining to the Structured Job Search and Training Program.

2. The rule as proposed to be amended provides as follows:

46.25.731 STRUCTURED JOB SEARCH AND TRAINING PROGRAM

Subsections (1) through (6)(b)(i) remain the same.

(ii) Payment will be made only for recipients who live one or more miles from the work site or service unit;

(iii) Use of private transportation will be reimbursed at the rate of ~~21 cents~~ $.185 per mile up to a maximum of ~~$25.00~~ $10.00 per ~~month~~ day for each recipient participating in the structured job search training and work program.

(c) Work clothing~~.~~ and haircut:

(i) if unavailable from another source~~;~~. ~~up to $75.00 per recipient worth of work clothing may be purchased by the department~~;

(ii) up to a maximum of $100.00 per recipient of which $10.00 may be used for a haircut;

(iii) ~~will be provided~~ only one time ~~to~~ for each recipient.

(d) Other: A maximum of $15.00 may be spent to obtain necessary employment and training items such as: school transcripts, birth certificates, driver's license and application fees.

AUTH: Sec. 53-2-201, 53-2-803 and 53-3-114 MCA; AUTH Extension, Sec. 3, Ch. 10, L. 1986 Sp. Sess., Eff. 7/1/86
IMP: Sec. 53-2-822, 53-3-304 and 53-3-305 MCA

3. The Structured Job Search, Training and Work Program was implemented July 1, 1986. The Department of Labor and Industry requested that the Montana Job Training Coordinating Council evaluate the program. The Council's evaluation identified a deficiency in support services and recommended the changes proposed in this notice.

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, 1987.

5. The Office of Legal Affairs, Department of Social and Rehabilitation Services has been designated to preside over and conduct the hearing.

Dave Lewis
Director, Social and Rehabilitation Services

Certified to the Secretary of State May 4, 1987.

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, 46.12.1204, 46.12.1205, 46.12.1206, 46.12.1209 and 46.12.1210 pertaining to nursing home reimbursement	)))))))	NOTICE OF PUBLIC HEARING ON THE PROPOSED AMENDMENT OF RULES 46.12.1201, 46.12.1202, 46.12.1204, 46.12.1205, 46.12.1206, 46.12.1209 AND 46.12.1210 PERTAINING TO NURSING HOME REIMBURSEMENT

TO: All Interested Persons

1. On June 3, 1987, at 10:00 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 proposed amendment of Rules 46.12.1201, 46.12.1202, 46.12.1204, 46.12.1205, 46.12.1206, 46.12.1209 and 46.12.1210 pertaining to nursing home reimbursement.

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

46.12.1201 TRANSITION FROM RULES IN EFFECT SINCE ~~JULY 1, 1983~~ APRIL 1, 1986

(1) These rules shall be effective ~~April 1, 1986~~ July 1, 1987.

(2) Includable costs for ~~cost reports with ending dates before April 1, 1986,~~ periods prior to July 1, 1987 will be determined in accordance with rules for includable costs then in effect.

(3) The payment rate is a result of computing the formula:

R=RO+RP

~~For facilities whose providers are owners on June 30, 1982, until ownership changes, and for facilities whose providers are not owners on June 30, 1982, until the June 30, 1982 provider changes:~~

~~RO=P, if A-P is less than 0~~

(a) For providers delivering services in long term care facilities who were owners on June 30, 1982, or for providers delivering services in long term care facilities who were not owners on June 30, 1982, until the June 30, 1982 provider changes:

~~RO=A, if A-P is equal to or greater than 0~~

RP=S, if M_1-S is less than 0

RP=S(1) for providers delivering services in long term care facilities constructing new beds after July 1, 1984 where M_1-S is less than or equal to 0

RP=S(2) for providers delivering services in long term care facilities extensively remodeled after July 1, 1984 where

M_1-S is less than or equal to 0

RP=M, if M-S is equal to or greater than 0

A change in provider will be considered to have occurred under any of the following circumstances:

(i) the addition or substitution of a partner as permitted by applicable state law;

(ii) the sale of an unincorporated sole proprietorship or the transfer of title to, or possession of, a facility used in the provision of long term care facility services from the provider to another party or entity;

(iii) the merger of the provider corporation into another corporation or the consolidation of two or more corporations. However, the transfer of corporate stock or the merger of another corporation into the provider corporation does not constitute a change of provider, unless the provider corporation is closely held and a substantial interest in stock held is transferred from one party or entity to another party or entity;

(iv) the lease of all or part of a provider-owned facility used in the provision of long term care services or the transfer of a lease from the provider to another party or entity.

(b) For all other providers delivering services in long term care facilities and for all providers delivering services in long term care facilities newly constructed after June 30, 1982, regardless of provider:

RO=A

RP=M

where:

R is the payment rate for the current year,

~~S is the interim property rate in effect on June 30, 1982. In the case where costs to a facility decrease such as through refinancing of debt or the renegotiation of a lease, S will be based on actual costs, if they are less. Decreased costs due to the normal change in interest and principal payments over the terms of an existing mortgage or lease will not lead to an adjustment by the department.~~

S is the lower of the interim property rate in effect on June 30, 1982, or the provider's actual property costs per patient day based on the provider's fiscal year 1985 cost report indexed to June 30, 1987. For purposes of indexing, the department incorporates by reference the Health Care Financing Administration (HCFA) nursing home input price index which was specifically designed to measure cost increases in the market basket of goods and services purchased by nursing homes. The HCFA nursing home input price index is published in the annual update to the federal register. A copy of the HCFA nursing home input price index as amended through June 30, 1987, is available from the Department of Social and Rehabilitation Services, Economic Assistance Division, III Sanders, Helena, Montana 59604.

In the case where costs to a facility decrease through refinancing of debt or the renegotiation of a lease, S will be based upon the lower of S determined as above or actual property costs per day beginning with the effective date of the refinancing or renegotiated lease.

S(1) = [(V x S) + (Y x ~~7.79~~ 7.98 effective July 1, ~~1985~~ 1987] ~~and 7.98 effective July 1, 1986)~~] divided by (V + Y)

where:

V is the total square footage of the original structure before construction of new beds.

Y is the square footage added to the facility as a result of the construction.

S(2) = the lower of 7.98 or S + ((F x 12) divided by 365) x ~~1.025~~ 1.0506 effective July 1, ~~1985~~ 1987 ~~and 1.0506 effective July 1, 1986)~~

where:

F is ((B divided by D) x .80) amortized over 360 months at 12% per annum.

D is the number of licensed beds in the facility.

B is the total allowable remodeling costs.

~~T is the interim operating rate plus estimated incentive factor in effect on June 30, 1982,~~

A is the operating rate effective July 1 of the current year in accordance with ARM 46.12.1204(2), and revised as of the effective date of a change which results in a change in rate or, at least annually, in accordance with ARM 46.12.1204(5),

M is the property rate effective July 1 of the current year in accordance with ARM 46.12.1204(3), and revised as of the effective date of a change which results in a change in rate or, at least annually, in accordance with ARM 46.12.1204(5).

M_1 = the M calculated under ARM 46.12.1204(3) in effect 6/30/85 times 1.0506 effective July 1, ~~1986~~ 1987.

AUTH: Sec. 53-6-113 MCA
IMP: Sec. 53-6-141 MCA

46.12.1202 PURPOSE AND DEFINITIONS (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, ~~1985~~ 1987 forward.

Subsections (1)(a) through (2)(i) remain the same.

(j) "Wage area" means the geographic area serviced by the Montana job service office in which a provider is located. State institution providers licensed for skilled or intermediate nursing services shall constitute a wage area regardless of locations.

~~(k) "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.~~

~~(i) "Non-wood frame construction" means all types of construction not included as wood frame construction.~~

Subsections (1)(m) through (1)(v) remain the same in text but will be recategorized as (1)(k) through (1)(t).

(u) "Resident" means a person admitted to a long term care facility who has been present in the facility for at least one 24-hour period.

(v) "Closely held corporation" is defined as a corporation having 15 or fewer shareholders.

(w) "Monitor" means a review performed by the department or its designee on a statistical sample of a specific month's medical record documentation to support the patient management minutes claimed by the provider for the same month.

(wx) The laws and regulations and federal policies cited in this sub-chapter shall mean those laws and regulations which are in effect as of ~~April 1, 1986.~~ July 1, 1987.

AUTH: Sec. 53-6-113 MCA
IMP: Sec. 53-6-141 MCA

46.12.1204 PAYMENT RATE (1) A provider's payment rate is the sum of an operating rate and a property rate, provided in ARM 46.12.1201(3).

(2) The operating rate A, in dollars per patient-day, is given by:

~~A=A(1), if P is equal to or greater than A(1), or~~
~~A=A(2), if P is equal to or less than A(2), or~~
~~A=P, if P is less than A(1) and greater than A(2), or~~
~~A=A(3) if the facility was constructed after 6/30/82~~
~~where:~~
~~A(1) = B times ((C times ((($28.80 + ($54,627 divided by B)) divided by 9)) + E), effective July 1, 1985 and B times ((C times ((28.12 + ($54,627 divided by B)) divided by 9)) + E), effective July 1, 1986~~
~~A(2) = B times ((C times ((($26.06 + ($54,627 divided by B)) divided by 9)) + E), effective July 1, 1985 and B times ((C times ((26.74 + ($54,627 divided by B)) divided by 9)) + E), effective July 1, 1986~~
A~~3~~ = B times ((C times ((~~27.43~~ 34.63 + ($54,627 $94,889 divided by D)) divided by .92)) + E),
B is the area wage adjustment for a provider,
C is the inflation factor used to compute the per diem rates. The inflation factor is the factor necessary to calculate increases in R(1) such that, effective July 1, 1987, R(2) = R(1) x 1.02 and, effective July 1, 1988, R(2) = R(1) x 1.04.
D is the number of licensed beds for a provider times 366 days,

or D is the number of licensed beds for a provider or 25, whichever is greater, times 366 for facilities newly constructed after June 30, 1985 or not in the program on June 30, 1985 or participating in the program with greater than 25 licensed beds on June 30, 1985.

E is the patient care adjustment for a provider,

~~F, is C times the interim operating rate in effect on June 30, 1982, indexed to December 31, 1982.~~

R(1) = The statewide weighted average per diem rate for R as of May 1, 1987.

R(2) = The statewide weighted average per diem rate for R indexed from R(1) by 1.02 effective July 1, 1987 and 1.04 effective July 1, 1988.

(a) The area wage adjustment for a provider is the result of computing the following formula:

B=1 + (((F-G) divided by G) times the ratio of total labor costs to total operating costs, based on the most current information available) 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:

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= L times (J-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 x Z except for facilities extensively remodeled or ~~constructing~~ with new beds constructed after July 1, 1984.

M = N(1) x Z for facilities ~~constructing~~ with new beds constructed after July 1, 1984,

M = N(2) x Z for facilities extensively remodeled after July 1, 1984.

where:

M is the property rate per day of service,

N is the ~~facility's~~ provider's property rate as of 6/30/85. For entire facilities built after 6/30/85

N is $7.60. ~~for a facility of non-wood frame construction, and $7.60 for a facility of wood frame construction.~~

For facilities new to the program constructed prior to 6/30/82 a 6/30/85 rate will be computed according to property rules effective 6/30/85. That rate will be carried forward using M = N x Z

N(1) is the lower of 7.98 or (((A x D) + B x 7.60)) divided by (A + B))) x ~~1.025~~ 1.0506 effective July 1, ~~1985~~ 1987. ~~and 1.0506 effective July 1, 1986.~~

~~N(2) is D x 1.025 effective April 1, 1986 and 1.0506 effective July 1, 1986 + ((F x 12) divided by 365) where remodeling is completed during the 7/1/85 to 6/30/86 period.~~

N(2) = the lower of 7.98 or D x ~~1.025~~ 1.0506 effective ~~January~~ July 1, ~~1986~~ 1987 ~~and 1.0506 effective July 1, 1986~~ + ((F x 12) divided by 365). ~~x 1.025 when remodeling is completed during the 7/1/84 to 6/30/85 period.~~

where:

A is the total square footage of the original structure.

B is the square footage added with the construction of new beds.

D is the property rate as of 6/30/85 for the original structure.

F is ((G divided by H x .80) amortized over 360 months at 12% per annum.

H is the number of licensed beds in the facility.

G is total allowable remodeling costs.

Z is ~~1.025~~ 1.0506 effective July 1, ~~1985~~ 1987. ~~and 1.0506 effective July 1, 1986.~~

(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 final rate in effect on June 30, 1982, as indexed to the mid-point of the rate year by 9% per 12-month year. for fiscal years ending on or before June 30, 1987, and 5.1% per year indexed to June 30 of the rate year for fiscal years ending on or after July 1, 1987.

(a) Prior to the billing of July services each year the department will compute an interim payment rate which is the department's estimate of actual includable cost divided by estimated patient days.

(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.

~~(c) For facilities constructing new beds after July 1, 1984, an adjustment to the property rate (as described at ARM 46.12.1204(3)(a)) will be allowed, beginning with a given rate~~

~~year,--provided-that-the-construction--or-the--claimed-portion thereof--ended-during--the-immediate--prior--July-1-to-June-30 period.~~

~~(d)--For--facilities--extensively-remodeled-after-July-1, 1984,--a--remodeling--adjustment--to--the--property--rate--(as described-in-ARM--46.12.1204(3)(a))-will-be-allowed,-beginning with-a-given-rate-year-provided-that-the-remodeling-or-claimed portion-thereof-ended--during-the--immediate--prior--July-1-to June-30-period.~~

(5) The averages, standard deviations, prorating for additions, or area wage adjustments~~,-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.

AUTH: Sec. 53-6-113 MCA
IMP: Sec. 53-6-141 MCA

46.12.1205 PAYMENT PROCEDURES (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 authorized medicaid recipients times the payment rate minus the amount each medicaid recipient ~~participates-in~~ pays toward the cost of care. Authorized medicaid recipients are those residents who have been determined eligible for medicaid and have been authorized for either skilled or intermediate level of care as a result of the screening process described in ARM 46.12.1101.

(a) Reimbursement for medicare co-insurance days will be limited to the payment rates as determined under ARM 46.12.1204 or the medicare co-insurance rate, whichever is lower.

(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 items, if such items are medically necessary, in accordance with ARM 46.12.306 which are prescribed by a physician:

~~(i)----catheter-insertion-tray;~~

~~(ii)---colostomy/ileostomy/urostomy-accessories-necessary to-apply/maintain-the-appliance;~~

~~(iii)--colostomy/ileostomy/urostomy-appliance;~~

~~(iv)---enteral-feeding-bags/bottles-and-associated-filters-and-tubing;~~

~~(v)----enteral-tubes-and-catheters;~~

~~(vi) intravenous catheters;~~
~~(vii) intravenous fluids;~~
~~(viii) irrigation tray;~~
~~(ix) oxygen and oxygen equipment;~~
~~(x) oxygen related disposable items, including cannulas, tubing, and masks;~~
~~(xi) suction catheters;~~
~~(xii) tracheostomy tubes and related trach care kits;~~
~~(xiii) urinary catheters;~~
~~(xiv) urinary drainage systems;~~
~~(xv) routine nursing supplies used in extraordinary amounts and prior approved by the department;~~
~~(xvi) nutrient solutions for parenteral and enteral nutrition therapy when such solutions are the only source of nutrition for patients who, because of chronic illness or trauma, cannot be sustained through oral feeding. These solutions will be allowable only if they are determined medically appropriate and prior authorized by the director of the department or his designee.~~

(i) colostomy set;
(ii) ostomy face plate;
(iii) ostomy skin barrier;
(iv) ostomy liquid barrier;
(v) ostomy skin bond or cement;
(vi) ostomy bag, disposable/closed;
(vii) ostomy bag, reuseable or drainable;
(viii) ostomy belt;
(ix) stoma wicks;
(x) tail closures;
(xi) ostomy skin bond or cement, remover;
(xii) ileostomy set;
(xiii) ileal bladder set;
(xiv) irrigation set for irrigation of ostomy;
(xv) ostomy lubricant;
(xvi) ostomy rings;
(xvii) not otherwise classified ostomy supplies;
(xviii) ureterostomy set;
(xix) ureterostomy supplies not otherwise classified;
(xx) colon tube;
(xxi) disposable colostomy appliance/acc;
(xxii) colostomy irrigation appliance;
(xxiii) colostomy irrigation accessory;
(xxiv) colostomy appliance, non-disposable;
(xxv) colostomy appliance;
(xxvi) disposable ileostomy accessory;
(xxvii) disposable urostomy bags;
(xxviii) piston irrigation set;
(xxix) blood or urine control strips or tablets;
(xxx) dextrostick or glucose test strips;

(xxxi) implantable vascular access portal/catheter (venous arterial or peritoneal);
(xxxii) indwelling catheter, Foley type, two-way, teflon;
(xxxiii) indwelling catheter, Foley type, two-way, latex;
(xxxiv) indwelling catheter, Foley type, two-way, latex with teflon coating;
(xxxv) indwelling catheter, Foley type, two-way, all silicone;
(xxxvi) indwelling catheter, Foley type, two-way, silicone with elastomer coating;
(xxxvii) indwelling catheter, Foley type, three-way, latex or teflon for continuous irrigation;
(xxxviii) external catheter, condom type;
(xxxix) urinary collection and retention system, drainage bag with tube;
(xl) urinary collection and retention system, drainage bag with tube;
(xli) urinary collection and retention system, leg bag with tube;
(xlii) catheter care kit;
(xliii) catheter insertion tray, without tube and drainage bag;
(xliv) 3-way irrigation set for catheter;
(xlv) uretheral catheter;
(xlvi) catheter miscellaneous supplies;
(xlvii) uretheral catheter with tray;
(xlviii) caudi-tip catheter;
(xlix) male mentor catheter;
(l) incontinence clamp;
(li) urinary drainage bag;
(lii) urinary leg bag;
(liii) bedside drainage bag;
(liv) tracheostomy care kit;
(lv) nasopharyngeal/tracheal suction kit;
(lvi) oxygen contents, gaseous, per cubic feet;
(lvii) oxygen contents, gaseous, per 100 cubic feet;
(lviii) oxygen contents, liquid, per pound;
(lix) oxygen contents, liquid, per 100 pounds;
(lx) cannula;
(lxi) tubing, unspecified length, per foot;
(lxii) regulator;
(lxiii) mouth piece;
(lxiv) stand/rack;
(lxv) face tent;
(lxvi) IPPB kit;
(lxvii) portable aspirator;
(lxviii) connectors;
(lxix) face mask;
(lxx) nasal catheter;

(lxxi) disposable IPPB tubing;
(lxxii) disposable humidifier(s);
(lxxiii) extension hoses;
(lxxiv) MADA plastic nebulizer with mask and tube;
(lxxv) nasal O_2 kit;
(lxxvi) O_2 contents, Linde reservoir;
(lxxvii) O_2 contents, Liberator;
(lxxviii) O_2 contents, LV 160;
(lxxix) O_2 contents, PCU reservoir;
(lxxx) O_2 contents, GP-45;
(lxxxi) O_2 contents, D cylinder;
(lxxxii) O_2 contents, E cylinder;
(lxxxiii) O_2 cylinder contents, GDL-K;
(lxxxiv) cylinder rental, one month;
(lxxxv) piped in oxygen;
(lxxxvi) oxygen cart for portable tank (purchase);
(lxxxvii) enteral feeding supply kit; syringe (monthly);
(lxxxviii) enteral feeding supply kit; pump fed (monthly);
(lxxxix) enteral feeding supply kit; gravity fed (monthly);
(xc) nasal gastric tubing with thin wire or cotton (e.g., Travasorb, Entriflex, Dobb Huff, Flexiflow, etc.);
(xci) nasogastric tubing without stylet;
(xcii) stomach tube - Levine type;
(xciii) enteral supply kit for prepackaged delivery system (monthly);
(xciv) nasogastric tubing with or without stylet (e.g., Travasorb);
(xcv) enteric feeding set;
(xcvi) flex-flo feeding set;
(xcvii) nutrition container;
(xcviii) IV intercath;
(xcix) IV tubing;
(c) IV piggyback tubing;
(ci) parenteral nutrition supply kit for one month - Premix;
(cii) parenteral nutrition supply kit for one month - Homemix;
(ciii) parenteral nutrition administration kit for one month;
(civ) enteral supplies not elsewhere classified;
(cv) parenteral supplies not elsewhere classified;
(cvi) feeding syringe;
(cvii) gavage feeding set.
(cviii) nutrient solutions for parenteral and enteral nutrition therapy when such solutions are the only source of nutrition for patients who, because of chronic illness or trauma, cannot be sustained through oral feeding. These solutions will be allowable only if they are determined medically appropriate and prior authorized by the director of the medicaid bureau.

(b) If the above items are also covered by the medicare program and provided to medicaid recipients who are also medicare recipients, reimbursement will be limited to the lower of the medicare prevailing charge or the provider's direct cost.

(bc) For purposes of combined facilities providing these items through the hospital direct cost will mean invoice price to the hospital with no indirect cost added.

(cd) Physical, occupational, and speech therapies may be billed additionally by the licensed therapist providing the service. Maintenance therapy and rehabilitation services reimbursed as long term care facility services under the per diem rate shall not be billed additionally by either the therapist or the provider. If the therapist is employed by or under contract with 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.

(de) 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; other anatomical supports; and oxygen may be billed additionally by the provider of medical supplies or equipment in accordance with ARM 46.12.801 - 802 and ARM 46.12.805 - 806.

(ef) All prescribed medication may be billed additionally by the pharmacy providing the medication including flu shots and tine tests in accordance with ARM 46.12.702.

(fg) Non-emergency (exclusive of those outlined in ARM 46.12.1202(2)(t)) transportation may be billed additionally in accordance with ARM 46.12.1012 and ARM 46.12.1015. Emergency transportation may be billed additionally by an ambulance service in accordance with ARM 46.12.1021-1022 and ARM 46.12.1025.

(gh) 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 46.12.1206(9), the department will conduct an audit of the provider's costs for the fiscal year in which the deficiency occurred and may 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 temporarily receiving medical services elsewhere, such as in a hospital, except in a situation where a provider is full and has a current waiting list of potential residents. The requirements of being full and maintaining a current waiting list applies to each hold bed day claimed for reimbursement. A provider will be considered full if all medicaid certified beds are occupied or being held for a ~~patient~~ recipient temporarily ~~in a hospital~~ receiving medical services elsewhere or away on a therapeutic home visit. A provider will also be considered full as to gender if all appropriate, available beds are occupied or being held. For example, if all beds are occupied or held except for one semi-private bed in a female room, the provider is full for purposes of hold days for male recipients. In this exceptional instance, a payment will be made for holding a bed while the resident is temporarily receiving ~~care in a hospital~~ medical services elsewhere 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 long term care bed would otherwise become available. The provider must provide documentation, upon request, that the absence is expected to be temporary and the anticipated duration of the absence. Temporary absences which are of indefinite duration should be followed up at least weekly by the provider in order to reasonably assure the department that the absence is indeed temporary. Furthermore, payment in this exceptional instance will be made only upon written approval from the ~~director of the department or his designee~~ department's medicaid bureau. A request for nursing home bed reservation during a resident's temporary ~~hospitalization~~ medical leave in this instance must be submitted to the department on the appropriate forms provided by the department within 90 days of the first day of the requested absence. The request form submitted to the department must be accompanied by a copy of the current waiting list applicable to each hold bed day claimed for reimbursement. In situations where conditions of billing for holding a bed are met, providers are required to hold the bed and may not fill the bed until these conditions are no longer met. The bed may not be filled unless prior approval is obtained from the department. In situations where conditions of billing for holding a bed are not met, providers must hold the bed and may not bill medicaid for the hold bed day until all conditions of billing are met.

(6) Reimbursement will be made to a provider for reserving a bed while the recipient is temporarily absent during a therapeutic home visit if the recipient's plan of care provides for therapeutic home visits. Therapeutic home visits may be allowed for trial placement in the home and community ~~based~~ services (medicaid waiver) program. A total of 24 days in each rate year will be allowed for therapeutic home visits. The provider is responsible for notifying the department on a form provided by the department within 90 days ~~of when~~ of the first day 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.~~ department's medicaid bureau.

(7) No item or service may be billed to the medicaid program if that item could be paid by any other payer such as private insurance, medicare, etc., regardless of whether the facility participates in that program. If the department finds that medicaid has made payments in such an instance, retroactive collections will be made from the provider.

AUTH: Sec. 53-6-113 MCA
IMP: Sec. 53-6-141 MCA

46.12.1206 PATIENT ASSESSMENTS, STAFFING REPORTS AND DEFICIENCIES (1) Each provider will report to the department each month the care requirements for each medicaid patient in the facility on forms provided and according to instructions supplied by the department.

(2) Each provider will report to the department each month the staffing provided at the facility on forms provided and according to instructions supplied 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. The administrator or his designee must certify that these reports, to the best of his knowledge and belief, are complete, accurate, and prepared consistent with all applicable rules and departmental instructions. 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 once annually the monthly patient assessment ~~reports~~ abstracts will be ~~validated~~ monitored for

accuracy and consistency with medical records maintained ~~at the facility~~. by the provider. If the department's ~~review~~ monitor team findings indicates that ~~facility--patient assessment~~ abstracts ~~submitted~~ verified by chart documentation are significantly different ~~from~~ than the abstracts ~~average determined~~ submitted by the ~~review team~~, provider for the same month, the provider's average nursing care time will be computed from the abstracts ~~submitted~~ monitored by the ~~review~~ monitor team.

(a) Within a reasonable length of time after the completion of the ~~review~~ monitor by the department's ~~review~~ monitor team, the department will notify the ~~facility~~ provider of the results of that ~~review~~ monitor. Such notice shall include the patient assessment score as determined by the ~~review~~, department from the monitor findings, the ~~facility's~~ provider's patient assessment score for the same month, and a statement of whether or not there is a "significant difference" which will ~~adversely~~ affect a ~~facility's~~ provider's reimbursement rate. If a significant difference exists, the facility will be notified that it may appeal the patient assessment score ~~generated by the review team~~ computed based upon the monitor findings in accordance with ARM 46.12.1210;

(b) For ~~facilities that~~ providers who object to the sampling technique used by the ~~review~~ monitor team to ~~compute the average nursing care time~~, select the abstracts to be monitored for rate years beginning July 1, 1986, the following procedure will be the only appeal available:

(i) ~~Any provider which disagrees with the department's computation of the average nursing care time, for rate years beginning July 1, 1986,~~ The provider may request a ~~review~~ monitor of 100% of the monthly patient assessment ~~reports~~ abstracts for the month originally ~~reviewed~~, monitored. This appeal must be made within thirty (30) days of receipt of the monitor findings. If the 100% ~~review~~ monitor indicates that ~~facility~~ the patient assessment abstracts submitted by the provider remain significantly different from the abstracts ~~average determined~~ monitored, ~~by the review team~~, the ~~facility~~ provider will reimburse the department for the cost of the additional ~~review~~ monitor and the provider's average nursing care time will be computed from abstracts ~~compiled by the review team~~ verified by chart documentation during the 100% ~~review~~ monitor. Reimbursement for the costs of the ~~review~~ monitor must be made within 30 days after receipt of notification ~~to the provider~~ of the costs of the ~~review~~ monitor, or the department will recover the cost by set-off against amounts paid for long term care facility services. If the 100% ~~review~~ monitor indicates that ~~facility~~ provider patient assessment abstracts submitted are not significantly different from the abstracts ~~average determined~~ verified by chart documentation by the ~~review~~ monitor team the cost of the

additional ~~review~~ monitor will be borne by the department and the provider's average nursing care time will be determined in accordance with ARM 46.12.1202(2)(g).

(c) Effective July 1, 1987, for providers who object to the monitor findings of a "significant difference", but not to the sampling technique, an administrative review and fair hearing may be requested in accordance with ARM 46.12.1210. This request for administrative review must be made within thirty (30) days of receipt of the monitor findings. The provider should submit the necessary documentation with the administrative review request to support its objections.

(d) For purposes of appeals made under ARM 46.12.1206(4)(b)(i) or ARM 46.12.1206(4)(c) above, only documentation available on the date of the initial monitor will be considered.

(~~e~~e) "Significantly different" shall mean a ten percent or greater variance.

(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 department's 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 department's medicaid ~~financing~~ bureau will respond to these reports by:

(a) taking no action if the review is successfully completed with no significant deficiencies; or

(b) informing the provider that corrective action is necessary. The department may require that a corrective action plan approved by the department or 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 may 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 department's medicaid ~~financing~~ bureau that a ~~facility's~~ provider's average patient assessment care requirement was ten percent or more in excess of actual ~~facility~~ provider nursing care staffing for two or more consecutive months.

AUTH: Sec. 53-6-113 MCA
IMP: Sec. 53-6-141 MCA

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~~ of 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~~ of the provider, the department will make deductions from rate payments with full recovery to be completed within ~~120~~ sixty (60) days from the

date of the initial request for payment. The sixty (60) day recovery period coincides with requirements of Section 1903(d)(2) of the Social Security Act, as amended. This section requires states to repay the federal share of Medicaid payments within sixty (60) days of determination of a medicaid overpayment. 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) In the event an underpayment has occurred, the department will reimburse the provider promptly following the department's determination of ~~error~~ the amount of the underpayment.

(5) Court or administrative proceedings 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.

(6) 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.

AUTH: Sec. 53-6-113 and 53-2-201 MCA
IMP: Sec. 53-6-111, 53-6-141 and 53-2-201 MCA

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~~,~~ or review. 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 or review 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~~,~~ or review. The department's medicaid ~~financing~~ bureau shall conduct the conference or review based on its 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~~,~~ or review, 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 will provide copies of requests, notices and written decisions to the department's director, medicaid ~~financing~~ bureau and office of legal affairs.

(f) The hearings 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 thirty 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 appeal may be submitted to the hearings officer for forwarding to the department director within ten days of the receipt of the hearings officer's decision. The notice of appeals shall set forth the specific grounds for appeal. If no notice of appeal is filed within ten days, the hearings 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 department director by the hearings officer. The decision of the department director 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 department director.

(b) The department director shall reduce his decision to writing and mail copies to the parties within fifteen 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.

AUTH: Sec. 53-6-113 and 53-2-201 MCA
IMP: Sec. 53-6-111, 53-6-141 and 53-2-201 MCA

3. The Department proposes to amend its rules for medicaid payments to providers of long-term care services in order to simplify and update the payment rate calculations and to clarify or delete other sections of the rule in order to make the rule consistent with Department policy.

ARM 46.12.1201 is amended to clarify the circumstances under which a change in provider is determined to occur for purposes of the retention or expiration of a provider's "grandfathered" rate. This section also is amended to provide for an adjustment of certain grandfathered property rates when a provider's 1985 property costs indexed forward to June 30, 1987 are computed and found to be lower than the cost-based grandfathered rate. This is intended to provide for updated grandfathered rates reflecting more current costs than those used to set the rates in 1982 and does not allow for a decline in property rate below that available under the property rate formula. It will provide for more equity in relative property rates.

ARM 46.12.1202 expands the definition of "wage area" to group state institution providers into one specific wage area to reflect the standard pay scale available to these providers which is independent of their location. New definitions are added in connection with use of the terms in other parts of the rule.

ARM 46.12.1204 amends the calculation of operating rates in four ways: elimination of "banding", updating of the fixed and variable operating costs and the occupancy factor used to calculate the formula operating rate, elimination of grandfathered operating rates and updating of the inflation factor used in setting both operating and total rates.

"Banding" was a transitory protection mechanism used to phase-in the prospective payment system for providers with relatively high or low operating costs. It has been progressively narrowed since inception and its elimination will simplify rate calculations without causing drastic increases or reductions in individual provider rates.

The fixed and variable operating costs and the occupancy factor were updated upon 1985 cost report data indexed to June 30, 1987. This will make the formula more current in terms of the most recent cost report data available.

Grandfathered operating rates are being eliminated for the remaining providers receiving these rates. This action is

being taken to simplify rate setting, provide more fairness and to reflect the fact that the protected rates still being applied after five years under the prospective system are not likely to phase out on their own even under a rebased formula.

The inflation factor to be applied to aggregate operating rates is estimated to be in excess of 4% for FY 1988. In order to provide at least a 2% increase in the statewide weighted average total rate, the Department proposes to use an inflation factor for operating rates above those projected by the HCFA Nursing Home Price Index.

Total rate increases over the FY 1987 average are 2% in FY 1988 and 4% in FY 1989. These increases are considered to be reasonable and adequate to insure that aggregate payments exceed projected total aggregate costs.

Other rule clarifications include a decreased inflation rate for cost-based ICF/MR providers, a more detailed list of reimbursable ancillaries, more definitive requirements for obtaining approval for hospital hold days and an additional administrative remedy for appeals of significant differences in patient assessment monitor findings. The repayment period by providers in the event of overpayments has been reduced to sixty (60) days in response to a change in federal regulations.

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, 1987.

5. The Office of Legal Affairs, Department of Social and Rehabilitation Services has been designated to preside over and conduct the hearing.

Dave Lewis
Director, Social and Rehabilitation Services

Certified to the Secretary of State May 4, 1987.

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

In the matter of the amendment of Rules 46.12.102 and 46.12.303 pertaining to electronic media claims submission in the Medicaid program	))))))	NOTICE OF PUBLIC HEARING ON THE PROPOSED AMENDMENT OF RULES 46.12.102 AND 46.12.303 PERTAINING TO ELECTRONIC MEDIA CLAIMS SUBMISSION IN THE MEDICAID PROGRAM

TO: All Interested Persons

1. On June 4, 1987, 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 proposed amendment of Rules 46.12.102 and 46.12.303 pertaining to electronic media claims in the Medicaid program.

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

46.12.102 MEDICAL ASSISTANCE, DEFINITIONS Subsections (1) through (37) remain the same.

(38) "Electronic media claims" means claims submitted to the Montana medicaid program via magnetic tape or another acceptable electronic media approved by the department in accordance with ARM 46.12.303(1)(d).

AUTH: Sec. 53-6-113 MCA
IMP: Sec. 53-6-101, 53-6-131 and 53-6-141 MCA

46.12.303 BILLING, REIMBURSEMENT, CLAIMS PROCESSING, AND PAYMENT Subsection (1) remains the same.

(a) Claims must be submitted in accordance with this rule to be valid.

(ab) Except as provided in subsection (1)(d) of this rule, Aall medicaid claims submitted to the ~~Montana--medicaid program-by-individual-practitioners-and-sole--proprietorships, whether--or-not--incorporated-as-a-public-service-corporation,~~ department are to be submitted on ~~personally--signed--state approved-billing~~ a state claim forms, either: ~~or-they-shall not-be-considered-valid-and-proper-claims.~~

(i) personally signed by that provider; or

(ii) personally signed by a person who has actual written authority to bind and represent the provider for this purpose. The department may require a provider to furnish this written authorization.

(bc) All medicaid claims submitted to the ~~Montana medicaid-program~~ department by ~~other-legal-business-entities are-to-be~~ a hospital for services provided by a physician who is required to relinquish fees to the hospital are to be

submitted on ~~state~~ a ~~approved-billing~~ state claim forms with the personal signature of either:

(i) the physician provider; or

(ii) a person who has actual written authority to bind and represent the physician provider for this purpose. The department may require a provider to furnish this written authorization.

(d) The department may require a hospital provider ~~must~~ to ~~furnish-a-verified-original~~ obtain on the claim form the signature of ~~this-person-on-a-form-that-has-been-furnished-by-the-department-for-this-purpose.--Claims-not-submitted-in-this-manner-shall-not-be-considered-valid-and-proper.~~ a physician providing services for which fees are relinquished to the hospital.

~~(c)--All-claims-submitted-to-the-Montana-medicaid-program-for-hospital-based--physician-services-shall-be-submitted-on-a-state-approved-claim-form--with-the-signature-of-the-physician-providing-the-service,-except-for-the-following-claims:~~

(e) Electronic media claims may be submitted by a provider who enters into an agreement with the department for this purpose and who meets the department's requirements for documentation, record retention and signature requirements.

Subsections (1)(c)(i) through (7)(b) remain the same in text. Subsections (1)(c)(i) through (1)(c)(iii) will be recategorized as (1)(e)(i) through (1)(e)(iii).

AUTH: Sec. 53-2-201 and 53-6-113 MCA
IMP: Sec. 53-6-101, 53-6-111 and 53-6-141 MCA

3. Four modifications are proposed in these amendments. First, the amendments are necessary to allow electronic media claims (EMC) submission. In 1985, the Department installed a certified Medicaid Management Information System (MMIS) to process provider claims for reimbursement. Included in the design of the MMIS was a requirement that the system accept electronic media claims (EMC). These amendments will define the administrative framework and implement the full MMIS capabilities.

Second, the amendments allow providers previously required to personally sign claim forms to grant written authority to their staff to sign claims on their behalf. The department retains the right to obtain the provider's personal signature as needed.

Third, the amendments implement the advice of the Federal System Performance Review Coordinator and delete the requirement that a sample of each authorized signature for claims be submitted by providers. There are now a very large number of providers and an increasingly burdensome workload to maintain updated signatures on file. This change would alleviate the burden on providers to submit all signatures and on

the Department to maintain this volume of original signatures. The Department will retain the right to obtain documentation of the authorization.

Fourth, the amendments allow hospitals to sign claims and utilize a single physician provider number for services provided by physicians. Many hospitals contract for or employ emergency room and professional component services. The Department currently requires all physicians who perform such services to enroll in the Medicaid program and sign personally for services performed in the hospital setting. The proposal would eliminate the need for hospitals to maintain large numbers of physician identification numbers and obtain the signatures.

No financial impacts are estimated from these changes.

Copies of this notice are available at local human services offices or county welfare departments.

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, 1987.

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 4, 1987.

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

In the matter of the amendment of Rules 46.12.302, 46.12.590, 46.12.591, 46.12.592 and 46.12.599 pertaining to inpatient psychiatric services	)))))	NOTICE OF PUBLIC HEARING ON THE PROPOSED AMENDMENT OF RULES 46.12.302, 46.12.590, 46.12.591, 46.12.592 AND 46.12.599 PERTAINING TO INPATIENT PSYCHIATRIC SERVICES

TO: All Interested Persons

1. On June 9, 1987, at 9:00 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 proposed amendment of Rules 46.12.302, 46.12.590, 46.12.591, 46.12.592 and 46.12.599 pertaining to inpatient psychiatric services.

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

46.12.302 CONTRACTS Subsections (1) through (1)(c) remain the same.

(2) Providers, whose services are covered by the Title XVIII program (medicare), shall meet the certification standards of medicare~~.~~ except as provided otherwise in these rules.

Subsections (3) through (4) remain the same.

AUTH: Sec. 53-2-201 and 53-6-113 MCA
IMP: Sec. 53-6-101, 53-6-111 and 53-6-141 MCA

46.12.590 INPATIENT PSYCHIATRIC SERVICES, PURPOSE AND DEFINITIONS Subsections (1) through (2) remain the same.

(a) "Inpatient psychiatric services" means services that are provided in accordance with Title 42 CFR, part 447, subpart A and sections 447.300 through 447.304 and section 447.325 which provide definitions and ~~service~~ program requirements and which are federal regulations which the department hereby adopts and incorporates by reference. A copy of the cited regulations may be obtained through the Department of Social and Rehabilitation Services, P.O. Box 4210, 111 Sanders, Helena, MT 59604. Inpatient psychiatric services are services that meet those provisions and are provided in a hospital facility that is devoted to the provision of psychiatric services for persons under the age of 21.

(b) "Devoted to the provision of psychiatric services for persons under the age of 21" means a hospital facility whose goals, purpose and care are designed for and devoted exclusively to persons under the age of 21.

Subsections (2)(c) through (2)(j) remain the same.

AUTH: Sec. 53-6-113 MCA
IMP: Sec. 53-6-141 MCA

46.12.591 INPATIENT PSYCHIATRIC SERVICES, PARTICIPATION REQUIREMENTS (1) Providers of inpatient psychiatric services are eligible for reimbursement under the Montana medicaid program if they meet the following requirements:

(~~1~~a) maintain a current license as a hospital under the rules of the department of health and environmental sciences to provide inpatient psychiatric services;

(~~2~~b) maintain a current certification for Montana medicaid under the rules of the department of health and environmental sciences to provide inpatient psychiatric services;

Original subsections (3) through (6) remain the same in text but will be recategorized as (1)(c) through (1)(f).

(~~7~~g) be in compliance with:

(i) Title 42 CFR sections ~~405.1020~~ 482.1 through ~~405.1035, 405.1037 and 405.1038~~ 482.62 and meet the requirements of section 1861(f) of the Social Security Act.; or

(ii) be accredited by the joint commission on accreditation of hospitals (JCAH).

(A) These ~~are~~ federal regulations cited above in subsection (1)(g)(i) ~~defining~~ define requirements for psychiatric facilities which the department hereby adopts and incorporates herein by reference. A copy of the ~~above-cited~~ regulations cited above may be obtained through the Department of Social and Rehabilitation Services, P.O. Box 4210, 111 Sanders, Helena, MT 59604;

(~~8~~h) ~~be fully certified and participating~~ participate in ~~the Title XVIII~~ medicare ~~program, and~~ or reimburse the department an amount adequate to cover the increased administrative and audit functions normally performed by the medicare intermediary. These funds shall be deposited with the state either upon entering a provider agreement or at the beginning of the applicable state fiscal year, whichever is earlier. The amount of funds per facility shall not be less than twenty five thousand dollars ($25,000) per state fiscal year;

(~~9~~i) provide inpatient psychiatric services according to the service requirements for individuals under age 21 specified in Title 42 CFR, part 441, subpart D, which is a federal regulation which is herein incorporated ~~herein~~ by reference. ~~at ARM 46.12.590.~~ A copy of these regulations may be obtained through the Department of Social and Rehabilitation Services, P.O. Box 4120, 111 Sanders, Helena, MT 59604;

(j) indemnify the department in the event of a loss of federal financial participation.

AUTH: Sec. 53-6-113 MCA
IMP: Sec. 53-6-141 MCA

46.12.592 INPATIENT PSYCHIATRIC SERVICES, REIMBURSEMENT Subsections (1) through (2)(a) remain the same.

(b) Bad debt expense shall not be an allowable cost.

(3) Providers located within the state will be reimbursed on an interim basis during the provider's fiscal year. The interim rate will be a percentage of customary charges as determined by the ~~provider's medicare intermediary.~~ department.

Subsection (3)(a) remains the same.

(4) Reimbursement for services provided to medicaid patients by providers outside of the state will be limited to the ~~lower~~ lowest of:

(a) 60% of the provider's customary charge or, upon submission of adequate financial documentation reflecting the facility's costs and charges, a rate determined by the department in accordance with these rules;

(~~a~~b) the medicare percentage of customary charges; or

(~~b~~c) the medicaid ~~percentage of customary charges~~ rate established under the respective state's medicaid regulations.

Subsections (5) and (5)(a) remain the same.

(b) Ceilings established under this section will be applied to all full 12-month cost reporting periods that follow a base period as described in subsection (5)(a). ~~of this section.~~

Subsections (5)(c) through (8)(b) remain the same.

AUTH: Sec. 53-6-113 MCA
IMP: Sec. 53-6-141 MCA

46.12.599 INPATIENT PSYCHIATRIC SERVICES, UTILIZATION REVIEW AND CONTROL (1) Prior to admission and as frequently as the department may deem necessary, the department will evaluate the necessity and quality of services for each medicaid patient, in accordance with Title 42 CFR, sections 441.152, 441.153, 456.3, 456.22, ~~and~~ 456.150 through 456.245 and 456.600 through 456.614, which are federal regulations which set forth utilization review and control criteria and which the department hereby adopts and incorporates by reference. A copy of the cited regulations may be obtained through the Department of Social and Rehabilitation Services, P.O. Box 4210, 111 Sanders, Helena, MT 59604.

Subsection (1)(a) remains the same.

AUTH: Sec. 53-6-113 MCA
IMP: Sec. 53-6-141 MCA

3. The Department implemented administrative rules on May 31, 1985, to provide program requirements for participation in and reimbursement for inpatient psychiatric services for persons under 21 years of age. The U.S. Department of Health and Human Services amended the federal regulations in

order to implement the provisions of the Deficit Reduction Act of 1984. The regulatory changes have effectively provided increased flexibility to the State Medicaid agency in determining standards for participation in Medicaid.

The Department has determined that the amendment to the rule proposed herein will allow providers greater flexibility in demonstrating that their facility and program meets adequate standards for Medicaid participation. Providers will also be allowed to determine whether they wish to participate in Medicare. Those providers who do not participate in Medicare will be required to provide the State funds sufficient in amount to perform administrative and audit functions that the Medicare intermediary would normally perform. All providers must also indemnify the Department in the event of a loss of federal financial participation (FFP). For example, non-participation in Medicare could result in a loss of FFP in situations where the federal Health Care Financing Administration determines (pursuant to its look behind authority), that the provider's facility does not meet the appropriate standards for participation in Medicaid. Finally, 46.12.599 is being amended to clarify the utilization review requirements.

A modification is also proposed for facilities located outside of Montana. To overcome the difficulties the Department has encountered in the past in setting reimbursement rates the Department proposes to establish a minimum reimbursement rate. This rate will be applied when a provider fails to provide documentation necessary to calculate a rate in accordance with this rule.

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, 1987.

5. The Office of Legal Affairs, Department of Social and Rehabilitation Services has been designated to preside over and conduct the hearing.

Dave Lewis
Director, Social and Rehabilitation Services

Certified to the Secretary of State May 4, 1987.

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

In the matter of the amendment of Rule 46.12.504 pertaining to mandatory screening and authorization of inpatient hospital services	)))))	NOTICE OF PUBLIC HEARING ON THE PROPOSED AMENDMENT OF RULE 46.12.504 PERTAINING TO MANDATORY SCREENING AND AUTHORIZATION OF INPATIENT HOSPITAL SERVICES

TO: All Interested Persons

1. On June 9, 1987, 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 proposed amendment of Rule 46.12.504 pertaining to mandatory screening and authorization of inpatient hospital services.

2. The rule as proposed to be amended provides as follows:

46.12.504 INPATIENT HOSPITAL SERVICES, REQUIREMENTS

Subsections (1) through (3) remain the same.

(a) No medicaid payment will be made unless the following conditions are met:

(i) For persons eligible for or who have applied for medicaid benefits prior to hospitalization, the provider must obtain authorization for each admission and length of stay from the department or its designee for each admission prior to or during the hospitalization;

(ii) For admissions occurring on holidays and weekends, the provider shall obtain authorization within two working days.

(iii) This authorization is not a guarantee of payment as medicaid policies, client eligibility, or additional medical information on retrospective review may cause medicaid to refuse payment.

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

AUTH: Sec. 53-6-113 MCA
IMP: Sec. 53-6-141 MCA

3. Medicaid has had this screening process in place since March 1985, but it has not been mandatory. Screening and authorization of inpatient stays on a pre-admission or concurrent basis has proven effective for Medicaid. It is assumed that making this review mandatory for all Medicaid admissions will provide better utilization control of the cases which are currently not being impacted by this program. Mandatory screening and authorization will also enable the provider to know prior to performing a service whether admission and length of stay will be deemed medically necessary.

Potential budgetary impact will occur when providers fail to comply with this requirement. The financial impact is not estimated based on this scenario as providers substantially comply with the current requirement.

Copies of this rule notice are available at local human services and welfare offices.

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, 1987.

5. The Office of Legal Affairs, Department of Social and Rehabilitation Services has been designated to preside over and conduct the hearing.

Dave Lewis
Director, Social and Rehabilitation Services

Certified to the Secretary of State May 4, 1987.

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

In the matter of the amendment of Rules 46.12.204, 46.12.501, 46.12.502, 46.12.515, 46.12.541, 46.12.602, 46.12.605, 46.12.702, 46.12.703, 46.12.902, 46.12.905 and 46.12.912 pertaining to Medicaid Optional Services and co-payments	)))))))))))	NOTICE OF PUBLIC HEARING ON THE PROPOSED AMENDMENT OF RULES 46.12.204, 46.12.501, 46.12.502, 46.12.515, 46.12.541, 46.12.602, 46.12.605, 46.12.702, 46.12.703, 46.12.902, 46.12.905 AND 46.12.912 PERTAINING TO MEDICAID OPTIONAL SERVICES AND CO-PAYMENTS

TO: All Interested Persons

1. On June 5, 1987, 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 proposed amendment of rules as listed above pertaining to Medicaid Optional Services.

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

46.12.204 RECIPIENT REQUIREMENTS, CO-PAYMENTS

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

~~(g)--hearing-aids,-$.50-per-service;~~

Subsections (1)(h) through (1)(n) remain the same in text but will be recategorized as (1)(g) through (1)(m).

(~~e~~n) outpatient drugs, ~~the--amount--specified--in--ARM 46.12.703;~~ $1.00 per prescription;

Subsections (1)(p) and (1)(q) remain the same in text but will be recategorized as (1)(o) and (1)(p).

~~(r)--eyeglasses,-$1.00-per-service;~~

(~~s~~q) physician's services, $1.00 per service; and

(~~t~~r) licensed clinical social workers' services, $.50 per service.

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

AUTH: Sec. 53-2-201 and 53-6-113 MCA
IMP: Sec. 53-6-141 MCA

46.12.501 SERVICES PROVIDED Subsections (1) through (1)(e) remain the same.

(f) physician's services, except for eyeglasses and those services required for the dispensing of eyeglasses;

(g) podiatry services;

(h) outpatient physical therapy services;

(i) speech therapy, and audiology ~~and hearing aids~~;

Subsections (1)(j) through (1)(o) remain the same.

(p) dental services, except for dentures and those services required for the provision of dentures;

(q) outpatient drugs;
(r) prosthetic devices and medical supplies;
(s) ~~eyeglasses--and~~ optometric services~~;~~, except for eyeglasses and those services required for the dispensing of eyeglasses;
(t) transportation and per diem;
(u) ambulance services;
(v) specialized non-emergency transportation;
(~~u~~w) family planning services;
(~~v~~x) psychological services;
(~~w~~y) licensed clinical social workers' services~~;~~;
(z) inpatient psychiatric services; and
(aa) home and community services.
Subsection (2) remains the same.

AUTH: Sec. 53-6-113 MCA
IMP: Sec. 53-6-103 and 53-6-141 MCA

46.12.502 SERVICES NOT PROVIDED BY THE MEDICAID PROGRAM Subsection (1) remains the same.

(2) The following medical and nonmedical services are explicitly excluded from the Montana medicaid program except for those services covered under the health care facility licensure rules of the Montana department of health and environmental sciences when provided as part of a prescribed regimen of care to an inpatient of a licensed health care facility, except as allowed under the early periodic screening, diagnosis and treatment rule at ARM 46.12.515, and except for those services specifically available, as listed in ARM 46.12.1404, to persons eligible for home and community-based services:

(a) hearing aids;
(b) eyeglasses and those services required for the dispensing of eyeglasses;
(c) dentures and those services required for the provision of dentures;

Subsections (2)(a) through (3)(d) remain the same in text. However, subsections (2)(a) through (2)(n) will be recategorized as (2)(d) through (2)(q).

AUTH: Sec. 53-2-201, 53-6-113 and 53-6-402 MCA
IMP: Sec. 53-2-201, 53-6-103, 53-6-141 and 53-6-402 MCA

46.12.515 EARLY PERIODIC SCREENING DIAGNOSIS AND TREATMENT, REQUIREMENTS Subsections (1) through (4) remain the same.

(a) ~~diagnosis and treatment for defects in vision and hearing, including eyeglasses and hearing aids;~~ optometric services including eyeglasses;

(b) dental ~~care needed for relief of pain and infections, restoration of teeth and maintenance of dental health;~~ services including dentures;

(c) appropriate immunizations~~.~~;

(d) hearing aids;

(e) eyeglasses and those services required for the dispensing of eyeglasses when provided by a physician.

AUTH: Sec. 53-6-113, MCA
IMP: Sec. 53-6-101 MCA

46.12.541 HEARING AID SERVICES, REQUIREMENTS (1) These requirements are in addition to those contained in ARM 46.12.301 through 46.12.308.

(2) Hearing aid services are available only to EPSDT-referred recipents.

Original subsections (1) through (7) remain the same in text but will be renumbered (3) through (9).

AUTH: Sec. 53-6-113 MCA
IMP: Sec. 53-6-101 and 53-6-141 MCA

46.12.602 DENTAL SERVICES, REQUIREMENTS (1) These requirements are in addition to those contained in ARM 46.12.301 through 46.12.308.

Original subsections (1) through (3)(g) remain the same in text but will be renumbered as (2) through (4)(g).

(h) pulpotomys~~.~~ - when authorized.

Original subsections (4) through (5)(e) remain the same in text but will be renumbered as (5) through (6)(e).

(6~~7~~) All full dentures must be prior authorized by the designated review organization. Requests for full dentures must show the approximate date of the most recent extractions, and/or the age of the present dentures. Dentures less than ten years old must be considered for relining or jumping. Tissue conditioners are considered a part of treatment. The following full denture services are ~~benefits of the medicaid program when~~ available only to EPSDT-referred recipients and must be provided by a dentist or prescribed by a dentist and provided by a licensed denturist.

Subsections (6)(a) through (6)(j) remain the same in text but will be recategorized as (7)(a) through (7)(j).

(7~~8~~) The following partial denture services are ~~benefits of the medicaid program when~~ available only to EPSDT-referred recipients and must be provided by a dentist or prescribed by a dentist and provided by a licensed denturist; and all partial dentures must be prior authorized by the designated review organization:

Original subsections (7)(a) through (8) remain the same in text but will be recategorized as (8)(a) through (9).

(a) deep scaling and curettage up to four ~~quadrants~~, one hour sessions for disabled and up to two one hour sessions for non-disabled.

Original subsections (8)(b) through (9)(d)(i) remain the same in text but will be recategorized as (9)(b) through (10)(d)(i).

~~(ii)--Steele's--facing-type-bridges-will-be--allowed-when replacing-more-than-2-teeth;~~

Original subsections (9)(e) through (13) remain the same in text but will be recategorized as (10)(e) through (14).

AUTH: Sec. 53-6-113 MCA
IMP: Sec. 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--or--the--department's--fee schedule-found-in-this-rule;~~ (1) Dental services listed in this rule and marked with an asterisk are available only to EPSDT-referred recipients.

(2) The department will pay the lowest of the following for dental services: ~~which-are-also-covered-by-medicare:~~

(a) the provider's actual (submitted) charge for the service;

(b) the amount allowable for the same service under medicare; or

(c) the department's fee schedule contained in this rule.

(~~1~~3) Preventive and diagnostic services~~:~~ include:

Original subsections (1)(a) through (1)(r) remain the same in text but will be recategorized as (3)(a) through (3)(r).

(~~2~~4) Amalgam restorations~~:~~ include:

Original subsections (2)(a) through (2)(i) remain the same in text but will be recategorized as (4)(a) through (4)(i).

(~~3~~5) Silicates and fiberglass restorations ~~(per--surface):~~ include:

(a) silicate - 14.30~~;~~ per surface;

(b) compost resin (addent, dakor, adaptic, concise, prestige, etc.) - 25.34~~;~~ per surface;

(c) composite fillings for posterior teeth will be paid at the rate of a similar amalgam restoration except for buccal surfaces.

(~~4~~6) Additional operative procedures~~:~~ include:

(a) acrylic jacket, immediate treatment for fractured anterior - 28.60;

(b) treatment filling (emergency) - 7.15;

(c) recement inlay - 7.15;

(d) pulpotomy including pulp capping - ~~need--authorization~~ when authorized - 25.34;

(e) No extra fee for pulp capping or bases.

(~~5~~7) Crowns and bridge~~s~~ include:

Original subsections (5)(a) through (5)(g) remain the same in text but will be recategorized as (7)(a) through (7)(g).

(~~6~~8) Pedodontics~~,~~ include spacers, certain crowns~~,--etc.~~ and amalgam restorations which are paid the same as permanent teeth~~.~~. The covered services are:

Original subsections (6)(a) through (6)(d) remain the same in text but will be recategorized as (8)(a) through (8)(d).

(e)* acrylic denture, without clasps, supplying 1 to 4 (flipper) - 71.50;

(f)* each additional tooth, permanent on acrylic denture (flipper) - 7.15;

(g) chrome wire clasps, adams, t or ball, each - 7.15;

(h) stainless steel band - 13.20.

(~~7~~9) Prosthodontics~~:~~ include:

(a)* complete maxillary denture, acrylic, plus necessary adjustment - 369.60 when provided by a dentist or 184.80 when provided by a denturist;

(b)* complete mandibular denture, acrylic, plus necessary adjustment - 369.60 when provided by a dentist or 184.80 when provided by a denturist;

(c)* acrylic upper or lower partial denture with cast chrome clasps and rests replacing at least 4 posterior teeth plus adjustments - 286.00 when provided by a dentist or 146.00 when provided by a denturist;

(d)* maxillary or mandibular cast chrome partial denture, acrylic saddles, 2 clasps and rests, replacing missing posterior teeth and one or more anterior teeth, plus adjustments - 357.50 when provided by a dentist or 178.75 when provided by a denturist.

(~~8~~10) Relines and repairs~~,~~ ~~etc.:~~ include:

(a)* cured resin reline, lower - 95.10 when provided by a dentist or 47.55 when provided by a denturist;

(b)* cured resin reline, upper - 95.10 when provided by a dentist or 47.55 when provided by a denturist;

(c)* broken denture repair, no teeth, metal involved - 42.24 when provided by a dentist or 21.12 when provided by a denturist;

(d)* denture adjustment - only where dentist or denturist did not make dentures - 8.58 when provided by a dentist or 4.29 when provided by a denturist;

(e)* replacing broken tooth on denture, first tooth - 26.40 when provided by a dentist or 13.20 when provided by a denturist;

(f)* each additional tooth after procedure (e) and (g) - 7.15 when provided by a dentist or 3.58 when provided by a denturist;

(g)* adding teeth to partial to replace extracted natural teeth, first tooth - 35.75 when provided by a dentist or 17.88 when provided by a denturist;

(h)* replacing clasp, new clasp - 50.05;

(i)* repairing (welding or soldering) palatal bars, lingual bars, metal connectors, etc. on chrome partials - 92.95 when provided by a dentist or 46.48 when provided by a denturist;

(j)* duplicate (jump) upper complete denture - 121.55~~.~~ when provided by a dentist or 60.78 when provided by a denturist;

(k)* lower jump or duplicate - 121.55 when provided by a dentist or 60.78 when provided by a denturist;

(l)* placing name on new, full or partial dentures - 11.00 when provided by a dentist or 5.50 when provided by a denturist.

(~~9~~11) Pontics: include:

(a) steele's facing type,

(i) per tooth up to 2 teeth - 107.25;

~~(ii) each additional tooth - 35.75;~~

(b) pontic - ceramic only, each tooth - 162.25;

(c) cured acrylic, laboratory processed, veneer, each tooth - 107.25;

(~~10~~12) Repairs: include:

(a) recement bridge - 14.30;

(b) recement crown - 7.15;

(c) porcelain facing - 28.60;

(d) replace broken steele's facing, post intact - 24.20;

(e) gold post - 60.50;

(f) steel post or dowel with amalgum buildup - 28.60;

(g) replace broken steele's facing, post broken - 35.75.

(~~11~~13) Oral surgery: includes:

Original subsections (11)(a) through (11)(r) remain the same in text but will be recategorized as (13)(a) through (13)(r).

(~~12~~14) Endodontics: include:

Original subsections (12)(a) through (12)(d) remain the same in text but will be recategorized as (14)(a) through (14)(d).

(~~13~~15) Anesthesia: includes:

(a) general anesthesia administered in office - 42.90;

(b) nitrous oxide - 4.40;

(c) oral premedication - 11.00;

(d) parenteral premedication - 42.90

(~~14~~16) Periodontal services: includes:

(a) periodontal prophylaxis per quadrant - 18.59;

(b) gingival resection - 35.75;

(~~15~~17) Dentist examining more than on 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~~18) Reimbursement - for orthodontia: includes:

Original subsections (16)(a) through (16)(m) remain the same in text but will be recategorized as (18)(a) through (18)(m).

AUTH: Sec. 53-6-113 MCA
IMP: Sec. 53-6-101 and 53-6-141 MCA

46.12.702 OUTPATIENT DRUGS, REQUIREMENTS (1) These requirements are in addition to those contained in ARM 46.12.301 through 46.12.308.

Original subsections (1) through (3) remain the same in text but will be renumbered as (2) through (4).

(45) Each prescription shall be dispensed in the quantity ordered by the physician, except that:

(a) Prescriptions for chronic conditions for which a physician has not ordered a specific quantity shall be dispensed in quantities of 100 dosages or a minimum of one month's supply of medication.

(b) Prescriptions for acute conditions for which a physician has not ordered a specific quantity shall be dispensed in sufficient quantities to cover the period of time for which the condition is being treated except for injectable antibiotics, which may be dispensed in sufficient quantities to cover a three day period.

(c) Notwithstanding the above, prescriptions for all conditions may not be dispensed in quantities greater than 100 dosages or a 34-day supply, whichever is greater.

Original subsections (5) through (5)(b) remain the same in text but will be recategorized as (6) through (6)(b).

AUTH: Sec. 53-6-113 MCA
IMP: Sec. 53-6-113, 53-6-101 and 53-6-141 MCA

46.12.703 OUTPATIENT DRUGS, REIMBURSEMENT Subsections (1) through (4) remain the same.

~~(5) Each recipient, unless eligible for exemption, must pay to the pharmacist 50¢ per prescription.~~

~~(6) The following recipients are exempt from the prescription co-payment:~~

~~(a) individuals under 21 years of age;~~

~~(b) pregnant women; and~~

~~(c) inpatients in a hospital, skilled nursing facility, intermediate care facility or other medical institution if such individual is required to spend for costs of medical care all but his personal needs allowance, as defined in ARM 46.12.4000.~~

~~(7) No co-payment will be imposed with respect to emergency prescriptions or family planning prescriptions.~~

AUTH: Sec. 53-6-113 MCA
IMP: Sec. 53-6-101, 53-6-113 and 53-6-141 MCA

46.12.902 OPTOMETRIC SERVICES, REQUIREMENTS

(1) Optometric services listed in ARM 46.12.905 and marked with an asterisk are available only to EPSDT-referred recipients.

Original subsections (1) through (3)(b) remain the same in text but will be renumbered (2) through (4)(b).

AUTH: Sec. 53-6-113 MCA
IMP: Sec. 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 or the department's fee schedule contained in this rule.~~ Optometric services listed in this rule and marked with an asterisk are available only to EPSDT-referred recipients.

(2) The department will pay the lowest of the following for optometric services: ~~which are also covered by medicare:~~

(a) the provider's actual (submitted) charge for the service;

(b) the amount allowable for the same service under medicare; or

(c) the department's fee schedule ~~contained~~ as specified in this rule.

(~~1~~3) The following procedures are included in ~~V~~visual ~~E~~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~~:~~ $28.13

(~~3~~4) The following procedures are included in ~~V~~visual ~~E~~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: $37.51

(45)* Measuring: services include the following:

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

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

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

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

(56)* Fitting: services include the following:

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

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

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

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

(67)* Hearing Aaid Bdispensing Sservices include the following:

(a)* Add to measuring and verifying services - $9.37

(b)* Add to fitting services - $9.37

(78)* Non-basic Bdiagnostic Sservices include the following:

(a) Visual examination, additional visits - $9.37

(b) Visual field, Peripheral field examination, using perimeter or equivalent, white fields - $9.37

(c) Visual fields, peripheral field examination using perimeter or equivalent, color fields - $13.12

(d) Visual fields, central field examination using tangent screen or equivalent

(i) white fields - $9.37

(ii) color fields - $13.12

(e) Screening, visual skills examination, using keystone tests or equivalent - $7.50

(f) Screening, multiple pattern visual fields, using harrington-flecks or equivalent - $5.62

(g) Screening, limited tests for completion of insurance, government or school forms - $7.50
(h) Color vision tests, using 20 isochromatic or equivalent - $3.75
(i) Tonometry, tension - $7.50
(j) Biomicroscopy - $7.50
(k) Special reports - $56.27 per hour
(l) Consultation (schools, government) - $56.27 per hour
(m) Office consultation - $7.50
(n) Out-of-office calls (add to other service)
(i) day-time - $9.37
(ii) night-time - $15.00
(o) Mileage charge (beyond 10 miles from office) - $.19 per mile
(p) Post cataract diagnostic examinaiton - $28.13
(q)* Cataract lens change or regrind - $18.76
(89)* Non-Basic Ophthalmic Lens Services include the following:
(a)* Non-Basic spherical and Sphero-Cylindric Powers (+ = + or - = +) for each 4 diopters of sphere over Basic Power up to 12.00D (not applicable to cataract lenses) - add, per pair $5.62
(b)* For each 2 diopters cylinder over basic power - add, per pair $5.62
(c)* Special base curve - add, per pair $3.75
(d)* Prism Power
(i)* total prism power less than 5 prism diopters - add, per pair $5.62
(ii)* total prism power 5 diopters or more - add, per pair $9.37
(e)* Lenticular grinding
(i)* concave - add, per pair $9.37
(ii)* convex - add, per pair $9.37
(f)* Slab-off grinding - add, per pair $9.37
(g)* Tinted or colored glass
(i)* single vision lenses - $3.75
(ii)* multifocal lenses - $3.75
(h)* Oversize, fused flat top multifocal segment, 35 & 45 mm wide - $3.75
(i)* Dual segment bifocal (to be added to bifocal value units) - add, per pair $18.76
(j)* Dual segment trifocal (to be added to trifocal value units) - add, per pair $18.76
(k)* High add fused bifocal, 3.00 - 4.00 diopters - add, per pair $3.75
(l)* High add fused bifocal, over - 4.00 - add, per pair $9.37
(m)* High add one-piece bifocal over 4.00 diopters - add, per pair $9.37
(n)* Plastic single vision lens - add, per pair $3.75
(o)* plastic multifocal lens - add, per pair $9.37
(p)* Coating, anti-reflection or color - add, per pair $3.75

(q)* Iseikonic lens - add, per pair $168.80
(r)* Safety Hhardening - add, per pair $3.75
(910)* Service ecode for metal frames - $7.50
(~~10~~11)* ~~Intact~~ Contact Llens Ttherapy. ~~These~~ services are to be performed at visits following the visual examination, and include the following:
(a) Contact lens diagnostic examination include biomicroscopy, corneal measurements, ocular adnexa measurements, control lens observations, and contact lens refraction - $18.76
(b)* Fitting Pprocedure, 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: $281.33
(c)* The following fees may be added to contact lens diagnostic examination or contact lens fitting procedure, basic spherical lens.
(i)* Fitting Pprocedures, Sspherical Pprism Bballast Llenses - $90.48
(ii)* Fitting Pprocedures, Llenticular and/or Aaphakic Llenses - $46.88
(iii)* Fitting Pprocedures, Ttoric Llenses - $93.78
(iv)* Fitting Pprocedures, Bbifocal Llenses - $187.55
(v)* Fitting Pprocedures, Kkeratoconus Llenses - $187.55
(vi)* Office ecall, observation and consultation - $9.37
(~~11~~12)* The following contact lense services are independent procedures:
(a)* Instruction visit for previous contact lens wearer;
(i)* fitted elsewhere - $28.13
(ii)* fitted in your office - $13.12
(b)* Fitting Pprocedure for previous contact lens wearer - $181.50
(c)* Duplication of new contact lenses - $70.32

(d)* Fitting procedure, monocular only - $181.50

(~~12~~13)* Contact lens laboratory adjustments

~~(a) This service applies~~ apply to new patients fitted elsewhere and ~~your~~ the provider's patients past customary servicing period~~. It includes~~ and include:

(a)* Edge-refinishing, size reducing, fenestrating, repolishing and bleeding - $9.37.

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

(~~13~~14)* Servicing, ~~and~~ repairs, and frame adjustments~~.~~ Apply to~~:~~ new patients fitted elsewhere and ~~your patients~~ the provider's past customary servicing period, and include the following:

(a)* Conventional frame (minor adjustments) - $3.75

(b)* Conventional frame (complete realignment) - $7.50

(c)* Iseikonic lenses $7.50

(d)* Low vision aid - $9.37

(e)* Special frame - $9.37

(f)* Hearing aid frame - $9.37

(~~14~~15)* Servicing, ~~and~~ repairs~~:~~ ~~Frame~~ and replacements ~~(standard frame)~~ of frames include the following:

(a)* Duplicate frame (~~1~~ 003 + 004 using single vision service units) - $16.87

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

(c)* Front replacement (~~1~~ 003 + 004 using single vision service units) - $14.06

(d)* Temple replacement, per temple (service per pair) - $5.08

(e)* Hinge repair - $5.62

(f)* Ptosis crutch - $18.76

(~~15~~16)* Minor servicing and repairs~~:~~ ~~Minor~~ of frames ~~Reports~~ include the following:

(a)* Replace screws - $1.87

(b)* Supply jumbo pads - $1.87

(c)* Supply temple covers - $1.87

(d)* Supply pad covers - $1.87

(e)* Supply hinge springs or tension washers - $3.75

(f)* Solder repair - $3.75

(g)* Rocking pads added to zyl or aluminum frame - $3.75

(h)* Rightening hinge to front or temple - $1.87

(i)* New top-rims - $3.75

(~~16~~17)* Servicing and repairs~~:~~ ~~Lens~~ of lenses include the following:

(a)* Neutralization of lenses for copy of prescription - $5.62

(b)* Lens replacment, one lens, single vision service - $11.25

(c)* Lens replacement, one lens, bifocal service - $15.00

(d)* Lens replacement, one lens, trifocal service - $18.76

(~~17~~18) Diagnostic ~~D~~drug ~~P~~procedures include the following:

(a) Cycloplegic examination/refraction, independent procedure - $46.88

(b) Supplemental mydiadic, add to fee for other procedures - $9.37

(c) Supplemental cycloplegic including post-cycloplegic office visit - $18.76

(d) Ophthalmoscopy, independent procedures, with mydriasis, direct and/or indirect - $18.76

(e) Ophthalmoscopy with contact fundus lens procedure, add to fee for other procedures - $13.10

(f) Gonioscopy, add to fee for other procedure - $15.00

(g) Gonioscopy, independent procedure - $26.26

(h) Tonography, independent procedure - $37.51

(i) Intra-ocular photography, independent procedure, anterior segment - $18.76

(j) Intra-ocular photography, independent procedure, posterior segment - $37.51

(k) Supplemental differential diagnostic procedures using topical pharmaceuticals, add to fee for other procedures - $13.12

(l) Ophthalmoscopy with contact fundus lens procedure, independent procedure - $26.26

(m) Ophthalmodynamometry, supplemental procedure, add to fee for other procedures - $11.25

(n) Ophthalmodynamometry, independent procedure - $17.05

(~~18~~19)* Visual training shall be reimbursed at the lowest of usual and customary charges, which are reasonable, the amount payable by medicare or $21.78 per hour.

AUTH: Sec. 53-6-113 MCA
IMP: Sec. 53-6-113 and 53-6-141 MCA

46.12.912 EYEGLASSES, REQUIREMENTS (1) Eyeglasses are available only to EPSDT-referred recipients.

(~~1~~2) Each EPSDT-referred recipient ~~21--years--old--or younger~~ is limited to one pair of eyeglasses per state fiscal year ~~and each recipient over 21 years old is limited to one pair of eyeglasses every two fiscal years~~ unless one of the following circumstances exists:

Original subsections (1)(a) through (3) remain the same in text but will be renumbered (2)(a) through (4).

AUTH: Sec. 53-6-113 MCA
IMP: Sec. 53-6-101 and Sec. 53-6-141 MCA

3. In appropriating funds for the Medicaid program, the 50th Legislature eliminated funding for eyeglasses, hearing aids and dentures and increased the co-payment on outpatient drugs from $.50 to $1.00 per prescription. The applicable program rules are being amended to reflect these legislative

decisions. The 50th Legislature also considered a number of cost containment measures, one of which was the imposition of a 34-day supply or 100 dosage maximum on prescription quantity. The Department is amending the applicable rule to include this latter cost containment measure. The reduction in general fund expenditure resulting from these changes is approximately one million dollars for the biennium. This will result in a loss of federal matching funds of approximately $2.4 million for the biennium. In addition, other technical amendments have been made to clarify the Department's current policies.

It should also be noted that the Department has recently published notice (MAR 46-2-497) of intent to eliminate many optional Medicaid services. The final outcome of that rule change will have an impact on this rule change.

Copies of this rule notice are available at local welfare and human services offices.

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, 1987.

5. The Office of Legal Affairs, Department of Social and Rehabilitation Services has been designated to preside over and conduct the hearing.

Dave Lewis

Director, Social and Rehabilitation Services

Certified to the Secretary of State May 4, 1987.

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

In the matter of the adoption of Rules I through III and the amendment of Rules 46.12.102, 46.12.1001, 46.12.1002 and 46.12.1005 pertaining to organ transplantations, transportation and per diem	)))))))	NOTICE OF PUBLIC HEARING ON THE PROPOSED ADOPTION OF RULES I THROUGH III AND THE AMENDMENT OF RULES 46.12.102, 46.12.1001, 46.12.1002 AND 46.12.1005 PERTAINING TO ORGAN TRANSPLANTATIONS, TRANSPORTATION AND PER DIEM

TO: All Interested Persons

1. On June 4, 1987, 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 proposed adoption of Rules I through III and the amendment of Rules 46.12.102, 46.12.1001, 46.12.1002 and 46.12.1005 pertaining to organ transplantations, transportation and per diem.

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

RULE I ORGAN TRANSPLANTATION, DEFINITIONS (1) "Organ transplantation" means the implantation of a living (viable) functioning human organ or organ system including bone marrow for the purpose of maintaining all or a major part of that organ function in the recipient.

(2) "Procedure" refers to an operation and those activities directly related to the transplantation. These activities include:

(a) evaluation of the patient as a potential transplant candidate;

(b) pre-transplant preparation;

(c) post surgical hospitalization;

(d) outpatient care, including Federal Drug Administration (FDA) approved medications deemed necessary for maintenance or because of resulting complications.

(3) "Heart transplant facility" means a medical facility which has received medicare certification as a heart transplant facility and participates in the Montana medicaid program.

AUTH: Sec. 53-6-113 MCA
IMP: Sec. 53-6-101 and 53-6-141 MCA

RULE II ORGAN TRANSPLANTATION, REQUIREMENTS (1) These requirements are in addition to those contained in ARM 46.12.301 through 46.12.308.

(a) The transplantation must be determined to be medically necessary by the attending physician and the transplant physician.

(b) Prior authorization for out-of-state referral to a transplant center must be obtained from the department or its designated review organization.

(c) The patient selection criteria set forth by the department's designated review organization and the criteria specified in subsections (2) and (3) of this rule must be met.

(2) For coverage of various types of organ transplantations, including bone marrow, liver, kidney/renal, pancreas and neurovascular, the department hereby adopts and incorporates by reference the following sections of the health insurance manual 10 published by the health care financing administration of the United States department of health services. A copy of the cited sections of the health insurance manual 10 may be obtained from the Department of Social and Rehabilitation Services, Economic Assistance Division, 111 Sanders, Helena, Montana 59604.

(a) Section 35-30, as amended through June 1985, defining coverage of allogenic bone marrow transplantation and non-coverage of autologous bone marrow transplantation.

(b) Section 35-53, as amended through July 1984, defining coverage of liver transplantation with respect to children under the age of 18 years.

(c) Section 35-58, as amended through April 1983, defining thoracic duct drainage (TDD) as a covered service when furnished to a kidney transplant recipient or individual approved to receive a transplant.

(d) Section 50-23, as amended through June 1981, defining safe and effective use of histocompatibility testing procedures.

(e) Section 50-26, as amended through July 1981, defining dental exam as part of a comprehensive workup prior to a renal transplant surgery.

(f) Section 45-22, as amended through February 1982, defining FDA approval and use of lymphocyte immune globulin preparations.

(g) Section 35-82, as amended through May 1985, defining non-coverage of pancreas transplantation.

(h) Section 35-50, as amended through June 1984, defining non-coverage of the medical procedure cochleostomy with neurovascular transplant for treatment of meniere's disease.

(3) For coverage of heart transplants, the department hereby adopts and incorporates by reference the criteria published in volume 52, no. 65 of the federal register of Monday, April 6, 1987, at pages 10935 through 10951. The medicare limit of one year reimbursement for immunosuppressive drugs does not apply to this rule. A copy of pages 10935 through 10951 of the federal register dated April 6, 1987,

may be obtained from the Department of Social and Rehabilitation Services, Economic Assistance Division, 111 Sanders, Helena, Montana 59604.

AUTH: Sec. 53-6-113 MCA
IMP: Sec. 53-6-101, 53-6-131 and 53-6-141 MCA

RULE III ORGAN TRANSPLANTATION, REIMBURSEMENT

(1) Physician services in organ transplantation will be reimbursed as defined in ARM 46.12.2003.

(2) All hospital services for organ transplantation will be reimbursed as defined in ARM 46.12.509.

AUTH: Sec. 53-6-113 MCA
IMP: Sec. 53-6-101, 53-6-131 and 53-6-141 MCA

3. The rules as proposed to be amended provides as follows:

46.12.102 MEDICAL ASSISTANCE, DEFINITIONS Subsections (1) through (2)(e) remain the same.

(i) ~~Except for heart transplants,~~ eExperimental services or services which are generally regarded by the medical profession as unacceptable treatment will not be considered medically necessary for the purpose of the medical assistance program. ~~Heart transplants are included as a service until June 30, 1987, unless specifically extended by future legislation.~~

Subsections (2)(e)(i)(A) through (37) remain the same.

AUTH: Sec. 53-6-113 MCA
IMP: Sec. 53-6-101, 53-6-131 and 53-6-141 MCA

46.12.1001 TRANSPORTATION AND PER DIEM, DEFINITION

Subsections (1) through (2) remain the same.

~~(3) Transportation and per diem services are available for an attendant when the recipient's medical condition or age requires the services of an attendant.~~

~~(4) Transportation and per diem services are available for a donor when a recipient's treatment involves the medical services of a donor.~~

AUTH: Sec. 53-6-113 MCA
IMP: Sec. 53-6-101 and 53-6-141 MCA

46.12.1002 TRANSPORTATION AND PER DIEM, REQUIREMENTS

Subsections (1) through (3) remain the same.

(a) Reimbursement will be made to the common carrier or a third party chosen by the client.

Subsections (4) through (7) remain the same.

(a) This limit does not apply to transplantation candidates/recipients and attendants if their presence is determined to be medically necessary. Prior approval by the department is required.

(8) When a recipient requires an attendant in order to travel for necessary hospital care outside his own community, the attendant's per diem will be allowed up to an amount not to exceed the maximum of one return round trip to the site of hospitalization based on the lowest available fares.

(9) Reimbursement of transportation by pressurized aircraft is limited to transporting recipients whose physical health would be endangered if non-pressurized aircraft were used.

(~~8~~10) When a recipient dies enroute to or during treatment outside of his community, the cost of the recipient's transportation to the medical service is allowed. The cost of returning a deceased recipient is not allowed.

AUTH: Sec. 53-6-113 MCA
IMP: Sec. 53-6-101 and 53-6-141 MCA

46.12.1005 TRANSPORTATION AND PER DIEM, REIMBURSEMENT

~~(1)--The-department-will-pay-the-lower-of-the--following for-transportation-and-per-diem--not-also-covered-by-medicare; the-provider's--actual-(submitted)--charge-for--the-service-or the-department's-fee-schedule-contained-in-this-rule.~~

~~(2)--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) The department will pay the lowest of the following rates for transportation services:

(a) the provider's actual submitted charge;

(b) the amount allowable for the same service under medicare; or

(c) the specified fees for the following services:

(i) A0170 personal or non-commercial ground vehicle mileage ..... current rate for state employees

(ii) A0150 regularly scheduled, air ..... usual ~~&-customary~~ fee

(iii) A0110 regularly scheduled, ground, including taxis and limousine service ..... usual ~~&-customary~~ fee

(iv) A0221 pressurized air charter .....
$1.40 per statutory mile, round trip

(v) A0040 non-pressurized air charter .....
$1.22 per statutory mile, round trip

(2) After negotiation and approval by the department, the rates contained in subsection (1) of this rule may be

exceeded for organ transplant candidates/recipients, donors and attendants when necessary to provide transportation commensurate with clients' health needs.

(3) Per diem costs are reimbursed at actual expenses up to the following specified fees:

(a)	A0180	breakfast (12:01 a.m. to 10:00 a.m.) ..	$2.75
(b)	A0190	lunch (10:01 a.m. to 3:00 p.m.)	$3.30
(c)	A0200	dinner (3:01 p.m. to 12:00 a.m.)	$6.60
(d)	A0210	per diem, including lodging	$22.44

~~(3) Per diem costs are reimbursed at actual expenses up to the maximum rates contained in this rule.~~

~~(4) Reimbursement for non-regularly scheduled air transportation shall be $1.22 per statutory mile for the round trip except as allowed below.~~

~~(a) Reimbursement of transportation by pressurized aircraft is limited to transporting recipients whose physical health would be endangered if non-pressurized aircraft were used. Reimbursement shall be $1.40 per statutory mile for the round trip.~~

(5) The department's per diem fees in subsection (3) of this rule may be exceeded to meet per diem costs determined medically necessary to preserve the health condition of an organ candidate/recipient. Those per diem costs may be negotiated by the department to be reimbursed at the lowest of the following rates:

(i) the SSI monthly benefit standard;

(ii) the per diem rates contained in subsection (3) of this rule; or

(iii) the state employee out-of-state per diem rate other than high cost areas.

(6) Per diem for organ candidates/recipients, donors and attendants may be extended for pre-surgical and post-surgical care if determined medically necessary by the department.

AUTH: Sec. 53-6-113 MCA
IMP: Sec. 53-6-101 and 53-6-141 MCA

4. The proposed rules revise the Department's policies and procedures regarding organ transplantation. The Department has been covering kidney, liver and bone marrow transplants as outlined under Medicare guidelines. Heart transplants have been covered by the Department under state authority which was to terminate June 30. Because Medicare no longer considers heart transplants as experimental, Medicaid will not need to terminate its coverage of heart transplants. These proposed amendments for heart transplants will:

(1) allow maximum use of Medicare funding; (2) when applicable, establish reasonable rates of reimbursement; and (3) allow for flexible arrangements for transportation, housing and per diem.

The financial impact of this rule has been accounted for in current level appropriations and should not increase current expenditures related to organ transplants. Copies of this rule notice are available for public review at local county welfare and human services offices.

5. 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, 1987.

6. 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 4, 1987.

BEFORE THE DEPARTMENT OF AGRICULTURE
OF THE STATE OF MONTANA

In the matter of the adoption of emergency rules pertaining to the administration of the alfalfa leaf-cutting bee program	))))	NOTICE OF ADOPTION OF EMERGENCY RULES PERTAINING TO THE ADMINISTRATION OF THE ALFALFA LEAF-CUTTING BEE PROGRAM

TO: All Interested Persons:

1. On March 31, 1987 the Legislature enacted House Bill 815, generally revising the alfalfa leaf-cutting bee laws. The legislation included an immediate effective date. It is therefore imperative to establish rules immediately in order to meet the legislative mandate of implementing the revised program. During the past few months the alfalfa leaf-cutting bee program has suffered from the lack of revenue of certification fees due to the depressed agricultural economic climate. The revised statutes remedy some of the sources of problems the program is facing by easing the registration process and by making the regulations more workable. It is the belief of the department that by implementing these rules on an emergency basis that the department can begin to generate the necessary revenue needed to keep the bee lab and related program going. The rules also better establish a workable method of controlling parasites and pathogens. If these rules are not implemented on an emergency basis the alfalfa leaf-cutting bee industry may be in jeopardy suffering great losses due to a delay in the transfering of regulations from the old program to the new program. A delay of implementing these rules would create an impossible task of registration of certification of bees after the bees are put into use for the season. Without a timely registration or certification of the bees the industry exposes itself to the possibility of contamination of diseased bees due to the lack of an established program to identify and control infected bees. It is because the department has determined that the program must be up and running immediately in order to control potential diseases carried by these bees, that the department deems it necessary to adopt these rules on an emergency basis.

2. The text of the rules is as follows:

RULE I PURPOSE OF RULES (1) The purpose of these rules is to implement HB 815 enacted by the 1987 Montana Legislature (80-6-1101 MCA, et. seq.).

AUTH: 80-6-1103, MCA IMP: 80-6-1103, MCA

RULE II REGISTRATION PROCEDURES AND FEES (1) All persons who own, possess or control alfalfa leaf-cutting bees shall register their bees with the department of agriculture.

(2) All registration requests shall be made on forms provided by the department.

(3) The registration fee shall be transmitted with each registration request.

(4) Annual registration shall be from the date of adoption of these rules to June 1, 1987 and from November 1 to January 1 for each year thereafter.

(5) Any person owning or possessing bees that are not reregistered on or before June 1, 1987 and then January 1 of each year thereafter shall be considered to be unregistered and shall be subject to the late penalty imposed under Section 5 HB 815 of the 1987 Session.

(6) Any bees not reregistered after June 15, 1987 and April 1 thereafter may in addition to the late registration penalty be subject to penalties set forth in Section 80-6-1110, MCA.

(7) Each person who registers bees shall pay a registration fee of $50.00. Upon payment of the registration fee, the registrant shall send in one sample for laboratory analysis for pathogens and parasites. Additional laboratory services may be provided upon request based on appropriate fee schedules.

(8) Parasites and pathogens that the bees are to be especially examined for include:

(a) Parasites:

(i) Minute chalcid (Telrastichus megachi),

(ii) Sapya wasp (Sapyga pumila),

(iii) Canadian chalcid (Pteromalus venustus),

(iv) Imported chalcid (Monodontomerus obscurus).

(b) Pathogens which include alfalfa leaf-cutting bee chalkbrood (Ascospaera sp.).

AUTH: 80-6-1103, MCA IMP: Section 5 HB 815 1987 Session
80-6-1109, MCA 80-6-1109, MCA

RULE III MINIMUM STANDARD FOR LEAF-CUTTING BEES REGISTERED BY THE DEPARTMENT (1) Alfalfa leaf-cutting bees registered with the department and determined as containing parasite infestation levels above 25% or pathogen levels above 30% shall be designated as failing minimum standards. The bees shall be destroyed (under department supervision) within 30 days of the issuance of said designation. Equipment shall be placed under quarantine and properly sterilized within 30 days of said designation.

AUTH: 80-6-1103, MCA IMP: Section 5 HB 815 1987 Session
80-6-1103, MCA

RULE IV SAMPLING PROCEDURE FOR THE REGISTRATION OF BEES (1) The following procedure shall be used by beekeepers to sample bees registered with the department:

(a) All bees must be loose cell stage before samples can be taken.

(b) A two ounce sample shall be taken from each 20 pounds of bees. A sample size shall consist of at least eight ounces (8 oz.). Only one composite sample shall be required to register the bees. The sample shall be submitted in a sample container provided by the department.

(c) All samples shall be collected by the beekeeper using a random sampling procedure.

(2) All samples shall become the property of the department.

AUTH: 80-6-1103, MCA IMP: Section 5 HB 815 1987 Session

RULE V OFFICIAL CERTIFICATION PROCEDURES AND FEES (1) In addition to the required registration of bees, beekeepers may certify bees according to the following procedure:

(a) All requests for official certification shall be made on forms provided by the department of agriculture.

(b) All certification fees shall be transmitted within 10 days after the official sampling has been completed.

(c) Any person owning or possessing bees within Montana who desires to apply for certification shall do so on or before May 15, 1987 and arrange a date for sampling of said lot(s) of bees, thereafter all requests shall be made before April 1 in future years.

(d) A certification fee of .36 cents per pound will be assessed for all bees certified by the state. Each person requesting certification shall pay a laboratory fee of $35.00 per sample.

(e) The certification fee shall provide laboratory services for the determination of pathogens, parasites, percent of emergence, predators, nest destroyers, live larvae count, and sex ratio.

(2) The certification fee may provide for limited amount of field service work.

(3) All bees certified for year 1987 at the date of the adoption of these rules shall be treated as being properly certified under these rules and shall be assigned a certification standard.

AUTH: 80-6-1103, 80-6-1104, MCA
IMP: 80-6-1103, 80-6-1105, & 80-6-1109, MCA

RULE VI BEE SAMPLING PROCEDURE FOR THE CERTIFICATION OF BEES (1) The following procedure shall be used to sample bees under the bee certification program:

(a) All bees must be in loose cell stage before samples can be taken.

(b) A two ounce (2 oz.) sample shall be taken from each 20 pounds of bees owned or possessed by a beekeeper. An official sample size shall not consist of less than eight ounces (8 oz.). If the beekeeper owns or possesses more than 200 pounds, then the cocoon larvae will be divided into 200 pound lots and official samples shall be obtained from each lot. All official samples shall become the property of the department.

(c) Once the official sample has been obtained, the remaining composite sample shall be officially sealed and left in the possession of the owner/manager. The owner/manager has 30 days from date of receipt of certification to appeal the original laboratory test results.

(d) All samples shall be collected using a random sampling procedure, i.e., a uniform sample from the top, middle, and bottom within the bee storage containers.

(e) All official samples shall be obtained by department personnel in the presence of the owner/manager of the bees or the owner/manager under the direct supervision of the department.

(f) All official sample containers shall be sealed with a label showing lot number, data sampled, and signature of department employee.

(g) All official sample lot numbers must correspond with lot numbers attached to beekeeper storage containers.

(h) A grower whose total bees consist of less than 100 pounds may have an official sample consisting of a 2 ounce (2 oz.) sample drawn from each 20 pounds of bees; and from a composite sample an official sample of 4 ounces (4 oz.) may be drawn.

AUTH: 80-6-1103, MCA IMP: 80-6-1105, MCA

RULE VII MINIMUM STANDARD FOR LEAF-CUTTING BEES CERTIFIED BY THE DEPARTMENT (1) The following bee certification standards apply to the official sample analyzed at a designated laboratory.

(a) Unconditional certification: Alfalfa leaf-cutting bees that have been officially examined and analyzed and determined to contain less than 10% composite infestation by parasites and contain 0% infestation by designated pathogens, shall be eligible for unconditional certification for:

(i) possession within the state,

(ii) for sale within or without the state,

(iii) import into the state of Montana.

Zero percent means nondetected within the official sample.

(b) Restricted certification: Alfalfa leaf-cutting bees that are officially reported as containing composite parasite infestation levels of 10% to 25%, or composite pathogens infestation levels of more than 0% to 30% shall be designated as being restricted certification and,

(i) may be sold out-of-state,

(ii) shall not be imported, transferred, or distributed in the state without prior written approval of the department.

(2) Parasites and pathogens that bees are to specifically be examined for are:

(a) Parasites:

(i) Minute chalcid (Telrastichus megachi),

(ii) Sapyga wasp (Sapyga pumila),

(iii) Canadian chalcid (Pteromalus venustus),

(iv) Imported chalcid (Monodontomerus obscurus).

(b) Pathogens:
(i) Alfalfa leaf-cutting bee chalkbrood (Ascosphaera sp.).

AUTH: 80-6-1103, MCA IMP: 80-6-1103 & 80-6-1105, MCA

RULE VIII IMPORTED ALFALFA LEAF-CUTTING BEES - CERTIFICATION
(1) Alfalfa leaf-cutting bees imported from any state or foreign country must meet the standards for certification of alfalfa leaf-cutting bees set forth in these rules.
(2) Alfalfa leaf-cutting bees that do not meet the unconditional certification standards shall not be released for distribution or delivery within the state without written approval.
(3) The importer of the bees shall be notified by certified mail of the fact of noncertification, together with a notice that said bees must be removed from the state of Montana, at the importer's expense within 30 days, or the said bees will be destroyed.

AUTH: 80-6-1103, MCA IMP: 80-6-1103 and 80-6-1105, MCA

RULE IX SALES OF BEES (1) All sales of bees shall be reported to the department. These sales report shall contain the name, address, pounds sold and location of the new owners. These sales shall be reported to the department within 30 days of sale.

AUTH: 80-6-1103, MCA IMP: 80-6-1105, MCA

RULE X FEES ESTABILSHED FOR SERVICE SAMPLES (1) Laboratory analysis - $35.00 per sample which includes pathogens and parasites. Additional services and respective fees are:
(a) Larvae count/lb. - $10.00 per sample.
(b) Sex ratio and percent emergence - $15.00 per sample.
(c) Percent Emergence - $10.00 per sample.
(d) Field service - current Montana rates for mileage/per diem.

AUTH: 80-6-1103, MCA IMP: 80-6-1109, MCA

RULE XI DISEASE CONTROL - WILD TRAPPING PERMIT - FEE
(1) A person intending to engage in wild trapping shall apply to the department for a permit prior to commencing trapping activities.
(2) The application for a permit to trap wild bees shall contain: name, address, location of wild trapping activities, (1/4 section, township, range), number of bee boxes, and permission of property owners.
(3) The fee for wild trapping shall be set at $10.00 per laminated board.

(4) Only new laminated boards or laminated boards sterilized using approved department methods will be used for wild trapping.

(5) The person applying for a permit shall obtain the signature of the property owner on which the bees are to be wild trapped.

(6) Any person keeping bees or nesting materials on property other than their own, shall clearly mark the trapping materials with his or her correct name, mailing address, and phone number. The lettering shall not be less than 1 inch in size.

AUTH: 80-6-1103 & 80-6-1109, MCA IMP: 80-6-1108, MCA

3. The rationale for the proposed rules is set forth in the statement of reasons for emergency,

4. These rules are authorized under section 80-6-1103 and 80-6-1109, MCA. They implement sections 80-6-1103, 80-6-1105, 80-6-1108 Section 5 HB 815 1987 Legislative Session, and 80-6-1109, MCA. The emergency action is effective April 29, 1987.

W. Ralph Peck
Deputy Director

Certified to the Secretary of State April 29, 1987.

STATE OF MONTANA
DEPARTMENT OF COMMERCE
BEFORE THE BOARD OF HORSE RACING

In the matter of the emergency amendment of ARM 8.22.1804 pertaining to Twin Trifecta wagering) NOTICE OF EMERGENCY AMENDMENT OF ARM 8.22.1804 TWIN TRIFECTA

TO: All Interested Persons:

1. When ARM 8.22.1804 was adopted, the method of selecting a consolation pay-off was not described in a manner as to allow the existing parimutuel software to pay. The method of paying has to be consistent with the formula described in ARM 8.22.1803 (3) Pool Calculations under the rules of Trifecta wagering.

Failure to change the rule will cause a multitude of problems for the patron, Board of Horse Racing, and management and could possibly result in a number of lawsuits.

To insure that all parimutuel pay-offs are in consort with the existing rules and the existing software and to prevent minor public uprisings at the tracks around the state, it becomes necessary to amend ARM 8.22.1804.

2. ARM 8.22.1804 is amended as follows: (new matter underlined, deleted matter interlined)

"8.22.1804 TWIN TRIFECTA (1) through (9) will remain the same.

(10) If, in the first half of the twin trifecta only there is a failure to select, in the exact order, the first three horses, payoffs and exchanges shall be made on twin trifecta tickets selected in the following order of priority:

~~(a)--tickets-selecting-the-first-and-second-place-horses;~~
~~(b)--tickets-selecting-the-first-and-third-place-horses;~~
~~(c)--tickets-selecting-the-second-and-third-place-horses;~~
~~(d)--tickets-selecting-the-horse-that-finished-first;~~
~~(e)--tickets-selecting-the-horse-that-finished-second;~~
~~(f)--tickets-selecting-the-horse-that-finished-third.~~

~~In-the-event-that-there-are-no-tickets-satisfying-(a)-through (f),-the-twin-trifecta-shall-be-refunded.~~

(a) first, second, fourth;
(b) first, third, fourth;
(c) second, third, fourth;
(d) first, second, fifth;
(e) first, third, fifth;
(f) first, fourth, fifth; and
(g) sequentially thereafter.

(11) through (21) will remain the same."

Auth: 23-4-104, MCA Imp: 23-4-104, 202, 301, MCA

3. This emergency amendment is effective April 22, 1987.

BOARD OF HORSE RACING
HAROLD GERKE, CHAIRMAN

BY: Keith L. Colbo
KEITH L. COLBO, DIRECTOR
DEPARTMENT OF COMMERCE

Certified to the Secretary of State, April 22, 1987.

STATE OF MONTANA
DEPARTMENT OF COMMERCE
BEFORE THE BOARD OF REALTY REGULATION

In the matter of the amendment of 8.58.419 concerning suspension or revocation and violations	))))	NOTICE OF AMENDMENT OF 8.58.419 SUSPENSION OR REVOCATION - VIOLATION OF RULES - UNWORTHINESS OR INCOMPETENCY

TO: All Interested Persons:

1. On March 12, 1987, the Board of Realty Regulation published a notice of amendment of the above-stated rule at page 229, 1987 Montana Administrative Register, issue number 5.

2. The Board voted to adopt the amendment as proposed.

3. One comment was received from the Legislative Council stating that the authority section was in error. The Board concurred and the authority section has been changed from 37-1-103 to 37-51-203.

4. No other comments or testimony were received.

BOARD OF REALTY REGULATION
JOHN DUDIS, CHAIRMAN

BY: Geoffrey L. Brazier
GEOFFREY L. BRAZIER, ATTORNEY
DEPARTMENT OF COMMERCE

Certified to the Secretary of State, May 4, 1987.

STATE OF MONTANA
DEPARTMENT OF COMMERCE
BEFORE THE BUREAU OF WEIGHTS AND MEASURES

In the matter of the amendment of 8.77.101 concerning scale pit clearance	)))	NOTICE OF AMENDMENT OF 8. 77.101 SCALE PIT CLEARANCE

TO: All Interested Persons:

1. On February 26, 1987, the Bureau of Weights and Measures published a notice of public hearing on the amendment of the above-stated rule at page 196, 1987 Montana Administrative Register, issue number 4. The hearing was held on Wednesday, March 18, 1987, at 3:00 p.m., in the downstairs conference room of the Department of Commerce, 1424 9th Avenue, Helena, Montana.

2. The Bureau has amended the rule exactly as proposed.

3. At the public hearing three people registered as proponents, of which two gave oral testimony. Senator Ed Smith submitted a letter in support of the proposed change. Two people registered as being interested in the rule, but were neither proponents nor opponents to the proposed amendment. Seven persons registered as opponents to the proposed amendment, of which two gave oral testimony. One of the persons who gave oral testimony also submitted a letter reaffirming his position, prior to March 26, 1987, the date on which the Bureau closed the hearing record.

4. The Bureau has thoroughly considered all comments received on the proposed rule amendment. Following is a summary of the comments received from the public and the Bureau's responses:

COMMENTS IN FAVOR: That the science and technology of weighing large bulk, heavy material has changed. That the new technology utilizes electronic components and eliminates the use of beams and balances. Scale pits were necessary for the installation, use and maintenance of the beam and balance scales but are not required for the new electronic scales. The pit structure required for the beam and balance scales were expensive to build. This cost would be eliminated if the use of a pit was not mandated by the rule proposed to be changed. The electronic scales are accurate.

RESPONSE: Electronic scales are accurate and can serve the same purpose as a beam and balance scale if installed and maintained in strict accordance with the manufacturer's specifications. Since electronic scales do not require a pit for their installation and use, no useful purpose is served by requiring a pit when a user purchases an electronic scale.

COMMENTS IN OPPOSITION: That electronic scales are subject to dirt, mud, and other material and debris getting into the system. As a result, the electronic scale requires considerable maintenance. With the beam and balance system located in a pit, the mechanism was not nearly so susceptible to foreign materials getting in to the mechanism.

RESPONSE: The State cannot take the position that new technology cannot be used because of the amount of maintenance required to keep it operational. It should be the choice of the purchaser of a scale as to what considerations he utilizes in determining what kind of a scale he acquires. Under the amendment proposed a purchaser could buy a beam and balance scale and install it in a pit. Or, he could choose an electronic scale that does not require a pit but does require more maintenance. It is not reasonable to require him to install a pit if his scale doesn't require it.

5. No other comments or testimony were received.

BUREAU OF WEIGHTS AND MEASURES

BY: Geoffrey L. Brazier
GEOFFREY L. BRAZIER, ATTORNEY
DEPARTMENT OF COMMERCE

Certified to the Secretary of State, May 4, 1987.

BOARD OF PUBLIC EDUCATION
OF THE STATE OF MONTANA

In the matter of the repeal of ARM 10.55.405A, Gifted and Talented	)	NOTICE OF REPEAL OF ARM 10.55.405A, GIFTED AND TALENTED

TO: All Interested Persons

1. On February 13, 1987, the Board of Public Education published notice of the proposed repeal concerning Gifted and Talented on page 130 of the 1987 Montana Administrative Register, Issue Number 3.

2. The Board has repealed the rule as proposed.

3. At the public hearing which was held March 23, 1987, no persons testified as proponents and one person testified as an opponent. The opponent agreed that the Board must repeal the rule but was concerned about present gifted and talented programs in the public schools. One written comment was received prior to March 20, 1987, the date on which the Board closed the hearing record, requesting that implementation of the rule be delayed until funding becomes available. The Board felt the rule must be repealed until current legislation can be changed to enable the rule to be in compliance with state law.

In the matter of the adoption of Definitions, Correspondence, Extension and Inservice Credit, Reinstatement, Certificates	)	NOTICE OF AMENDMENT OF ARM 10.57.102, DEFINITIONS, ARM 10.57.207, CORRESPONDENCE, EXTENSION AND INSERVICE CREDIT, ARM 10.57.208, REINSTATEMENT, ARM 10.57.401, CLASS 1 PROFESSIONAL TEACHING CERTIFICATE, ARM 10.57.402, CLASS 2 STANDARD TEACHING CERTIFICATE, ARM 10.57.403, CLASS 3 ADMINISTRATIVE CERTIFICATE

TO: All Interested Persons

1. On February 13, 1987, the Board of Public Education published notice of proposed amendments concerning Definitions, Correspondence, Extension and Inservice Credit, Reinstatement, Class 1 Professional Teaching Certificate, Class 2 Standard Teaching Certificate and Class 3 Administrative Certificate on page 130 of the 1987 Montana Administrative Register, Issue Number 3.

2. The Board has amended the rules as proposed with the following change:

10.57.102 DEFINITIONS (1) through (15) (a)(ii) remain the same.

(iii) ~~Professional conferences that include as part of their agenda a business meeting.~~ The business meeting portion of professional conferences.

(15)(b) through (21) remain the same.

3. At the public hearing which was held March 23, 1987, three persons testified as proponents and no persons testified as opponents. No written comments were received prior to March 20, 1987, the date on which the Board closed the hearing record.

Alan Nicholson, Chairman
Board of Public Education

BY: Claudette Morton

Certified to the Secretary of State May 4, 1987.

VOLUME NO. 42 OPINION NO. 14

COUNTIES - County treasurer as custodian of irrigation district revenues;
COUNTY OFFICERS AND EMPLOYEES - County treasurer as custodian of irrigation district revenues;
PROPERTY, REAL - Assessment and payment of irrigation district taxes;
TAXATION AND REVENUE - Assessment and payment of irrigation district taxes;
MONTANA CODE ANNOTATED - Sections 15-16-104, 85-7-1501, 85-7-1702, 85-7-1902, 85-7-2012, 85-7-2101, 85-7-2104, 85-7-2133, 85-7-2136, 85-7-2151, 85-7-2155, 85-7-2157 to 85-7-2159, 85-7-2163;
OPINIONS OF THE ATTORNEY GENERAL - 40 Op. Att'y Gen. No. 45 (1984).

HELD: 1. The board of commissioners of an irrigation district may not, even with the consent of all water users within the district, bypass the annual tax levy procedure in section 85-7-2104, MCA, and directly assess those water users' lands for amounts otherwise subject to levy under such provision.

2. The county treasurer may issue receipts of payment for those amounts levied under section 85-7-2104, MCA, but remitted directly to the board of commissioners of an irrigation district upon appropriate certification by the district of such payments. However, the practice of direct payments to the commissioners must terminate, and all unexpended monies so received must be remitted to the county treasurer for deposit and supervision.

21 April 1987

John T. Flynn
Broadwater County Attorney
Broadwater County Courthouse
Townsend MT 59644

Dear Mr. Flynn:

You have requested my opinion concerning the following questions:

1. May the board of commissioners of an irrigation district, with the consent of all water users within the district, opt to apportion the amounts authorized by section 85-7-2104, MCA, to be collected through an annual tax levy and directly bill the water users for their apportioned amounts in lieu of the tax levy and thereafter pay the expenses and obligations of the district themselves rather than directing the county treasurer to make such payments?

2. If water users within an irrigation district tender annual taxes levied under section 85-7-2104, MCA, directly to the board of commissioners of an irrigation district and not to the county treasurer, may the county treasurer issue a receipt of payment for such taxes upon verification from the irrigation district that the taxes have been paid?

I conclude that the tax assessment provisions in section 85-7-2104, MCA, are mandatory in nature and that an irrigation district board of commissioners is not authorized to substitute the direct payment system suggested in your first question for the statutory procedure. With reference to your second question, I conclude that the county treasurer may issue receipts for tax payments made directly to the board of commissioners although the practice of such payments should cease.

Irrigation districts have long been recognized as constituting "public corporations ... with such powers and authority as may be found in the law." State ex rel. Blenkner v. Stillwater County, 104 Mont. 387, 392, 66 P.2d 788, 791 (1937). Accord In re Gallatin Irrigation District, 48 Mont. 605, 609, 140 P. 92, 93 (1914). They are administered by elected boards of commissioners. See §§ 85-7-1051, 85-7-1702, 85-7-1902, MCA. A board's powers are broad and include the

authority to "require the prompt payment of all current and delinquent taxes and assessments and other financial obligations owing the district as a prerequisite to water service." § 85-7-1902(4), MCA. Revenue necessary for a district's operations is raised through the issuance of bonds, special taxes or assessments, and annual tax levies. §§ 85-7-2012, 85-7-2101, 85-7-2104, MCA. See Cosman v. Chestnut Valley Irrigation District, 74 Mont. 111, 117, 238 P. 879, 881 (1925).

The commissioners forward annually to the Department of Revenue a list of all district lands, together with the total amount of taxes or assessments against those lands. § 85-7-2136(1), MCA. The taxes or assessments are thereafter entered into the county treasurer's assessment book and collected in a manner similar to real property taxes. § 85-7-2136(1) and (2), MCA. Detailed provisions govern the sale of lands struck off to the county for delinquent district taxes or assessments and the landowner's right of redemption. §§ 85-7-2151, 85-7-2155, 85-7-2157, 85-7-2158, 85-7-2159, 85-7-2163, MCA.

The comprehensive procedures controlling the methods by which irrigation district revenue may be raised reflect a legislative determination that such procedures be exclusive; i.e., districts are not authorized to substitute alternative methods for those statutorily prescribed. The provisions in section 85-7-2104(1), MCA, are thus mandatory in nature, requiring the commissioners on or before the second Monday in July each year to "ascertain the total amount required to be raised in that year for the general administrative expenses of the district ... and the total amount to be raised that year for interest on and principal of the outstanding bonded or other indebtedness of the district" and to levy such amounts against the land within the district. While the commissioners are given substantial authority in administering the district's affairs, there is no basis upon which to conclude that they are vested with the power to circumvent these carefully structured statutory mechanisms for assessing and collecting monies essential to the district's maintenance. Consequently, your first question must be answered negatively.

Your second question presents the situation in which annual tax levies under section 85-7-2104, MCA, have

been remitted directly to the commissioners and not the county treasurer. Such a procedure is inconsistent with section 85-7-2133(2), MCA, which provides in part that "[t]he county treasurer of the county where the office of an irrigation district is located is the custodian of all funds belonging to the district." It is further inconsistent with the comprehensive statutory taxation and levying procedure described above and could well complicate determination of when delinquencies exist and subsequent proceedings to enforce tax liens against assessed lands. As to tax levies directly received by the commissioners, the county treasurer should be notified of the taxpayer's name, the description of the assessed property, the amount paid, the date of the payment's receipt and, if mailed, the date of the payment's mailing. The treasurer should then issue a receipt pursuant to section 15-16-104, MCA, indicating the amount of payment. See 40 Op. Att'y Gen. No. 45 at 180, 182-83 (1984). The commissioners should, of course, terminate the practice of directly accepting payments and notify district water users of their obligation to remit the payments to the county treasurer. Finally, I note that, because the county treasurer is the custodian of the irrigation district's funds, any unexpended monies directly received by the commissioners should be remitted to the treasurer for appropriate deposit and supervision.

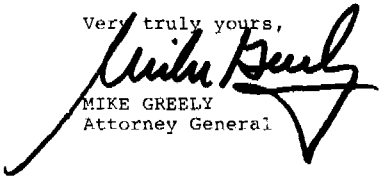
THEREFORE, IT IS MY OPINION:

1. The board of commissioners of an irrigation district may not, even with the consent of all water users within the district, bypass the annual tax levy procedure in section 85-7-2104, MCA, and directly assess those water users' lands for amounts otherwise subject to levy under such provision.

2. The county treasurer may issue receipts of payment for those amounts levied under section 85-7-2104, MCA, but remitted directly to the board of commissioners of an irrigation district upon appropriate certification by the district of such payments. However, the practice of direct payments to the

commissioners must terminate, and all unexpended monies so received must be remitted to the county treasurer for deposit and supervision.

Very truly yours,



MIKE GREELY
Attorney General

VOLUME NO. 42 OPINION NO. 15

CONSTABLES - Mileage reimbursement for;
COURTS - Mileage reimbursement for constables who serve legal process;
PUBLIC OFFICERS - Mileage reimbursement for constables;
MONTANA CODE ANNOTATED - Title 3, chapter 10, part 7; sections 2-18-503, 3-10-701, 3-10-703, 7-32-2143, 25-3-203, 25-31-408.

HELD: 1. Parties involved in civil litigation in justice court who desire to have legal process served by a constable should prepay the cost of service based upon the estimated roundtrip mileage involved and the mileage reimbursement rate established in section 2-18-503, MCA.

2. A constable should be reimbursed for travel only upon the amount of miles actually traveled at the legally established rate.

3. Any difference between the amount paid by the parties to litigation for service of process by a constable and the amount which the constable is reimbursed accrues to the benefit of the local governing body providing the service.

24 April 1987

Robert L. Deschamps, III
Missoula County Attorney
Missoula County Courthouse
Missoula MT 59802

Dear Mr. Deschamps:

You have recently requested my opinion on the following question:

> What are the mileage fees, if any, which constables may charge for the service of civil papers from justice and small claims courts?

It is first necessary to make a distinction between mileage reimbursement to constables in the performance of their duties and the mileage costs assessed to a party in a civil proceeding for whom process is being served. In other words, one issue is how much the constable should be reimbursed for mileage, and the other issue is how much a party to a civil proceeding should be charged for mileage costs. The answers to these separate questions are different based on existing Montana law.

I will first address the issue of mileage reimbursement for constables. Title 3, chapter 10, part 7, MCA, establishes the public office of constable and delineates the duties of the officeholder. Section 3-10-701, MCA, states:

> Constables must attend the courts of justices of the peace within their counties whenever so required and execute, serve, and return all process and notices directed or delivered to them by a justice of the peace or by any competent authority of such county.

Section 3-10-703, MCA, provides that the salary for the office of constable is established annually by the board of county commissioners, and further states:

> Constables shall receive mileage, at the rate provided by law, when performing their official duties.

Section 2-18-503, MCA, provides the method of determining mileage rate reimbursement for all public employees in Montana. The basic reimbursement rate for the use of a private automobile is "the mileage rate allowed by the United States internal revenue service for the preceding year." § 2-18-503(3), MCA. The law also limits reimbursement to "mileage for the distance actually traveled by automobile and no more unless otherwise specifically provided by law." § 2-18-503(1), MCA.

That reimbursement is limited to miles actually traveled is reiterated in former section 25-216, R.C.M. 1947 (now codified as section 7-32-2143(3)(b), MCA):

> When any sheriff or constable serves more than one process in the same cause, not requiring more than one journey from his office, he shall receive mileage only for the more distant service, and no mileage in any case may be allowed for less than 1 mile actually traveled.

The case of State ex rel. Wynne v. Examining and Trial Board of Police Department of City of Butte, 43 Mont. 389, 117 P. 77 (1911), is also instructive. In that case, the police chief of Butte submitted a travel claim for roundtrip travel to Great Falls for the stated purpose of returning two prisoners. In fact, the sheriff had not made the trip and one of his deputies, who happened to be in Great Falls on personal business, had returned the prisoners. The sheriff paid his deputy $13 out of his own funds, and then submitted a claim for $68.80 to the county.

The Montana Supreme Court expressed its disapproval of this practice in the strongest possible terms:

> The statute is plain. There are no perquisites, as such, attached to the performance of official duty in Montana. Our laws contemplate that officers shall be paid for actual service. The statute expressly declares that a sheriff, constable, or other peace officer, traveling in the discharge of his duties, shall charge only for each mile actually and necessarily traveled. Rev. Codes, § 3137. [Emphasis in original.]

Examining and Trial Board, supra, at 80.

Based on the foregoing citations, it is my opinion that a constable in the performance of public duties, which includes the serving of legal process in criminal and civil proceedings, is entitled to reimbursement for actual miles traveled by automobile according to the reimbursement rate established in section 2-18-503, MCA.

The second issue is the amount of mileage costs, if any, which should be charged to a party in a civil proceeding who desires to have legal process served by a constable. Section 25-3-203, MCA, provides:

> In no case shall the officer receiving papers for service be required to serve the same unless the person in whose behalf the service is made or his agent or attorney first pay the cost of the service upon a demand therefor by the officer.

This section is applicable to justice courts according to section 25-31-408(2), MCA. Unfortunately, the statute does not specify what constitutes "cost of service." However, common practice and usage in Montana has always been to pay for the mileage of the process server. It is my opinion that the reimbursement rate established in section 2-18-503, MCA, should be used in calculating the "cost of service" together with an estimate of the number of miles required for roundtrip travel from the justice court.

A complicating factor is that mileage reimbursement is necessarily paid prior to service of the process. Mileage is based upon an estimate and does not assume any operating efficiencies, such as being able to serve two or more legal processes in one trip. It would be very difficult to foresee such possibilities, however. Consequently, if there are actual operating efficiencies in the service of legal process they should accrue to the benefit of the governmental entity providing the service.

THEREFORE, IT IS MY OPINION:

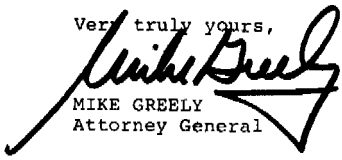
1. Parties involved in civil litigation in justice court who desire to have legal process served by a constable should prepay the cost of service based upon the estimated roundtrip mileage involved and the mileage reimbursement rate established in section 2-18-503, MCA.

2. A constable should be reimbursed for travel only upon the amount of miles actually traveled at the legally established rate.

3. Any difference between the amount paid by the parties to litigation for service of process by a constable and the amount which the

constable is reimbursed accrues to the benefit of the local governing body providing the service.

Very truly yours,



MIKE GREELY
Attorney General

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

IN THE MATTER of the Montana Power Company's Motion for a Declaratory Rule that Sale/Leaseback Arrangements Do Not Constitute Security, or in the Alternative, an Application for Approval of a Lease Between the Montana Power Company and Beneficial Finance Corporation.)	DECLARATORY RULING

Background

1. On or about April 2, 1986, the Montana Power Company (MPC) filed a Motion for a Declaratory Ruling that Sale/Leaseback Arrangements Do Not Constitute Security, or in the Alternative, an Application for Approval of a Lease Between the Montana Power Company and Beneficial Finance Corporation (Beneficial).

2. MPC was contemplating a leveraged lease of a new computer center building. MPC paid for the construction of the building and was considering a sale and leaseback of it. The lease with Beneficial was to be a net lease, with an initial term of 20 years. The purchase of the new building would be accomplished through debt and equity investments, with notes issued as debt secured by the building itself and/or the lease payments. For the amount of $1.00 (one dollar) per year, MPC would lease all land and property rights upon which the building was located to Beneficial, for a period of twenty (20) years. MPC would have an option to purchase the building for fair market value at the end of the initial term, or to renew the lease for various additional terms at prevailing fair market rental value. MPC was required to represent that the useful life of the building would be at least twenty-five (25) years, with a residual value at the end of the initial term of at least 20 percent of total building cost. The proceeds of the sale to Beneficial would be used by MPC to pay down short-term debt incurred for construction of the building. The lease payments would be approximately $250,000 per year. However, the lease contemplated the possibility of adjustments to this amount, in order to preserve Beneficial's "After-tax Economic Return, After-tax Cash Flow and Ratio of After-tax Cash to Initial Investment," collectively described as "Net Return."

3. On April 21, 1986, at a regularly scheduled meeting, the Montana Public Service Commission (PSC) voted to approve the lease as a security, in the event that it was later determined to require such action. The question raised for purposes of a declaratory ruling, that is, whether or not such a lease constitutes security which must receive PSC approval under §69-3-501, MCA, was not resolved.

4. On October 7, 1986, the PSC voted to inform interested parties of the pending Motion for Declaratory Ruling, and to allow said parties an opportunity to comment on the issues

raised therein. Notice was sent to the following: Montana Power Company (MPC); Montana-Dakota Utilities Co.; Pacific Power & Light Co. (PP&L); Great Falls Gas Co.; and the Montana Consumer Counsel. Comments were received from MPC and PP&L.

Discussion, Analysis and Findings

5. Section 69-3-501, MCA, provides as follows:

> Regulation of issuance of securities and creation of liens by utilities. (1) Whenever a public utility furnishing electric or gas service in the state has revenue derived from sources in Montana which exceeds $5 million or 5% of its gross revenue, the utility's right to issue, assume, or guarantee securities and to create liens on its property in the state is subject to the regulation and supervision of the commission, as set forth in this part.
>
> (2) The public utility, when authorized by order of the commission and not otherwise, may issue stocks and stock certificates and may issue, assume, or guarantee other securities payable at periods of more than 12 months thereafter for the following purposes:
>
> (a) the acquisition of property;
>
> (b) the construction, completion, extension, or improvement of its facilities;
>
> (c) the improvement or maintenance of its service;
>
> (d) the discharge or lawful refunding of its obligations;
>
> (e) the reimbursement of money actually expended for said purposes from income or from other money; or
>
> (f) any other purpose approved by the commission.

6. The comments filed by both MPC and PP&L contend, for various reasons, that the type of transaction at issue in this proceeding does not constitute a security or a security issuance, assumption or guarantee, as found in §69-3-501, MCA. Both parties rely on technical application and construction of the language found in the statute.

7. In addition, both parties point out that this type of transaction is a frequent occurrence. In this regard, if the PSC finds that these transactions are subject to regulation and review under §69-3-501, MCA, then both parties argue that the PSC should adopt some type of exemption for "immaterial" transactions falling within this category.

8. In general terms, there are two different types of lease transactions. The first is described as an ordinary or operating lease. The second is usually referred to as a capital (or financing) lease. In certain important respects, the two are quite the same: for specific periodic payments, the lessor acquires the right, for a specified duration, to take possession of and to put to its own use certain property whose legal title remains with the lessee.

9. However, a capital lease is typically for the entire useful life of the property (or a substantial portion of it), and the total lease payments equal the lessor's cost, usually with a suitable return on investment. Finally, a capital lease is usually a net lease, wherein the lessee (not lessor) is responsible for such matters as maintenance, insurance, taxes, and other traditional "incidents of ownership." See Re Green Mountain Power Corporation, 76 PUR 4th 270 (Vt. PSC, 1986).

10. Generally, the lease agreement between MPC and Beneficial shares these features. The initial term of the lease is for 20 years. The lease may be renewed for up to five years. MPC is required to represent that the building will have a useful life of at least twenty-five (25) years. In addition, the annual lease payments, and thus, total lease payments, are adjustable to insure a particular "net return" to Beneficial from the transaction. Further, the lease is a "net lease," with MPC assuming responsibility for the majority of the "incidents of ownership." Finally, at the end of the initial term, MPC would have the option to purchase the building, apparently at a price not lower than 20 percent of the total cost.

11. The question, then, is whether or not this type of transaction is covered by the requirements of §69-3-501, MCA. That is, whether or not the legislature intended the PSC to have jurisdiction over this sort of transaction. The answer to this question necessarily involves a review of the language found in §69-3-501, MCA, in light of the broad purposes for its enactment.

12. The broad purposes behind legislation such as §69-3-501, MCA, are twofold. First, the regulation of securities in this manner helps to protect investors from overcapitalization. Second, and in addition, proper securities regulation also protects the interests of ratepayers in assuring continued service without interruption from utilities and in receiving that service at reasonable rates.

13. It is in this light that the phrase "...issue, assume, or guarantee other securities..." must be examined. With the broad, underlying purposes of §69-3-501, MCA, in mind, it is reasonable to conclude that this language encompasses not only standard debt investments, but also nontraditional forms of debt-type financing. A capital lease serves the same basic purpose as debt, and is essentially a form of financing. R.E. Brealey & S. Myers, Principles of Corporate Finance, 541-42 (1984); J. Mao, Corporate Financial Decisions,

465-66 (1976); VanHorne, Financial Management and Policy, 478 (6th ed.).[1]

14. Accordingly, the Commission believes that capital leases, such as the one in this proceeding, are covered by §69-3-501, MCA. However, the Commission also recognizes that §69-3-501, MCA, was intended to require regulation of financing transactions which have a significant impact upon the utility. The traditional forms of such financing transactions do not usually occur in insignificant amounts. The capital lease at issue in this proceeding involves assets of substantial value, but such leases are often used to finance relatively small "acquisitions." Individual proceedings to review such matters would be an inappropriate use of resources, and possibly contrary to the intent underlying §§69-3-501 et seq., MCA. To this end, the Commission believes that some type of "blanket approval" for these smaller transactions would be appropriate. It would appear that every year, and for each utility subject to §69-3-501, MCA, the Commission could issue an order "approving in advance" sale/lease transactions under a certain amount (to a cumulative total). The utilities subject to §69-3-501, MCA, are encouraged to work with the Commission staff to develop such guidelines.

15. The Commission finds and declares by law that capital leases, such as the one at issue in this proceeding, fall within the reach of §69-3-501, MCA. Consistent with this funding, Commission approval of such a transaction is required. The declaratory ruling requested by Montana Power in its Petition is denied.

APPROVED BY THE COMMISSION MAY 4, 1987.

---

1 Even the MPC Board of Directors referred to the subject lease as a "financing" transaction. See Application, Exhibit B, Resolution of the Board of Directors Approving the Transaction.

BY ORDER OF THE MONTANA PUBLIC SERVICE COMMISSION

CLYDE JARVIS, Chairman

JOHN B. DRISCOLL, Commissioner

HOWARD L. ELLIS, Commissioner

TOM MONAHAN, Commissioner

DANNY OBERG, Commissioner

ATTEST:
Ann Purcell
Acting Secretary

(SEAL)

NOTE: Any interested party may request the Commission to reconsider this decision. A motion to reconsider must be filed within ten (10) days. See ARM 38.2.4806.

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 bill repealing a rule, or directing an agency to adopt or amend a rule, or a Joint Resolution recommending that an agency adopt or amend 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 the 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

Definitions:

Administrative Rules of Montana (ARM) is a looseleaf 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 statutes 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 ARM topical index, volume 16. Update the rule by checking the accumulative table and the table of contents in the last Montana Administrative Register issued.

Statute Number and Department

2. Go to cross reference table at end of each title which list MCA section numbers and corresponding ARM rule numbers.

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, 1987. This table includes those rules adopted during the period March 31, 1987 through June 30, 1987 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, 1987, 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 1987 Montana Administrative Register.

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