MONTANA ADMINISTRATIVE REGISTER

1989 ISSUE NO. 12
JUNE 29, 1989
PAGES 800-898

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 The notice section contains state agencies' proposed new, amended or repealed rules, the rationale for the change, date and address of public hearing and where written comments may be submitted.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.

Page Number

TABLE OF CONTENTS

NOTICE SECTION

BEFORE THE TEACHERS' RETIREMENT BOARD
OF THE STATE OF MONTANA

In the matter of the adoption of new rules relating to laws adopted by the 51st legislature and amendment of Rules 2.44.402 2.44.506, 2.44.507, 2.44.514 and 2.44.515 for the purpose of crediting military service, payment of benefits at death, payment of child's benefit, bonuses as compensation and correcting errors on wages not reported relating to the Teachers' Retirement System	NOTICE OF PUBLIC HEARING ON PROPOSED NEW RULES, AND AMENDMENT OF RULES RELATING TO THE TEACHERS' RETIREMENT SYSTEM

TO: All Interested Persons.

1. On July 20, 1989, at 10 A.M. a public hearing will be held in the office of the Teachers' Retirement System, at 1500 Sixth Avenue, Helena, Montana, to consider the adoption of rules I, II, III, IV, V, VI and VII; and amendment of rules 2.44.402, 2.44.506, 2.44.507, 2.44.514, and 2.44.515.

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

3. The proposed new rules are as follows:

RULE I TRANSFER OF SERVICE CREDIT FROM THE PUBLIC EMPLOYEES' RETIREMENT SYSTEM (1) A member may at any time before retirement request that his or her Public Employees' Retirement service be transferred in accordance with the provisions of 19-4-409 MCA provided that the member:

(a) is an active contributing member of the Teachers' Retirement System and;

(b) is not eligible for membership under the Public Employees' Retirement System.

(2) If the member chooses to receive credit for PERS service transferred based on the ratio between the retirement systems' combined employee and employer contributions rates, their PERS service will not be credited to their TRS account until:

(a) the members' accumulated contributions under PERS have been deposited in the TRS, and

(b) the amount due from the PERS trust fund has been deposited in the TRS.

(3) In no instance shall a member be able to qualify more service into the Teachers' Retirement System than they had or have in the Public Employees' Retirement System. (Auth: Sec. 19-4-201 MCA; IMP, 19-4-409 MCA;)

REASON: This rule is proposed to implement HB 159, permitting the transfer of service between the Teachers' and Public Employees' Retirement Systems' and to clarify the accounting and payment of funds and service transferred.

RULE II LIMIT ON EARNED COMPENSATION (1) The amount of earnings that may be used in calculating a member's average final compensation may not exceed either the member's actual earned compensation or earnings adjusted by this rule for a preceding year, by more than 10% except for earnings increases that:

(a) result from collective bargaining agreements;

(b) have been granted by the employer to all other similarly situated employees;

(c) have been received as compensation under contract for summer employment;

(d) have resulted from change of employer or;

(e) have resulted from re-employment for a period of not less than one year following a break in service.

(2) The member must provide adequate documentation to permit the Board to make an informed decision concerning exceptions to the 10% limitation. Adequate documentation includes but is not limited to the following:

(a) employment contracts;

(b) official minutes of board meetings.

(3) The assignment of additional duties of a one time or temporary nature shall not be exempt from the 10% limitation. (Auth: Sec. 19-4-201 MCA; IMP, 19-4-101 (5) MCA;)

REASON: This rule is proposed to implement HB 317, limiting compensation used in the calculation of benefits.

RULE III POST RETIREMENT ADJUSTMENT (1) If a member has elected to receive an optional retirement allowance, the post retirement adjustment will be made using the most recent tables as adopted by the Board. (Auth: Sec. 19-4-201 MCA; IMP, Ch. 115, L. 1989;)

REASON: This bill is proposed to implement HB 421, post retirement adjustment and fairly inform the members upon what basis adjustments will be made.

RULE IV ACTUARIAL ASSUMPTIONS, RATES AND TABLES (1) All actuarial assumptions, rates and tables shall be adopted at a meeting of the Board and included in the minutes of that meeting.

(2) This rule refers to but is not limited to the following:

(a) Optional retirement table;

(b) Monthly annuity table;

(c) Rates for mortality, disability, retirement, and withdrawal;

(d) Assumptions for future salaries, investment earnings, administrative expense and termination.

(3) The assumptions, rates and tables shall be effective as provided in the minutes. (Auth: Sec. 19-4-201 MCA; IMP, 19-4-206 MCA;)

REASON: This rule is proposed to document the process by which actuarial assumptions, rates and tables are adopted.

RULE V PURCHASE OF ONE YEAR ADDITIONAL SERVICE FOR EACH FIVE YEARS OF MEMBERSHIP SERVICE (1) The cost to qualify one year of additional service for each five years of membership service will be the combined employee and employer rate on July 1, 1989, or the rate in effect when the member becomes eligible to purchase the additional service, whichever is later, multiplied by the member's earned compensation for the 1988-89 school year or their earned compensation when eligible, whichever is later. For a part-time employee, the earned compensation used to calculate the cost to purchase the additional service is the compensation that would have been earned if the part-time employment had been full-time.

(2) To qualify additional service under this provision, members eligible to purchase creditable service under 19-4-402, 19-4-403, 19-4-408, 19-4-410 or 19-4-411 MCA must waive their rights to purchase service under these provisions on a form as prescribed by the board.

(3) Additional service purchased under this provision may not be used to qualify a member for retirement under 19-4-801 MCA or in determining the early retirement adjustment under 19-4-802 MCA. (Auth: Sec. 19-4-201 MCA; IMP, Ch. 113, L. 1989;)

REASON: This rule is proposed to fairly implement SB 125, allowing members to purchase additional service.

RULE VI CREDITABLE SERVICE FOR EMPLOYMENT IN A FEDERAL, PUBLIC OR PRIVATE SCHOOL OUTSIDE THE UNITED STATES OR ITS POSSESSIONS (1) A member may apply to purchase creditable service for employment outside the United States or its possessions in a federal, public or private school if it is an organized, existing organization established and operated for the purpose of instructing students.

(2) A member must provide adequate documentation to permit the board to reasonably ascertain:

(a) if the services performed would be eligible for membership under the teachers' retirement system had they been performed in Montana and;

(b) if the school is an educational organization

established for the purpose of instructing students. An educational organization is an organization that normally maintains a regular faculty and curriculum, and normally has a regularly enrolled body of pupils or students in attendance at the place where its educational activities are regularly carried on. (Auth: Sec. 19-4-201 MCA; IMP, 19-4-402 MCA;)

REASON: This rule is proposed to implement SB 346, permitting the purchase of creditable service for teaching service outside the United States.

RULE VII MEMBERSHIP OF TEACHERS'S AIDES (1) Teacher's aides employed after July 1, 1989, are required to participate in the teachers' retirement system provided that they are:

(a) employed in an instructional services capacity for 50% or more of the academic day and;

(b) employed for the equivalent of 30 full-time days during the school year.

(2) A teacher's aide will be considered in an instructional services capacity if they are assisting a certified teacher in the education and instruction of students in the regular curriculum of the institution.

(3) Teacher's aides employed prior to July 1, 1989 may elect to be members of the teachers' retirement system provided they meet the requirements under (1) and (2) of this rule and:

(a) each school district must give written notice, no later than September 30, 1989, to all teacher's aides employed prior to July 1, 1989 of their right to elect membership in the teachers' retirement system and;

(b) each teacher's aide must file the notice of election with the school board and the teachers' retirement board by October 31, 1989.

(4) Teacher's aides electing membership under the teachers' retirement system may qualify their previous service provided:

(a) the employee and employer contributions that would have been made had the teachers' aide been a member of the TRS, and

(b) the interest that would have accrued on the contributions, are deposited with the retirement system. (Auth: Sec. 19-4-201 MCA; IMP, 19-4-302 MCA;)

REASON: Proposed to clarify requirements for membership or teacher's aides and to implement the rule in a reasonable time frame.

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

2.44.402 CREDIT FOR MILITARY SERVICE (1) For those eligible, military credit will be given for active service in World War II from October 1940 through June 1947, ~~service in the Korean Conflict from June, 1950 through January, 1955~~ and for any period of active service allowed under 19-4-404, MCA.

(2) Any member having purchased military service that is subsequently granted at no cost shall receive a refund of their accumulated contributions.

~~(2)~~ (3) Verification of military service should be submitted on form DD 214, or if inapplicable, a form which certifies the date of entry into and separation from active military duty. A form should be provided for each term of active duty.

~~(3)~~ (4) The period of time used for crediting military service shall be the fiscal year of July 1 through June 30. Military service shall be credited on the basis of twelve (12) full months of active duty equals one year of creditable service or a proportion thereof, based on the number of full months to twelve (12). A partial month will be credited on the basis of the number of active duty days divided by 360.

AUTH: Sec. 19-4-201 MCA; IMP, 19-4-404 MCA;

REASON: This rule is proposed to allow for the refund of accumulated contributions made to purchase military service that is granted at no cost under the provisions of HB 114.

2.44.506 BENEFIT PAYMENTS (1) The first benefit will be payable the last day of the month in which the benefit began and future benefits will be payable the last day of each succeeding month.

(2) Monthly benefits will be paid based upon estimates provided by the teachers' retirement system until final salary information and contributions are received.

(3) Adjustments will be retroactive to the retirement effective date.

(4) Monthly benefits will be prorated to the date of death of the retiree or beneficiary.

AUTH: Sec. 19-4-201 MCA IMP: 19-4-703 MCA

REASON: This modification is proposed to clarify procedures for payment of benefits upon the death of the benefit recipient.

2.44.507 PAYMENT OF CHILDREN'S BENEFITS (1) The child's benefit ~~of $100.00 per month~~ will be last payable the month in which he attains age 18.

(2) A birth certificate or some evidence of birth date is required for each child eligible to receive the

child benefit ~~of $100.00 per month~~.
AUTH: Sec. 19-4-201 MCA IMP: 19-4-1002 MCA

REASON: This modification facilitates implementation of HB 314, or any future adjustments to minor child benefits.

2.44.514 LUMP SUM PAYMENTS AT THE END OF THE SCHOOL TERM (1) Lump sum payments made under contract to all similarly situated employees at the end of the school term for bonuses, unused personal leave days or for accruals of leave in excess of that allowed under contract will be treated as earned compensation unless paid on account of termination. When paid as a result of termination, all payments will be considered as termination pay as defined under 19-4-101(5) MCA.

(2) No service credit shall be awarded for lump sum payments made under contract at the end of the school term or on account of termination.

AUTH: Sec. 19-4-201 MCA IMP: 19-4-101(8) MCA

REASON: This amendment is proposed to clarify the procedures for reporting bonuses and subsequent calculation of benefits.

2.44.515 CORRECTION OF ERRORS ON CONTRIBUTIONS (1) Corrections of errors may be made by the employer on subsequent monthly reports ~~via~~ by a letter of explanation and credit taken or additional payment remitted. Corrections reducing an employee's contributions cannot be accepted if the employee has received a refund.

(2) Contributions and wages reported for prior school years must be corrected using the employee and employer contribution rates in effect for the period the wages were earned.

(3) If the error caused membership service to be credited incorrectly, the members account must be adjusted accordingly.

(4) Interest shall accrue on contributions not reported or overpaid at the same rate as that credited to member accounts.

AUTH: Sec. 19-4-201 MCA IMP: 19-4-208 MCA

REASON: This amendment is proposed to insure equal treatment of all members by clarifying that contributions due on wages not reported for prior periods must be based upon the contribution rates in effect for the period the wages were earned and providing the calculation of interest on those contributions.

5. Interested parties may submit their data, views or arguments concerning the proposed adoption or amendments orally or in writing at public hearing. Written views, comments or data may also be submitted to David L. Senn, Administrator, Teachers' Retirement System, 1500 Sixth Avenue, Helena, MT 59620-0139, no later than July 27, 1989.

6. Paul Smietanka has been designated to preside over and conduct the hearing.

By: David L. Senn

David L. Senn, Administrator
Teachers' Retirement System

Certified to the Secretary of State June 16, 1989.

BEFORE THE DEPARTMENT OF AGRICULTURE
OF THE STATE OF MONTANA

In the matter of the amendment of rule 4.15.101 Fees, and the proposed adoption of a rule on agricultural debt mediation scheduling and agreement procedures.	NOTICE OF PROPOSED AMENDMENT OF ARM 4.15.101 FEES, AND ADOPTION OF A NEW RULE ON AGRICULTURAL DEBT MEDIATION.

NO PUBLIC HEARING CONTEMPLATED

TO: All Interested Persons

1. On July 31, 1989, the Department of Agriculture proposes to adopt an amendment of ARM 4.15.101 Fees, and a new rule on agricultural debt mediation procedures.

2. ARM 4.15.101 as proposed to be amended would read as follows: (new matter underlined, deleted matter interlined)

4.15.101 FEES (1) Each farmer or rancher who requests and receives professional financial consulting services shall be charged a fee of up to 50 percent of the actual direct cost of such services. In no case will such fee exceed $250.00.

(2) Each farmer or rancher and secured creditor participating in voluntary agricultural debt mediation shall be charged a fee based upon an equal pro rate share, and the actual direct cost of such mediation. An individual participant in the mediation activities will not be charged more than 50 percent of the actual direct cost of the mediation. In no case will the fee charged to any farmer/rancher or secured creditor exceed $300.00.

(3) Each unsecured creditor participating in voluntary agricultural debt mediation shall be charged a flat fee of $50.00.

~~(3)~~(4) The department shall send a notice or billing statement to the farmer/rancher or ~~secured~~ creditor as appropriate, within a reasonable time following receipt by the department of a final report indicating substantial completion of the financial consulting or debt mediation activity.

~~(4)~~(5) Ability of the farmer/rancher or ~~secured~~ creditor to pay the maximum or a reduced fee shall be determined by the department based upon the financial condition, debts, assets, and cashflow of the respective farmer/rancher or ~~secured~~ creditor and the recommendation of the financial consultant and/or mediator.

AUTH: Sec. 80-13-104 MCA; IMP, Sec. 80-13-104 MCA

3. The proposed amendment to rule 4.15.101 Fees is intended to inform the public and clarify the amount of fee to be charged to unsecured creditors who may participate in and benefit from mediation.

4. The proposed new rule will read as follows:

Rule I MEDIATION SCHEDULING AND AGREEMENT PROCEDURES (1) Upon receipt of all information required by 80-13-201, MCA, from the party requesting mediation, the borrower or the creditor of whom mediation is requested shall have thirty (30) days to agree or decline to participate in the mediation.

(2) The department shall set a date, time and place for the initial mediation session dependent on availability of program funding and mediators. The department shall attempt to set this date within fifteen (15) days of receipt of the agreement to mediate and required information from all participating parties.

(3) The department has fifteen (15) business days following the date that a tentative agreement is reached (the terms and provisions agreed upon and presented to the mediator) to put the tentative agreement in a typed format and mail it to the participating parties for their review and approval. As the department's role is strictly clerical, it is the responsibility of the parties to the mediation to ensure that the agreement is accurate, complete and consistent with the intent of the parties.

(4) The parties involved in mediation will have a maximum of thirty (30) days to approve, modify or reject the tentative agreement. The 30-day period begins on the postmarked date that the typed draft of the mediation agreement is mailed. Any proposed modifications to the agreement must be submitted to the mediator. Upon acceptance of the agreement, the department will return the agreement to the mediation participants for signature.

(5) Mediation will be assumed terminated if any of these time schedules are not met. A new request and agreement must be initiated for mediation to proceed. An exception to this rule will be allowed if both the creditor and the borrower provide the department with a signed statement agreeing to deviation from the respective deadlines.

AUTH: Sec. 80-13-104 MCA; IMP: Sec. 80-13-201, 202 and 203 MCA

5. The department is proposing to adopt the proposed rules in order to define the time frame for debt mediation and the expectations of the parties involved in order to expedite the mediation process.

6. Interested parties may submit their data, views or comments concerning the proposed rules in writing to Michael Murphy, Administrator, Agricultural Development Division, Agriculture/Livestock Building, Capitol Station, Helena,

Montana 59620, no later than July 28, 1989.

7. 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 Michael Murphy at the above stated address, no later than July 28, 1989.

8. 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 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 240 persons based on the number of farmers/ranchers and financial institutions in the state that may require mediation assistance. As 10 percent of those persons directly affected has been determined to be 240 persons, the lesser and therefore required number is 25 persons.

9. The authority of the department to make the proposed amendment and adoption is Sec. 80-13-104, MCA, and the new rule implements Sec. 80-13-201, 202, and 203, MCA.

EVERETT M. SNORTLAND, DIRECTOR
DEPARTMENT OF AGRICULTURE

Everett M Snortland

Certified to the Secretary of State June 19, 1989

STATE OF MONTANA
DEPARTMENT OF AGRICULTURE
BEFORE THE MONTANA AGRICULTURE DEVELOPMENT COUNCIL

In the matter of the proposed adoption of new rules pertaining to the "Growth Through Agriculture Program" and the transfer of ARM 8.121.103, 8.121.201 8.121.301, 8.121.401 and the amendment of ARM 8.121.301	NOTICE OF PUBLIC HEARING ON PROPOSED RULES PERTAINING TO THE "GROWTH THROUGH AGRICULTURE PROGRAM" AND AMENDMENT OF ARM 8.121.301

TO: ALL INTERESTED PERSONS

1. On August 2, 1989 at 9:00 A.M. a public hearing will be held in the second floor conference room (room 225) of the Agriculture/Livestock Building located on the corner of Sixth Avenue and Roberts Street in Helena, Montana. Effective February 4, 1989 the Montana Legislature in HB 18 transferred the "Growth Through Agriculture Program" from the Department of Commerce to the Department of Agriculture. The Department of Agriculture now has administrative responsibility for the program and in the implementation thereof is proposing the adoption of new rules I through XIII. In addition the Department of Agriculture is transferring existing rules for the program to its title, rules 8.121.101-8.121.103, 8.121.201, 8.121.301, and 8.121.401, and will reassign numbers at the time of adoption of the new rules. One of the transferred rules, 8.121.301, is proposed for amendment in this notice.

2. The proposed new rules will read as follows:

I. APPLICATION PROCEDURES FOR A SEED CAPITAL PROJECT LOAN- SUBMISSION AND USE OF EXECUTIVE SUMMARY (1) An applicant for a seed capital project loan shall submit a brief executive summary of the proposal to the Council.

(2) The executive summary must include the following items:

(a) a description of the agricultural product and/or process being developed or marketed with particular emphasis on any proprietary characteristics which would result in a competitive advantage for the applicant;

(b) a characterization of the market for the product or process, including potential size, customers, and methods required for selling the product or process to the market;

(c) a description of the management team's experience and qualifications which are relevant to the particular agricultural business area in which the company is proposing to enter;

(d) an estimate of projected sales revenue and new jobs; and

(e) the amount of capital needed for the current round of financing, in addition to a listing of other potential investors.

(3) The executive summary should not contain any information that the applicant does not want subject to public inspection.

(4) The executive summary is evaluated by the Council for a determination of whether the project complies with (2) above and whether the project should be advanced to the business plan development and review phases.

AUTH: Section 9, Ch. 284, L. 1989, IMP: Sections 1, 2, 3 and 9, Ch. 284, L. 1989.

II. APPLICATION PROCEDURES FOR A SEED CAPITAL PROJECT LOAN - SUBMISSION OF BUSINESS PLAN (1) When the executive summary is deemed complete and the seed capital project deemed appropriate for further consideration, the applicant must submit a business plan to the Council.

(2) This plan must contain the following items:

(a) the executive summary;

(b) the company's history and business development objectives;

(c) the product and technology description;

(d) the market size and characteristics assessment;

(e) the sales and marketing strategy;

(f) a description and assessment of the competition;

(g) the financial projections, including income statements, balance sheets, and cash flow projections for five (5) years;

(h) the historical financial statements of the company including balance sheets and income statements for the three previous years or as many as are available;

(i) a description of the management team, including a detailed resume for each member;

(j) a manufacturing and operations plan;

(k) the ownership structure; and

(l) an organization and personnel plan.

(3) If deemed necessary, personal financial data may be requested.

(4) A cover letter must also accompany the business plan and include a description of other capital or matching fund efforts. The cover letter must also contain the names of up to three individuals who could provide the Council with a threshold review of the products, technology, process and market potential of the company if such a review is deemed necessary by the Council."

AUTH: Section 9, Ch. 284, L. 1989, IMP: Sections 1, 2, 3, 9 and 12, Ch. 284, L. 1989.

III. APPLICATION PROCEDURES FOR A SEED CAPITAL PROJECT LOAN - REVIEW PROCESS (1) The following steps are taken by the Council to complete its evaluation in order to arrive at a loan decision:

(a) Upon receipt of the completed business plan, threshold evaluations may be obtained from technical and financial reviewers.

(b) Once the threshold evaluation step is completed, Council staff will schedule an on-site meeting with the company's management team to discuss the applicant's objectives and financing needs.

(c) The applicant shall make a formal presentation to the Council at a regularly scheduled Council meeting.

(d) The Council staff will then conduct its own due diligence examination of the seed capital project proposal, which involves, at a minimum, a thorough assessment of the project's compliance with the applicable criteria and goals as set forth in the act and rules, the company's management team, the company's potential market, other investors, ownership, and management and financial references.

(e) Council staff will then develop a recommendation for the Council for its review and consideration.

AUTH: Section 9, Ch. 284, L. 1989. IMP: Sections 1, 2, 3 and 9, Ch. 284, L. 1989.

IV. APPLICATION PROCEDURES FOR A SEED CAPITAL PROJECT LOAN - COUNCIL ACTION (1) Upon receipt of the staff's recommendation, the Council shall determine whether to make a seed capital project loan.

(2) The Council shall determine whether the applicant has complied with the act and applicable rules, and whether the project would provide an opportunity for the Council to exit the loan with a return as provided by Section 7 of the Act.

(3) All decisions of the Council are final and not subject to the contested case provisions of the Administrative Procedure Act.

AUTH: Section 9, Ch. 284, L. 1989. IMP. Sections 1, 2, 3, 9, 11 and 12, Ch. 284, L. 1989.

V. SEED CAPITAL PROJECT LOAN - POST-DISBURSEMENT ACTIVITIES (1) The Council may take an active role in working with an agricultural business in which it has entered into a seed capital project loan.

(2) The activities in which the Council may participate include, but are not limited to:

(a) assisting the company in seeking additional investment capital when necessary; and

(b) designating a person(s) to sit on the company's board of directors or other governing body and/or to hold observer rights.

AUTH: Section 9, Ch. 284, L. 1989. IMP: Sections 1, 2, 3, 6, 7 and 9, Ch. 284, L. 1989.

VI. APPLICATION PROCEDURES FOR A RESEARCH AND DEVELOPMENT PROJECT LOAN - SUBMISSION AND USE OF EXECUTIVE SUMMARY

(1) An applicant for a research and development project loan must submit a brief executive summary of the proposal to the Council.

(2) The executive summary must include the following items:

(a) a description of the proposed research and development project, including the product and/or process involved;

(b) an analysis of the project's commercial potential and prospective commercial partners;

(c) an estimate of total financing needs; and

(d) the amount of funds requested from the Council including the expected use of proceeds.

(3) The summary should not contain any information that the applicant does not want subject to public inspection.

(4) The executive summary is evaluated by the Council for a determination of whether the project complies with (2) above and whether the project should be advanced to the research and development proposal and review phases.

AUTH: Section 9, Ch. 284, L. 1989. IMP: Sections 1, 4, 5 and 9, Ch. 284, L. 1989.

VII. APPLICATION PROCEDURES FOR A RESEARCH AND DEVELOPMENT PROJECT LOAN - SUBMISSION OF RESEARCH AND DEVELOPMENT PROPOSAL (1) When the executive summary is deemed complete and the research and development project deemed appropriate for further consideration, the applicant must submit a research and development proposal to the Council.

(2) This proposal must contain the following items:

(a) a title page;

(b) a table of contents;

(c) the executive summary;

(d) the project objectives;

(e) a background review of the research and development project;

(f) the project design;

(g) a list of required facilities and equipment;

(h) a description of potential commercial partners;

(i) a description of the project's potential impact on the state's economy;

(j) a list of milestones which describe specific tasks to be achieved on a specific time schedule;

(k) the budget and use of proceeds, plus documentation showing source of funds and use of proceeds for each line of the budget;

(l) the feasibility and/or availability of matching funds;

(m) a description of funding efforts made to obtain funding for the proposed project;

(n) the resumes of the major principals identified in the project design describing the education and employment experience of each; and

(o) a list of three technical reviewers who are qualified to review the proposal including their names, addresses and phone numbers.

AUTH: Section 9, Ch. 284, L. 1989. IMP: Sections 1, 4, 5, 9 and 12, Ch. 284, L. 1989.

VIII. APPLICATION PROCEDURES FOR A RESEARCH AND DEVELOPMENT PROJECT LOAN - EVALUATION - DUE DILIGENCE (1) After receiving the research and development proposal, Council staff will determine if the proposal is complete. Once the proposal is deemed complete, the formal review process begins.

(2) Upon receipt of a complete research and development proposal, the proposal may be subjected to an outside technical review conducted by reviewers selected by the Council. Each reviewer will be asked to comment on the technical feasibility of the proposed research and development project's design and implementation, as well as the project's prospects for market success, when applicable.

(3) If deemed necessary, a research and development proposal may also be subjected to a financial review.

(4) If the technical and financial reviews are favorable, the Council will initiate and pursue its own due diligence process on the research and development project. The purpose of this process is to further verify the feasibility of the agricultural project, the credibility and expertise of the project principals and the market or commercial potential of the proposed product or process.

AUTH: Section 9, Ch. 284, L. 1989. IMP: Sections 1, 4, 5 and 9, Ch. 284, L. 1989.

IX. APPLICATION PROCEDURES FOR A RESEARCH AND DEVELOPMENT PROJECT LOAN - REVIEW PROCESS (1) In addition to the technical and financial reviews, the Council will evaluate each proposal in light of the loan criteria and goals as set forth in the act and rules.

(2) The applicant will then be asked to attend a regularly scheduled Council meeting and make a brief presentation on the project to the Council.

(3) The Council staff will then develop a recommendation to the Council for its review and consideration.

AUTH: Section 9, Ch. 284, L. 1989. IMP: Sections 1, 4, 5 and 9, Ch. 284, L. 1989.

X. APPLICATION FOR A RESEARCH AND DEVELOPMENT PROJECT LOAN - COUNCIL ACTION (1) Upon receipt of the staff's recommendation the Council shall determine whether to make an agricultural loan.

(2) The council shall determine whether the proposal complies with the act and applicable rules.

(3) All decisions by the Council are final and not subject to the contested case provisions of the Administrative Procedure Act.

AUTH: Section 9, Ch. 284, L. 1989. IMP: Sections 1, 4, 5, 9, 11, and 12, Ch. 284, L. 1989.

XI. RESEARCH AND DEVELOPMENT PROJECT LOANS - MONITORING REPORTS (1) A loan recipient must submit progress reports to the Council staff as specifically required in the research and development project loan agreement.

(2) The progress reports shall include, but not be limited to:

(a) financial status of the loan recipient;

(b) overall project performance;and

(c) progress in accomplishing the designated milestones.

(3) A final project report is due upon completion of the project term.

(4) Annual commercialization reports are required until the loan recipient has satisfied the payback terms contained in the agreement.

AUTH: Section 9, Ch. 284, L. 1989. IMP: Sections 1, 4, 5, 6, 8, and 9, Ch. 284, L. 1989.

XII. FAILURE TO COMMERCIALIZE OR PRODUCE IN MONTANA - ALL LOAN PROGRAMS (1) A loan recipient must agree that the production or manufacturing of the new agricultural product shall occur in the state and should production or manufacturing be located out-of-state, the loan recipient shall immediately reimburse the Council for its original investment with the current rate of interest.

(2) The Council may determine that a loan recipient is not complying with the agricultural development project loan agreement if:

(a) the loan recipient has not complied with the terms and conditions of the loan agreement,

(b) commercial production, marketing or distribution of the product is not commenced by the company within a reasonable time;

(c) the company fails to use its best efforts to achieve the benefits of increased employment in Montana; or

(d) the company fails to maintain such offices or facilities in Montana.

(3) If the Council determines that a loan recipient is not complying with the term and conditions of the loan, the Council may terminate funding of the loan.

AUTH: Section 9, Ch. 284, L. 1989. IMP: Sections 1, 2, 3, 4, 5, 6, 7, 8, 9 and 11, Ch. 284, L. 1989.

XIII. RIGHTS TO INTELLECTUAL PROPERTY - CONFIDENTIALITY - ALL LOAN PROGRAMS (1) All intellectual property rights including any patents, copyrights, trademarks, and trade secrets developed by the loan recipient with use of funds

provided by the Council shall be owned by the recipient.

(2) The loan recipient shall have each of its employees, agents, independent contractors and others who may reasonably be expected to create intellectual property rights sign an agreement with the loan recipient, subject to approval by the Council, whereby such other persons shall assign any and all intellectual properties to the funding recipient where any invention, discovery, improvement or other intellectual property right is conceived, created or reduced to practice during the term of the loan.

(3) Unless otherwise required by law, information submitted by an applicant will be treated as confidential, except the following:

(a) name and address of applicant;

(b) short description of proposed agricultural development project;

(c) amount of requested loan;

(d) the program(s) under which the applicant is applying;

(e) any other information in which the demand of individual privacy does not clearly exceed the merits of public disclosure; and

(f) any information in which the demand of individual privacy clearly exceeds the merits of public disclosure when the applicant has expressly waived his right to privacy.

(4) The Council shall maintain public files on each completed application received containing the following information:

(a) items (3) (a) through (f) of this rule;

(b) all written documents received or prepared concerning items (3) (a) through (f) of this rule;

(c) a brief statement of Council action regarding the application including the Council's approval or disapproval of the application, the terms and payback provision.

(5) This rule is based on the Council's finding that except for the information described in items (3) (a) through (f), the demands of individual privacy clearly exceed the merits of public disclosure of the personal, financial and business information that is contained in applications submitted to the Council.

AUTH: Section 9, Ch. 284, L. 1989; Section 2-3-103, MCA; IMP: Section 1, 2, 3, 4, 5, 6, 7, 8, 9, and 11, Ch. 284, L. 1989; Title 2, Chapter 3, MCA.

3. ARM 8.121.301 as proposed to be amended would read as follows:

8.121.301 AGRICULTURAL BUSINESS INCUBATOR PROGRAM-PURPOSE-INVESTMENTS-CRITERIA AND LIMITATIONS

(1) For purposes of this rule, an agricultural business incubator is a self-financing business development entity providing such services as training, management consultation, accounting and office space if necessary to eligible

agricultural businesses.

(2) The purpose of the agricultural business incubator program is to encourage the strengthening and diversification of economic activity in rural communities through assisting early-stage agricultural businesses.

(3) Investments may be made only in agricultural business incubators that are located in different geographic areas of the state.

(a) An incubator may not be located in a municipality or community with a population in excess of 15,000 people.

(b) The municipality or community in which the agricultural business incubator is located must provide funding or contributions ~~of a value at least three times the amount of the investment under this section~~ on at least a dollar-to-dollar basis.

(c) Contributions by the municipality or community may include but not be limited to land, buildings, office space or professional services.

(4) In order for an agricultural business incubator to qualify for a council investment, the applicant must:

(a) submit a completed application to the council, signed by the chief executive officer of the entity desiring to establish the agricultural business incubator;

(b) demonstrate, through supporting documentation, the ability of the incubator to operate independent of council investment within 5 years of receiving a council investment;

(c) demonstrate, through supporting documentation, the ability of the incubator to provide quality business development assistance and management skills including but not limited to:

(i) appropriate educational background of management team and key personnel;

(ii) previous experience of applicant relating to business and/or incubator management,

(d) demonstrate, through supporting documentation, community support for the proposed incubator;

(e) present in writing and before the council, a plan that addresses the business development needs of specific user groups, including, but not limited to displaced farmers, and how this proposed incubator will meet those needs;

(f) demonstrate, that at a minimum, the following services will be provided by the incubator,

(i) training,

(ii) management consultation, and

(iii) necessary professional services.

(5) A council investment in an incubator shall not exceed $100,000.

(6) As required by 2-4-305, MCA, notice is hereby given that parts of this rule, repeat parts of 90-9-302, MCA, in order to provide full notification to applicants of the incubator program.

AUTH: Section 9, Ch. 284, L. 1989. IMP: Section 13, Ch. 284, L. 1989.

4. The Montana Agriculture Development Council is proposing to adopt new rules in order to implement the agriculture development project loan program established in the Montana Growth Through Agriculture Act. (Title 90, Chapter 9, MCA), and to amend ARM 8.121.301 to conform to the statutory amendment made during the 1989 legislative session.

5. Interested persons may present their views and comments either orally or in writing at the hearing. Written views and comments may also be submitted to Mr. Michael Murphy, Department of Agriculture, Sixth and Roberts, Helena, Montana, 59620 by no later than August 2, 1989.

6. Mona Jamison has been designated to preside over and conduct the hearing.

Montana Agriculture Development Council

Barbara Skelton, Chairman

By: Everett M Snortland
Everett M. Snortland, Director
Department of Agriculture

Certified to the Secretary of State, June 19, 1989.

STATE OF MONTANA
DEPARTMENT OF COMMERCE
BEFORE THE BOARD OF OCCUPATIONAL THERAPISTS

In the matter of the proposed amendment of rules pertaining to definitions, applications for limited permit, pass-fail criteria, fees, unprofessional conduct, and limited permits, the proposed repeal of a rule pertaining to reciprocity	)	NOTICE OF PROPOSED AMENDMENT OF 8.35.402 DEFINITIONS, 8.35.405 APPLICATIONS FOR LIMITED PERMIT, 8.35.406 PASS-FAIL CRITERIA, 8.35.407 FEES, 8.35.408 UNPROFESSIONAL CONDUCT, AND 8.35.413 LIMITED PERMITS AND REPEAL OF 8.35.410 RECIPROCITY

NO PUBLIC HEARING CONTEMPLATED

TO: All Interested Persons:

1. On July 29, 1989, the Board of Occupational Therapists proposes to amend and repeal the above-stated rules.

2. The proposed amendments will read as follows: (new matter underlined, deleted matter interlined) (full text of the rules is located at pages 8-1053 through 8-1059, Administrative Rules of Montana)

"8.35.402 DEFINITIONS (1) will remain the same.

~~(2)--"Reciprocity-licensee"-means-a-person-licensed-under the-law-of-another-state-that-had-licensure-requirements-at least-as-stringent-as-the-requirements-of-Chapter-24,-Title 37,-MCA,-at-the-time-of-original-licensure,-or-the-person-who meets-the-requirements-for-certification-as-an-occupational therapist-registered-(OTR)-or-a-certified-occupational therapist-assistant-(COTA)-established-by-the-American Occupational-Therapy-Association.~~

~~(3)--"Occupational-Therapist-Student"-means-a-person pursuing-a-supervised-course-of-study-leading-to-a-degree or-certificate-in-occupational-therapy-at-an-accredited institution-or-under-an-approved-educational-program.~~"

Auth: Sec. 37-1-131, 37-24-201, 37-24-202, MCA; IMP, Sec. 37-24-104, 37-24-307, MCA

REASON: These proposed deletions now recognize the facts that "Occupational Therapist Student" is an occupation or classification that is not contained in or recognized by statute and that the subject of reciprocity licensure is controlled by statute.

"8.35.405 EXAMINATIONS (1) For the purpose of section 37-24-304(2), MCA, the board adopts as its examination the examinations in existence on 5/30/86, offered through the ~~American Occupational Therapists Association~~ American Occupational Therapy Certification Board (AOTCB).

(2) Arrangements and fees for examinations are the responsibility of the application and shall be made with the ~~AOTA~~ AOTCB.

(3) It shall be the responsibility of the applicant to assure that his or her examination score is forwarded by the ~~AOTA~~ AOTCB to the board.

~~(4) Applicants will be notified of the examination results following receipt of the examination score by the board.~~

~~(5)~~ (4) Applicants who fail an examination may be reexamined upon payment of another examination fee to the ~~AOTA~~ AOTCB.

~~(6)~~ (5) Examinations will be given two times a year as set by the ~~AOTA~~ AOTCB."

Auth: Sec. 37-1-131, 37-24-201, 37-24-202, MCA; IMP, Sec. 37-24-304, MCA

REASON: This amendment is intended to reflect the fact that the American Occupational Therapy Certification Board now administers the national exam, and to conform to recent legislative amendments.

"8.35.406 PASS-FAIL CRITERIA (1) The board will utilize the pass/fail criteria ~~in existence on 5/30/86 of the American Occupational Therapists Association~~ applied by the American Occupational Therapy Certification Board (AOTCB)."

Auth: Sec. 37-1-131, 37-24-201, 37-24-202, MCA; IMP, Sec. 37-24-304, MCA

REASON: This amendment is intended to reflect the fact that the American Occupational Therapy Certification Board now administers the national exam, and to conform to recent legislative amendments.

"8.35.407 FEES (1) Fees adopted by the board under section 37-24-310, MCA, are as follows:

(a) through (g) are as follows:

(h) If a new applicant for licensure successfully applies on or after March 15, his license will be valid for the remainder of the license year and for the following license year. An inactive license renewal granted on or after March 15 will apply for the remainder of the license year and for the following year. Any new therapist in Montana who wishes to practice as a registered occupational therapist, or an occupational therapist student, or under a limited permit must apply for licensure within 10 working days after arrival in this state.

(i) The application fee of $80 for the limited permit holder will be applied toward the fee for a permanent license issued within 6 months of permit issuance.

(2) will remain the same."

Auth: Sec. 37-1-131, 37-1-134, 37-24-201, 37-24-202, MCA; IMP, Sec. 37-24-310, MCA

REASON: This amendment is being proposed to make clear that the application fee will be applied both to the balance of the license year in which it is paid and to the next full license year.

"8.35.408 ~~ETHICAL STANDARDS OF PRACTICE~~ UNPROFESSIONAL CONDUCT RULES For the purpose of implementing section 37-24-309(1)(b), MCA, the board ~~establishes the following~~ defines ~~ethical standards of practice~~ "unprofessional conduct" ~~violation of which will be grounds for license revocation or suspension or other disciplines, as contemplated by section 37-1-136(1), MCA, and ARM 8.35.409~~ as follows: ~~(1)~~ through (9) will remain the same."

Auth: Sec. 37-1-131, 37-24-201, 37-24-202, 37-24-309, MCA; IMP, Sec. 37-24-309, MCA

REASON: This amendment is being proposed to conform the rule to recent legislative amendments.

"8.35.413 LIMITED PERMIT (1) ~~Limited permit~~ Examinations will be given by the ~~American Occupational Therapists Association~~ American Occupational Therapy Certification Board (AOTCB) twice a year. Limited permits ~~can~~ may be issued for a one year period. If renewal ~~time comes~~ falls before the ~~year is up~~ end of the year, the limited ~~period~~ permit ~~can~~ may be renewed one time to allow the graduate or student to pass the examination."

Auth: Sec. 37-1-131, 37-24-201, 37-24-202, MCA; IMP, Sec. 37-24-307, MCA

REASON: This amendment is intended to reflect the fact that the American Occupational Therapy Certification Board now administers the national qualifying exam. It is also intended to clarify the status of limited permits pending the examination.

3. ARM 8.35.410 RECIPROCITY is being proposed for repeal because the subject of reciprocity is controlled by statute. The authority sections are 37-24-201 and 37-24-202, MCA and the implementing section is 37-24-305, MCA.

4. Interested persons may submit their data, views or arguments concerning the proposed amendments and repeal in writing to the Board of Occupational Therapists, 1424 - 9th Avenue, Helena, Montana 59620-0407, no later than July 27, 1989.

5. If a person who is directly affected by the proposed amendments and repeal wishes to express his data, views or arguments orally or in writing at a public hearing, he must make written request for a hearing and submit this request along with any comments he has to the Board of Occupational Therapists, 1424 - 9th Avenue, Helena, Montana 59620-0407, no later than July 27, 1989.

6. If the board receives requests for a public hearing on the proposed amendments and repeal from either 10% or 25,

whichever is less, of those persons who are directly affected by the proposed amendments and repeal, from the Administrative Code Committee of the legislature, from a governmental agency or subdivision or from an association having no less than 25 members who will be directly affected, a public 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 12 based on the 128 licensees in Montana.

BOARD OF OCCUPATIONAL THERAPISTS
DEBRA J. AMMONDSON, OTR/L
CHAIRMAN

BY: 
MICHAEL L. LETSON, DIRECTOR
DEPARTMENT OF COMMERCE

Certified to the Secretary of State, June 19, 1989.

STATE OF MONTANA
DEPARTMENT OF COMMERCE
BEFORE THE BOARD OF VETERINARY MEDICINE

In the matter of the proposed amendment of rules pertaining to annual renewal of certificate of registration, and continuing education; repeal of a rule pertaining to conduct; and adoption of a new rule pertaining to unprofessional conduct	NOTICE OF PROPOSED AMENDMENT, REPEAL AND ADOPTION OF RULES PERTAINING TO VETERINARY MEDICINE

NO PUBLIC HEARING CONTEMPLATED

TO: All Interested Persons:

1. On July 29, 1989, the Board of Veterinary Medicine proposes to amend, repeal and adopt the above-stated rules.

2. The proposed amendments will read as follows: (new matter underlined, deleted matter interlined) (full text of the rules is located at pages 8-1790 and 8-1791, Administrative Rules of Montana)

"8.64.504 ANNUAL RENEWAL OF CERTIFICATE OF REGISTRATION (1) Notice for annual renewal of certificate of registration ~~and forms for certifying continuing educational hours~~ shall be mailed annually to each licensed veterinarian at his/her last known address at least 30 days prior to the November 1st deadline. Notices will be considered properly mailed when addressed to the last known address on file in the board office.

(2) The proper annual renewal of certificate of registration fee and completed renewal form ~~proof of continuing education~~ are due by November 1st of each year."

Auth: Section 37-1-131, 37-18-202, MCA; IMP, Sec. 37-18-202, 37-18-307, MCA

"8.64.505 CONTINUING EDUCATION (1) Each veterinarian licensed shall be required to obtain every two years a minimum of ~~10~~ 20 credit hours of continuing education approved by the board ~~in the year preceding the deadline for renewal before becoming eligible for the annual renewal of certificate of registration~~. The credit hours must be obtained within the 24 months prior to renewal on November 1 of the even-numbered years.

(a) It is the responsibility of the veterinarian to maintain proof of his/her continuing education attendance and to report programs attended on the renewal application in the even-numbered years only. During the renewal process in the odd-numbered years no continuing education is to be reported.

~~(a)~~ (b) A veterinarian may be granted a grace period to ~~include a month prior to November 1st of the year preceding~~

~~the application for renewal and~~ of three months after the November 1st deadline in which to fulfill the continuing educational requirements. This grace period shall be granted only upon written request to the board, payment of the restoration fee, and upon board approval. ~~This grace period, however, will not allow a veterinarian to use the same continuing educational program for two separate annual renewal of certificate of registrations.~~ A license to practice veterinary medicine valid for the duration of the grace period will be issued to those persons granted grace by the board.

(c) Continuing education credits obtained during a grace period or restoration period cannot be used for the next reporting period.

(2) Credit hours shall be earned by 1 hour credit for each hour of attendance at or participation in ~~in-depth~~ meetings and programs approved by the board. Board approved programs include, but are not limited to, those sponsored by the American veterinary medical association, American animal hospital association, western states veterinary conferences, veterinary college conferences, and state association meetings, and any other affiliated association, society, etc., related to veterinary medicine that have specific ~~seminars~~ topics for veterinarians. Programs shall be of a professional veterinary nature to qualify, with the number of practice management hours reported not to exceed 25% of the total required continuing education hours.

(3) through (b) will remain the same."

Auth: Sec. 37-1-131, MCA, 37-18-202, MCA; IMP, Sec. 37-18-202, 37-18-307, MCA

REASON: These amendments are being proposed to allow licensees the cost savings of attending one large meeting and obtaining enough cumulative continuing education for two license years renewals, as well as giving them more flexibility in accumulating the required CE in the light of current video technology. The rule amendments implement amendments to sections 37-18-202 and 37-18-307, MCA.

3. ARM 8.64.507 IMMORAL, UNPROFESSIONAL, OR DISHONORABLE CONDUCT is being proposed for repeal. The authority section is 37-18-202 and the implementing section is 37-18-311, MCA. This rule is being proposed for repeal due to the amendment in wording of section 37-18-311, MCA, effective May 11, 1989. It is being replaced by proposed unprofessional conduct rules under the amended statute.

4. The new rule will read as follows:

"I. UNPROFESSIONAL CONDUCT For the purpose of implementing the provisions of section 37-18-311(1)(e), MCA, the board defines "unprofessional conduct" as follows:

(1) Any act involving moral turpitude, dishonesty, or corruption relating to the practice of veterinary medicine whether the act constitutes a crime or not. If the act constitutes a crime, conviction in a criminal proceeding is

not a condition precedent to disciplinary action. Upon such a conviction, however, the judgment and sentence is conclusive evidence at the ensuing disciplinary hearing of the guilt of the license holder or applicant of the crime described in the indictment or information, and of the person's violation of the statute on which it is based. For the purpose of this section, conviction includes all instances in which a plea of guilty is the basis for the conviction and all proceedings in which the sentence has been deferred or suspended.

(2) Violation of any state or federal statute or administrative rule regulating the practice of veterinary medicine, including any statute or rule defining or establishing standards of patient care or professional conduct or practice.

(3) Advertising which is false, fraudulent, or misleading.

(4) Resorting to fraud, misrepresentation or deception in the examination or treatment of an animal or in billing or reporting to a person, company, institution or agency.

(5) Incompetence, negligence, or use of any practice or procedure in the practice of the profession which creates an unreasonable risk of physical harm or serious financial loss to the client.

(6) Malpractice, or an act or acts, including failure to obtain informed consent and failure to provide follow-up care, falling below the generally accepted standard of care for veterinarians in the same practice situation whether actual harm was suffered by any patient or client.

(7) Suspension, revocation or restriction of the individual's license to practice the profession by competent authority in any state, federal or foreign jurisdiction for reasons that would be grounds for disciplinary sanction in this jurisdiction, a certified copy of the order or agreement being conclusive evidence of the revocation, suspension, or restriction.

(8) Possession, use, addiction to, prescription for use, diversion or distribution of controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes, or violation of any drug law.

(9) Failure to cooperate with an investigation authorized by the Board of Veterinary Medicine by:

(a) Not furnishing any papers or documents in the possession of and under the control of the licensee;

(b) Not furnishing in writing a full and complete explanation covering the matter contained in the complaint; or

(c) Not responding to subpoenas issued by the board or the department, whether or not the recipient of the subpoena is the accused in the proceedings.

(10) Interfering with an investigation or disciplinary proceeding by willful misrepresentation of facts or by the use of threats or harassment against any client or witness to prevent or discourage them from providing evidence in a disciplinary proceeding or any other legal action.

(11) Failing to comply with an order issued by the board or an assurance of discontinuance entered into with the board.

(12) Practice beyond the scope of practice encompassed by the license; except when reasonably undertaken in an emergency situation to protect life, health, or property.

(13) Offering, undertaking or agreeing to cure or treat disease or affliction by a secret method, procedure, treatment or the treating, operating or prescribing for any health condition by a method, means or procedure which the licensee refuses to divulge upon demand from the board.

(14) Failing to adequately supervise auxiliary staff to the extent that the patient's physical health or safety is at risk.

(15) Aiding or abetting an unlicensed person to practice when a license is required.

(16) Practicing veterinary medicine while the practitioner's license is suspended, revoked or not currently renewed.

(17) Wilful or repeated violations of rules established by any health agency or authority of the state or a political subdivision thereof.

(18) Engaging in the practice of veterinary medicine while suffering from a contagious or infectious disease creating a serious risk to public health.

(19) Cruel or inhumane treatment of animals.

(20) A veterinarian may choose whom to serve. Once the veterinarian has undertaken treatment of a patient, the veterinarian shall not neglect it."

Auth: Sec. 37-1-131, 37-18-202, 37-18-311, MCA; IMP, Sec. 37-1-131, 37-18-311, MCA

REASON: This rule is being proposed to adopt a definition of "unprofessional conduct" to implement the recent amendment of section 37-18-311(1)(e), MCA, effective May 11, 1989.

5. Interested persons may submit their data, views or arguments concerning the proposed amendments, repeal and adoption in writing to the Board of Veterinary Medicine, 1424 - 9th Avenue, Helena, Montana 59620-0407, no later than July 27, 1989.

6. If a person who is directly affected by the proposed amendments, repeal and adoption wishes to express his data, views or arguments orally or in writing at a public hearing, he must make written request for a hearing and submit this request along with any comments he has to the Board of Veterinary Medicine, 1424 - 9th Avenue, Helena, Montana 59620-0407, no later than July 27, 1989.

7. If the board receives requests for a public hearing on the proposed amendments, repeal and adoption from either 10% or 25, whichever is less, of those persons who are directly affected by the proposed amendments, repeal and adoption, from the Administrative Code Committee of the legislature, from a governmental agency or subdivision or from an association having no 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 81 based on the 815 licensees in Montana.

BOARD OF VETERINARY MEDICINE
WILLIAM J. QUINN, DVM

BY: _____
MICHAEL L. LETSON, DIRECTOR
DEPARTMENT OF COMMERCE

Certified to the Secretary of State June 19, 1989.

BEFORE THE DEPARTMENT OF REVENUE
OF THE STATE OF MONTANA

IN THE MATTER OF THE AMENDMENT of ARM 42.12.205 and 42.12.208 relating to Requirements When Licensing Is Subject to Lien.	NOTICE OF PUBLIC HEARING on the PROPOSED AMENDMENT of ARM 42.12.205 and 42.12.208 relating to Requirements When Licensing Is Subject to Lien.

TO: All Interested Persons:

1. On July 19, 1989, at 10:00, a public hearing will be held in the Fourth Floor Conference Room, Mitchell Building, Helena, Montana, to consider the amendment of ARM 42.12.205, and 203 relating to Requirements When License is Subject to Lien.

2. The amendments as proposed provide as follows:

42.12.205 REQUIREMENTS WHEN LICENSE SUBJECT TO LIEN ~~(1) All beverage and beer licenses may be subject to a mortgage, security interest, and other valid lien. Upon written request to the department, accompanied by a financing statement or by a copy of the note or mortgage, security agreement, or other lien (in which the license or licenses to be affected are described with common certainty such as inclusion of license number) together with a fee of $10, the name of the mortgagee, secured party, or other lien holder must be endorsed upon the license. All such requests shall be upon forms prescribed by the department and signed in each case by the licensee and the mortgagee, secured party, or other lien holder.~~

~~(2) No transfer of any license subject to any mortgage security interest, or other lien shall be approved unless the mortgagee, secured party, or lien holder shall subscribe and acknowledge the instrument of assignment.~~

~~(3) At such time as any mortgage, security interest, or lien affecting any license has been satisfied and fulfilled, the name of the mortgagee, secured party, or lien holder shall be removed upon written request of all parties in interest and upon the payment of a fee of $10, provided, however, that in the case of foreclosure and the transfer of license to the mortgagee, secured party, or lien holder, no such fee is required.~~

(1) Alcoholic beverage licenses may be subject to mortgage and other valid liens. The perfection of a mortgage or other lien in an alcoholic beverage license does not depend upon filing with the department. If a mortgagee or other lien holder desires to give additional public notice he may do so by filing a claim of mortgage or other lien with the department. The department acts only as an additional source of public notice for voluntarily filed claims of mortgage and other liens.

(2) The consent of a mortgagee or lien holder is not required to transfer a license. Persons having current claims of mortgage or lien will be given notice by the department of any application for transfer of the license.

(3) Upon written request to the department, together with a fee of $20, the name of a person claiming a mortgage shall be endorsed upon the license and shall be kept on file with the department. All such requests shall be upon forms prescribed by department and signed in each case by the licensee and mortgagee.

(4) The name of person claiming a lien shall not be endorsed upon the license. However, upon written request to the department, the department shall keep the name of a person claiming a lien on file. The request must be accompanied by sufficient proof of perfection of the lien claimed. No fee is required.

(5) Any notice of mortgage or other lien may be deleted from the department's file upon written request of the mortgagee or lien holder. If the mortgagee or lien holder is deceased, the written request for deletion may be made by a personal representative, heir, or devisee upon providing sufficient proof that the person has authority to act on behalf of the estate or has received the right to the lien. Any notice of mortgage or other lien may also be deleted from the department's file upon the written request of the licensee or applicant for the license if accompanied by a court order releasing the mortgage or lien, or other sufficient proof showing that the mortgage or lien has expired, been discharged, or extinguished.

(6) A mortgage or other lien may be foreclosed upon in any manner provided by law. For the transfer of a license pursuant to a foreclosure, the department shall accept a foreclosure bill of sale, which specifically refers to the license by number, in lieu of the voluntary assignment of the license by the licensee. In non-judicial foreclosures, the department may require sufficient documentation that the proper foreclosure proceedings were followed. Purchasers of a license at a foreclosure sale must apply to the department for transfer of the license and are subject to all statutes and rules required of any other applicant. AUTH: 16-1-303, MCA IMP: 16-4-404, MCA

42.12.208 TEMPORARY AUTHORITY (1) through (3) remain the same.

(4) ~~In the event liens, attachments, or judgments have attached to the license, the department will not grant an extension beyond the initial 45 days.~~ The recorded owner of the license must resume operation of the business conducted under the license in cases where the temporary authority has expired and cannot be extended.

(5) and (6) remain the same.

AUTH: 16-1-303, MCA IMP: 16-4-404, MCA

3. The amendments to ARM 42.12.205 are proposed for the following reasons:

Subsection (1) clarifies the department's role and responsibility in the perfection of mortgages and liens

involving alcoholic beverage licenses. There are no statutory requirements that mortgages and liens affecting alcoholic beverage licenses be recorded with the department in order to perfect.

Subsection (2) specifically deletes the current provision that mortgagees and lien holder must give their consent in order for the license to be transferred. There is no statutory basis or administrative reason to require such consent. Instead all persons claiming a mortgage or lien will be given notice of any applications for transfer.

Subsection (3) clarifies the process for filing a claim of mortgage and placing the mortgagee's name on the license. The $20 fee does not represent a $10 increase in the fee because the current $10 fee required to remove the mortgagee's name from the license is deleted.

Subsection (4) clarifies the process for filing a claim of lien. The names of lien holders are not required by statute to be placed on the license. Since the primary administrative cost is associated with physically placing a name on the license, no fee is required for claims of lien.

Subsection (5) clarifies the process for removing claims of mortgage or lien from the license and from the department files.

Subsection (6) clarifies the process for the transfer of a license pursuant to a mortgage or lien foreclosure.

The amendment to ARM 42.12.208 deletes that portion of subsection (4) which provides liens, attachments or judgments with ability to prevent temporary operating authority. There are no statutory authority or administrative reason to support such provision.

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:

Cleo Anderson
Department of Revenue
Office of Legal Affairs
Mitchell Building
Helena, Montana 59620

no later than July 27, 1989.

5. Eric Fehlig, Tax Counsel, Department of Revenue, Office of Legal Affairs, has been designated to preside over and conduct the hearing.

KENNETH NORTVEDT, Director
Department of Revenue

Certified to Secretary of State June 19, 1989

BEFORE THE DEPARTMENT OF REVENUE
OF THE STATE OF MONTANA

IN THE MATTER OF THE ADOPTION of Rule I, relating to Bad Debt Credit - Motor Fuels Taxes.	NOTICE OF THE PROPOSED ADOPTION of Rule I, relating to Bad Debt Credit - Motor Fuels Taxes.
	NO PUBLIC HEARING CONTEMPLATED

TO: All Interested Persons:

1. On August 18, 1989, the Department proposes to adopt Rule I relating to Bad Debt Credit - Motor Fuels Taxes.

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

RULE I SUPPORTING DOCUMENTATION FOR BAD DEBT CREDIT (1) A claim for credit for taxes paid on accounts for which the distributor received no compensation must be accompanied by documents or copies of documents showing that the accounts were worthless and claimed as bad debts on the distributor's federal income tax return. Any further information pertaining to claim shall be furnished as required by the Department.

3. The authority for the Department to adopt this rule is found at 15-70-104, MCA and the implementing sections are 15-70-225 and 15-70-328, MCA, as amended. Section 15-70-225, MCA, as amended provides that a claim for credit for taxes by distributors for the unpaid accounts must be accompanied by documents showing that the accounts are uncollectible. The section further provides that any further information pertaining to a claim shall be furnished as required by the Department. Section 15-70-328, MCA, as amended provides that a special fuel dealer can claim a credit for taxes by declaring an account worthless as indicated for federal income tax purposes.

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

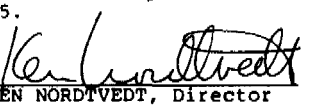
Cleo Anderson
Department of Revenue
Office of Legal Affairs
Mitchell Building
Helena, Montana 59620

no later than July 27, 1989.

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 Cleo Anderson at the above address no later than July 27, 1989.

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 subdivision, or agency; or from an association having no 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 25.



KEN NORDTVEDT, Director
Department of Revenue

Certified to Secretary of State June 19, 1989.

STATE OF MONTANA
DEPARTMENT OF COMMERCE
BEFORE THE BOARD OF PHYSICAL THERAPY EXAMINERS

In the matter of the repeal and amendment of rules pertaining to conduct, violations and complaints and adoption of new rules pertaining to unprofessional conduct and disciplinary actions	) NOTICE OF REPEAL OF 8.42.601) THROUGH 8.42.625 AND 8.42.) 702 THROUGH 8.42.706 AND) AMENDMENT OF 8.42.701 AND) THE ADOPTION OF NEW RULES) PERTAINING TO UNPROFESSIONAL) CONDUCT AND DISCIPLINARY) ACTIONS

TO: All Interested Persons:

1. On January 26, 1989 the Board of Physical Therapy Examiners published a notice of public hearing on the proposed repeal of ARM 8.42.601 through 8.42.625, the amendment of ARM 8.42.701 and the adoption of new rules pertaining to unprofessional conduct and disciplinary actions at page 174, 1989 Montana Administrative Register, issue number 2. The hearing was held on February 21, 1989, at 9:00 a.m. in the downstairs conference room, Department of Commerce, 1424 - 9th Avenue, Helena, Montana.

2. On April 17, 1989, the Board of Physical Therapy Examiners published a notice of proposed repeal of ARM 8.42.702 through 8.42.706 at page 463, 1989 Montana Administrative Register, issue number 8. These rules were inadvertently omitted in the original notice of public hearing.

3. The Board has repealed, amended and adopted the above-stated rules as proposed but with the following changes: (new rule I will be numbered 8.42.412 and new rule II will be numbered 8.42.413 under sub-chapter 4)

"I, (8.42.412) UNPROFESSIONAL CONDUCT (1) through (1)(d) will remain as proposed.

(e) ~~Malpractice, or a~~An act or acts below the standard of care for physical therapists providing similar treatment;

(f) through (v) will remain the same.

(w) Fee-splitting and over-utilization of services.

Auth: Sec. 37-1-131, 37-11-201, 37-11-321, MCA; IMP, Sec. 37-11-321, MCA

4. The Board has thoroughly considered all oral and written comments received. Those comments and the Board's responses are as follows:

COMMENT: Jerome B. Connolly, P.T., representing himself, suggested the Board address fee-splitting, over-utilization of services, and written disclosure prior to initiation of services of any relationship a physical therapist may have with any other practitioner which could in any way affect or bias the professional judgment of that physical therapist or that referring practitioner or other professional.

RESPONSE: The Board concurs with the suggestion that fee-splitting and over-utilization of services be defined as unprofessional conduct and subsection (w) has been added. The Board did not concur with the suggestion to include disclosure of any relationship a physical therapist may have with another professional. It is the opinion of the Board that this suggestion is outside the scope of the Board's Notice of Intent and therefore could not be addressed in these proceedings.

COMMENT: Richard Smith, P.T., representing himself, questioned whether standard of care has been adequately defined in the proposed rule and suggested that "adequate supervision" of auxiliary staff should be defined more specifically.

RESPONSE: The Board's response to the question of defined "standard of care" is that the applicable standard would be established on a "per-case" basis in cases brought before the Board, and that "adequate supervision" is defined as "direct supervision" under ARM 8.42.409.

5. No other comments or testimony were received.

BOARD OF PHYSICAL THERAPY EXAMINERS
LORIN WRIGHT, P.T., CHAIRMAN

BY: _____
MICHAEL L. LETSON, DIRECTOR
DEPARTMENT OF COMMERCE

Certified to the Secretary of State June 19, 1989.

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

In the matter of the adoption of Rules and the amendment of Rules 46.12.101, 46.12.302, 46.12.303, 46.12.401, 46.12.501, 46.12.502, and 46.12.3203 pertaining to a program for medicaid payment of medicare insurance premiums, deductibles, and coinsurance	))))))))	NOTICE OF THE ADOPTION OF RULES AND THE AMENDMENT OF RULES 46.12.101, 46.12.302, 46.12.303, 46.12.401, 46.12.501, 46.12.502, AND 46.12.3203 PERTAINING TO A PROGRAM FOR MEDICAID PAYMENT OF MEDICARE INSURANCE PREMIUMS, DEDUCTIBLES, AND COINSURANCE

TO: All Interested Persons

1. On May 11, 1989, the Department of Social and Rehabilitation Services published notice of the proposed adoption of ARM 46.17.101 (I), 46.17.102 (II), 46.12.4101 (III), 46.12.4102 (IV), 46.17.105 (V), 46.17.107 (VI), 46.17.108 (VII), (VIII), 46.17.109 (IX), 46.17.115 (X), 46.17.116 (XI), 46.17.117 (XII), 46.17.119 (XIII), 46.17.121 (XIV), 46.17.123 (XV), 46.17.124 (XVI), 46.12.309 (XVII) and the amendment of Rules 46.12.101, 46.12.302, 46.12.303, 46.12.401, 46.12.501, 46.12.502, and 46.12.3203 pertaining to a program for medicaid payment of medicare insurance premiums, deductibles, and coinsurance at page 569 of the 1989 Montana Administrative Register, issue number 9.

2. The Department has amended Rules 46.12.101, 46.12.302, 46.12.303, 46.12.401, 46.12.501, 46.12.502, and 46.12.3203 as proposed.

3. The Department has adopted Rules 46.17.101, MEDICAID COVERAGE FOR QUALIFIED MEDICARE BENEFICIARIES; 46.12.4101, QUALIFIED MEDICARE BENEFICIARIES, APPLICATION AND ELIGIBILITY FOR MEDICAID; 46.12.4102, QUALIFIED MEDICARE BENEFICIARIES, EFFECTIVE DATE OF ELIGIBILITY; 46.17.107, QUALIFIED MEDICARE BENEFICIARIES, PAYMENT OF MEDICARE PREMIUMS; 46.17.115, QUALIFIED MEDICARE BENEFICIARIES, FREE CHOICE OF PROVIDERS; 46.17.116, QUALIFIED MEDICARE BENEFICIARIES, PROVIDER REQUIREMENTS; 46.17.124, QUALIFIED MEDICARE BENEFICIARIES, DETERMINATION OF MEDICAL NECESSITY; and 46.12.309, MEDICAL ASSISTANCE MEDICAID PAYMENT as proposed.

4. The Department has adopted the following rules as proposed with the following changes:

(RULE II) 46.17.102 QUALIFIED MEDICARE BENEFICIARIES, DEFINITIONS (1) "Assignment" means an agreement between the medicare carrier and by a medicare provider under which

the carrier makes payment to the provider rather than the recipient, and the provider agrees to accept the medicare allowable rate as payment in full.

(2) "Carrier" means the private insurance company contracted with by the United States health care financing administration to process medicare Part B claims and issue payments to physicians and other providers or to recipients. ~~covered under medicare Part B insurance.~~

Subsections (3) through (11) remain as proposed.

(12) "Medicare allowable rate" means the reasonable charge for the medical service reimbursable under medicare Part B and is the lowest of:

Subsections (12)(a) through (19) remain as proposed.

AUTH: Sec. 53-2-201 and 53-6-113 MCA; Sec. 5, Ch. 310 L. 1989, Eff. 3/24/89 (HB 453)

IMP: Sec. 53-6-101 MCA; Sec. 1, Ch. 310, L. 1989, Eff. 7/1/89 (HB 453)

(RULE V) 46.17.105 QUALIFIED MEDICARE BENEFICIARIES, GENERAL REQUIREMENTS (1) A ~~medicaid~~ qualified medicare beneficiary is subject to the requirements in the following rules.

Subsections (1)(a) and (1)(b) remain as proposed.

AUTH: Sec. 53-2-201 and 53-6-113 MCA; Sec. 5, Ch. 310 L. 1989, Eff. 3/24/89 (HB 453)

IMP: Sec. 53-6-101 MCA; Sec. 1, Ch. 310, L. 1989, Eff. 7/1/89 (HB 453)

(RULE VII) 46.17.108 QUALIFIED MEDICARE BENEFICIARIES, COVERAGE AND REIMBURSEMENT OF DEDUCTIBLES AND COINSURANCE FOR MEDICARE SERVICES ALSO COVERED BY FULL MEDICAID

Subsections (1) through (1)(d) remain as proposed.

(e) hospice care;

(~~e~~f) outpatient physical therapy services;

(~~f~~g) outpatient speech therapy services;

(~~g~~h) outpatient occupational therapy services;

(~~h~~i) prosthetic devices, durable medical equipment and medical supplies;

(~~i~~j) physician services, including laboratory and x-ray services; and

(~~j~~k) dental services which are oral surgery services.

Subsections (2) through (3) remain as proposed.

(a) Subsections (1)(a) through (~~d~~e) above is ~~the lowest of:~~

~~(i) the medicare deductibles and coinsurance; or.~~

~~(ii) the medicaid fee or rate.~~

(b) Subsections (1)(~~e~~f) through (~~j~~k) above is the lowest of:

(i) the provider's submitted charge;
(ii) the medicare allowed rate; or
(iii) the medicaid fee or rate.

(4) Reimbursement from medicaid may not exceed an amount which would cause total payment to the provider from both medicare and other third party payors and medicaid to be greater than the medicare allowable charge or rate.

AUTH: Sec. 53-2-201 and 53-6-113 MCA; Sec. 5, Ch. 310 L. 1989, Eff. 3/24/89 (HB 453)
IMP: Sec. 53-6-101 MCA; Sec. 1, Ch. 310, L. 1989, Eff. 7/1/89 (HB 453)

(RULE IX) 46.17.109 QUALIFIED MEDICARE BENEFICIARIES, PAYMENT FOR CHIROPRACTIC SERVICES AS MEDICARE SERVICES NOT COVERED BY FULL MEDICAID

(1) Chiropractic services are a medicaid covered service for a qualified medicare beneficiary when the subluxation is demonstrated by x-ray to exist. The x-ray must be taken and interpreted by a doctor of ~~medicare~~ medicine or osteopathy.

Subsections (2) through (4) remain as proposed.

AUTH: Sec. 53-2-201 and 53-6-113 MCA; Sec. 5, Ch. 310 L. 1989, Eff. 3/24/89 (HB 453)
IMP: Sec. 53-6-101 MCA; Sec. 1, Ch. 310, L. 1989, Eff. 7/1/89 (HB 453)

(RULE XII) 46.17.117 QUALIFIED MEDICARE BENEFICIARIES, PROVIDER CHOICE OF PARTICIPATION AND OTHER RIGHTS

(1) A provider may choose to provide services to a person either as a private pay client or as a medicaid client. A medicaid client is a person ~~may be~~ who is medicaid eligible either as a qualified medicare beneficiary or as a qualified medicare beneficiary who is also eligible under another medicaid category.

Subsection (2) remains as proposed.

AUTH: Sec. 53-2-201 and 53-6-113 MCA; Sec. 5, Ch. 310, L. 1989, Eff. 3/24/89 (HB 453).
IMP: Sec. 53-6-101 MCA; Sec. 1, Ch. 310, L. 1989, Eff. 7/1/89 (HB 453).

(RULE XIII) 46.17.119 QUALIFIED MEDICARE BENEFICIARIES, PAYMENTS TO PROVIDERS (1) Payments ~~for the medicare insurance deductibles and coinsurance~~ for services provided to medicaid qualified medicare beneficiaries may only be made to a provider. A provider in order to receive payments must be enrolled in the medicaid program.

(2a) Medicaid payment ~~of the medicare insurance deductibles and coinsurance~~ will be made to the provider even when the provider for medicare purposes has not accepted assignment.

(32) Payment in full, except as otherwise provided in (32)(a) below, ~~for the medicare insurance deductibles and coinsurance~~ for services provided to medicaid qualified medicare beneficiaries, is the medicaid payment as determined under Rules VII, ~~VIII~~ and IX plus the qualified medicare beneficiary's copayment as provided for in Rule XIV. A provider may not collect any amount from the person which is in excess of payment in full even if that payment is less than the medicare insurance deductibles and coinsurance. Where a person is eligible for medicaid under both medicaid qualified medicare beneficiary and another medicaid category, a provider must accept the medicaid payment as payment in full.

Original subsection (3)(a) remains as proposed but will be recategorized as subsection (2)(a).

AUTH: Sec. 53-2-201 and 53-6-113 MCA; Sec. 5, Ch. 310, L. 1989, Eff. 3/24/89 (HB 453).
IMP: Sec. 53-6-101 MCA; Sec. 1, Ch. 310, L. 1989, Eff. 7/1/89 (HB 453).

(RULE XIV) 46.17.121 QUALIFIED MEDICARE BENEFICIARIES, COPAYMENTS Subsections (1) through (1)(g) remain as proposed.

(h) prosthetic devices, durable medical equipment and medical supplies, $.50 per line item;

Subsections (1)(i) through (4) remain as proposed.

AUTH: Sec. 53-2-201 and 53-6-113 MCA; Sec. 5, Ch. 310 L. 1989, Eff. 3/24/89 (HB 453)
IMP: Sec. 53-6-101 MCA; Sec. 1, Ch. 310, L. 1989, Eff. 7/1/89 (HB 453)

(RULE XV) 46.17.123 QUALIFIED MEDICARE BENEFICIARIES, BILLING Subsections (1) through (1)(a)(i) remain as proposed.

(ii) claims for medicare Part B insurance services must be submitted to the medicare Part B insurance carrier for medicare payment and then submitted to medicaid on the appropriate claim form with the medicare explanation of medical benefits (EOMB) attached for payment of the deductibles and coinsurance ~~with the patient's medicaid eligibility as a qualified medicare beneficiary indicated in that submission~~. The part B carrier may, under an agreement with the department, ~~will then~~ submit the claims by electronic media to medicaid for payment of the deductibles and coinsurance.

AUTH: Sec. 53-2-201 and 53-6-113 MCA; Sec. 5, Ch. 310 L. 1989, Eff. 3/24/89 (HB 453)
IMP: Sec. 53-6-101 MCA; Sec. 1, Ch. 310, L. 1989, Eff. 7/1/89 (HB 453)

5. The Department will not adopt proposed Rule VIII.

6. The Department has thoroughly considered all commentary received:

COMMENT: For chiropractic services under Medicare, the "lowest of" methodology using "prevailing rate" is no longer applicable.

RESPONSE: The department has confirmed with the Medicare Part B carrier that the "lowest of" methodology using "prevailing rate" is still applicable.

COMMENT: The definition of "assignment" should be eliminated from the rule because it is incorrect. A physician who accepts assignment has the Medicare payment sent to him, not to the recipient. It does not mean that he agrees to accept the Medicare allowable as payment in full.

RESPONSE: The department has checked with the Medicare Part B carrier and the federal regulations. The payment on assigned claims are made to the provider and the department has made this clarification to this rule. However, 42 CFR §424 (previously designated 42 CFR §405.1675) clearly states that in accepting assignment the provider agrees to accept the Medicare allowable charge as payment in full and that he will not collect from the recipient or any other source an amount in excess of the applicable amount of deductibles and coinsurance.

COMMENT: "Medicare allowable rate" is a term applicable to Medicare Part B services as opposed to Medicare Part A services.

RESPONSE: The department has made this clarification.

COMMENT: It should be made clear that Rule VII (ARM 46.17.109) lists Medicare services also covered by full Medicaid.

RESPONSE: The department has made this clarification.

COMMENT: In Rule VII (ARM 46.17.109), reimbursement from Medicaid payment should never cause total payment to the provider from Medicare, other third party payors, and Medicaid to be greater than the Medicare allowable charges or rate.

RESPONSE: The department has made this clarification.

COMMENT: The 51st legislature mandated coverage of hospice care as a Medicaid service. The rules should be adjusted to indicate that.

RESPONSE: The department will add hospice under Rule VII (ARM 46.17.111), which lists Medicare services also covered by full Medicaid, and will drop proposed Rule VIII.

COMMENT: The caption for Rule IX (ARM 46.17.113) should indicate that chiropractic services are a Medicare service not covered by full Medicaid.

RESPONSE: The department has made this clarification.

COMMENT: Under Rule IX (ARM 46.17.113), x-rays must be taken and interpreted by a doctor of medicine, not a doctor of medicare.

RESPONSE: The department has corrected this mistake.

COMMENT: Under Rule XIV (ARM 46.17.121), the copayment for prosthetic devices, durable medicaid equipment and medical supplies is $.50 per line item, as opposed to per item. This reflects current practice.

RESPONSE: The department has made this change.

COMMENT: Under Rule XV (ARM 46.17.123), does the department intend to mandate that all Medicare Part B claims be submitted to Medicaid by electronic media? For example, out-of-state Medicare Part B carriers may not have an electronic media agreement with the state.

RESPONSE: The department has made the language on electronic media claims permissive.

COMMENT: Under Rule V (ARM 46.17.105), the department should not impose restricted card program requirements on QMB recipients because Medicare and Medicaid may not agree on what is medically necessary and Medicaid is paying only for the Medicare deductible and coinsurance.

RESPONSE: The department may not always agree with Medicare on what is medically necessary and reserves the right to make its own judgement. The restricted card program's primary emphasis is on prescription drugs. In 1991, the Medicare drug coverage will be effective with a $600 deductible. Medicaid will essentially pick up a new clientele with no Medicare payment involvement until the deductible is met. The department believes it is prudent to review this new QMB clientele for any abuse of prescription drugs.

COMMENT: Rule VII (ARM 46.17.109) should be modified to reflect current policy of Medicaid reimbursement of the full deductible and coinsurance for Part A services.

RESPONSE: The department has made this modification.

COMMENT: Rules XII and XIII need some clarification in language to make them more understandable.

RESPONSE: Changes have been made in those rules to make them more understandable.

COMMENT: The UB-82, rather than the HCFA 1500, should be used for hospice care under the QMB program and for hospice coverage under the full Medicaid program.

RESPONSE: The design of QMB program payment procedures was completed prior to the legislature passing HB 663, which mandates coverage of hospice care under Medicaid. This design calls for hospice providers to bill Medicaid using the HCFA 1500, even though they bill Medicare using the UB-82. This approach parallels our current practice with respect to home health agencies and skilled nursing facilities. Both these provider types bill Medicare on the UB-82, but bill Medicaid for services using the HCFA 1500. Moreover, these provider types normally bill Medicaid for services to Medicaid clients using the HCFA 1500. After all QMB procedures are implemented, the department will evaluate the use of the UB-82 for such provider types as hospice, home health and skilled nursing.

Director, Social and Rehabilitation Services

Certified to the Secretary of State June 19, 1989.

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

In the matter of the adoption of Rules I through X and the amendment of ARM 46.12.204 and 501 pertaining to medicaid coverage of hospice services	)))))	NOTICE OF THE ADOPTION OF RULES I THROUGH X AND THE AMENDMENT OF ARM 46.12.204 AND 46.12.501 PERTAINING TO MEDICAID COVERAGE OF HOSPICE SERVICES

TO: All Interested Persons

1. On May 11, 1989, the Department of Social and Rehabilitation Services published notice of the proposed adoption of Rules I through X and the amendment of ARM 46.12.204 and 501 pertaining to medicaid coverage of hospice services at page 584 of the 1989 Montana Administrative Register, issue number 9.

2. The Department has adopted Rule VI, HOSPICE, PHYSICIANS, as proposed. However, its two subsections will be codified as ARM 46.12.1821(4) and (5).

3. The Department has amended ARM 46.12.204 as proposed.

4. The Department has adopted the following rules as proposed with the following changes:

(RULE I) 46.12.1819 HOSPICE, DEFINITIONS

(1) ~~"Attending physician" means a doctor of medicine or osteopathy who is identified by the individual at the time he elects to receive hospice care as having the most significant role in the determination and delivery of the individual's medical care. The physician must be licensed to practice medicine in the state of Montana.~~ "Department" means the Montana department of social and rehabilitation services.

(2) ~~"Basic interdisciplinary assessment group" means a group comprised of at least a nurse, physician, medical social worker or counselor. The physician may be either a doctor of medicine or osteopathy. This group is responsible for completing the initial assessment and the plan of care of the individual.~~ Except for the definition of "physician", the department hereby adopts and incorporates by reference 42 CFR 418.3, as amended through October 1, 1988, which sets forth definitions of terms related to services covered as hospice care. Copies of 42 CFR 418.3, as amended through October 1, 1988, are available from the Montana Department of Social and Rehabilitation Services, Economic Assistance Division, 111 N. Sanders, P.O. Box 4210, Helena, Montana 59620.

(3) ~~"Benefit period" means a period of time that begins on the first day of the month the recipient elects hospice and~~

~~ends or the last day of the eleventh successive calendar month.~~ "Physician" means an individual licensed under the state medical practice act to practice medicine or osteopathy.

~~(4) "Bereavement counseling" means counseling services provided to the individual's family after the individual's death.~~

~~(5) "Cap amount" means the maximum amount of reimbursement the Montana medicaid program will pay a designated hospice for providing services to medicaid recipients.~~

~~(6) "Cap period" means the twelve (12) month period beginning November 1 and ending October 31 of the next year.~~

~~(7) "Continuous Home Care" means primarily nursing care provided in a period of crisis which will achieve palliation or management of acute medical symptoms. A minimum of 8 hours of care must be provided during a 24 hour day.~~

~~(8) "Counseling services" mean services under a hospice program provided to the terminally ill recipient and family members or other persons who will care for the individual in the home. These services, including dietary, are provided for the purposes of training the care givers how to provide the home care and helping the individual and the care givers to adjust to the individual's approaching death.~~

~~(9) "Election period" means any calendar month in which an individual receives medicaid hospice benefits.~~

~~(10) "Election statement" means a statement filed by the terminally ill individual with a particular hospice, indicating that he chooses to receive hospice services rather than standard health care benefits for terminal illness.~~

~~(11) "Hospice" means an agency or organization, that is primarily engaged in providing care to an individual who is certified as terminally ill.~~

~~(12) "Medical director of a hospice" means a doctor of medicine or osteopathy currently licensed to practice in the state of Montana, who performs as a hospice's medical director.~~

~~(13) "Nursing services" means those services provided by or under the supervision of a registered nurse and defined by the nurse practice act.~~

~~(14) "Representative" means a person who is, because of the individual's mental or physical incapacity, authorized to execute or revoke an election for hospice care or terminate medical care on behalf of the terminally ill individual.~~

~~(15) "Respite care" means short term inpatient care provided only when necessary to relieve the family members or other persons caring for the individual at home.~~

~~(16) "Routine home care" means each day the patient is at home, under the care of the hospice and not receiving continuous home care.~~

~~(17) "Social worker" means a person who has at least a bachelor's degree from a school accredited or approved by the council on social work education.~~

~~(10)--"Terminally-ill"-means-an-individual-who-has-a-medical-prognosis-that-his-life-expectancy-is-six-months-or-less.~~

AUTH: Sec. 53-6-113 MCA; Sec. 2, Ch. 633, L. 1989, Eff. 7/1/89 (HB 663)
IMP: Sec. HB 663 MCA; Sec. 1, Ch. 633, L. 1989, Eff. 7/1/89 (HB 663)

(RULE II) 46.12.1821 HOSPICE, CONDITIONS OF PARTICIPATION

(1) The hospice **program** must be licensed under state law and must meet medicare's conditions of participation for hospice programs and have a valid provider agreement with medicare as conditions of enrollment in medicaid.

(2) The department hereby adopts and incorporates by reference 42 CFR 418.50 through 418.100, as amended through October 1, 1988, which set forth medicare's conditions of participation for hospice providers. Copies of 42 CFR 418.50 through 418.100, as amended through October 1, 1988, are available from the Montana Department of Social and Rehabilitation Services, Economic Assistance Division, III N. Sanders, P.O. Box 4210, Helena, Montana 59620.

(3) The above requirements are in addition to those contained in ARM 46.12.102 and 46.12.301 through 46.12.308.

(4) The hospice must submit a physician listing with their provider application and update changes in the listing of the physicians which are hospice employees, including physician volunteers.

(5) The designated hospice must notify the department when the designated attending physician of a recipient in their care is not a hospice employee.

AUTH: Sec. 53-6-113 MCA; Sec. 2, Ch. 633, L. 1989, Eff. 7/1/89 (HB 663)
IMP: Sec. HB 663 MCA; Sec. 1, Ch. 633, L. 1989, Eff. 7/1/89 (HB 663)

(RULE III) 46.12.1823 HOSPICE, ~~REQUIRED~~ COVERED SERVICES

(1) ~~All-required-services-must-be-performed-by-appropriately-qualified-personnel.--It-is-the-nature-of-the-service,-rather-than-the-qualification-of-the-person-who-provides-it,-that-determines-the-category-of-the-service.--The-following-services-are-required:~~ To be covered, hospice services must meet the following requirements:

(a) ~~nursing-services-provided-by-or-under-the-supervision-of-a-registered-nurse;~~ they must be reasonable and necessary for the palliation or management of the terminal illness as well as related conditions;

(b) ~~medical-social-services-provided-by-a-social-worker-who-has-a-least-a-bachelor's-degree-from-a-school-accredited-or-approved-by-the-council-on-social-work-education-and-who-is~~

~~under the direction of a physician;~~ the individual must elect hospice care in accordance with ARM 46.12.1831 (Rule VII);

(c) ~~physician's services performed by a physician as defined in ARM 46.12.2001 through 46.12.2003;~~ a plan of care must be established as set forth in ARM 46.12.1821 (Rule II) and ARM 46.12.1825 (Rule IV) before services are provided. The services must be consistent with the plan of care; and

(d) ~~counseling services provided to the terminally ill individual and the family members or other home care givers caring for the individual at home. Counseling, including bereavement and dietary counseling, are core hospice services provided both for the purpose of training the family member or other care giver to provide the care, and to help the individual, family members or other care giver to adjust to the individual's approaching death;~~ a certification that the individual is terminally ill must be completed as set forth in ARM 46.12.1827 (Rule V).

~~(e) short term inpatient care provided in a participating hospice inpatient unit, or a participating hospital, SNF, or ICF that additionally meets the hospice staff and patient standards. Services provided in an inpatient setting must conform to the written plan of care. General inpatient care may be required for procedures necessary for pain control or acute or chronic symptom management, which cannot be provided in other settings. Respite care is the only type of inpatient care that may be provided in an ICF;~~

~~(f) medical equipment and supplies include drugs and biologicals. Only drugs as defined in subsection 1861(t) of the social security act and which are used primarily for the relief of pain and symptom control related to the patient's terminal illness are allowed. Appliances include durable medical equipment as well as other self help and personal comfort items related to the palliation or management of the patient's terminal illness. Equipment is provided by the hospice for use in the individual's home while they are under hospice care. Medical supplies include only those that are part of the written plan of care;~~

~~(g) home health aide and homemaker services furnished by qualified aides. Home health aides will provide personal care services and will also perform household services necessary to maintain a safe and sanitary environment in areas of the home used by the individual. Aide services must be provided under the general supervision of a registered nurse. Homemaker services include assistance in maintenance of a safe and healthy environment and services to enable the individual to carry out the plan of care;~~

~~(h) physical therapy, occupational therapy and speech therapy provided for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills; and~~

~~(i) nursing care, physician's services, medical social services and counseling are core hospice services and must be routinely provided by hospice employees. Supplemental core services may be contracted during periods of peak patient loads and to obtain physician specialty services.~~

(2) For covered hospice services, medicaid will generally pay for the services covered by medicare. The department hereby adopts and incorporates by reference 42 CFR 418.202 through 418.204, as amended through October 1, 1988, except for those provisions of 42 CFR 418.202 which apply to physicians' services and to drugs and biologicals. The incorporated material sets forth requirements for medicare coverage of hospice services. Copies of 42 CFR 418.202 through 418.204, as amended through October 1, 1988, except for those provisions of 42 CFR 418.202 which apply to physicians' services and to drugs and biologicals, are available from the Montana Department of Social and Rehabilitation Services, Economic Assistance Division, 111 N. Sanders, P.O. Box 4210, Helena, Montana 59620.

(a) Physicians' services is a covered hospice service and must be performed by a doctor of medicine or osteopathy.

(b) Outpatient drugs and biologicals will be reimbursed separately under the provisions of ARM 46.12.701 through 46.12.703.

AUTH: Sec. 53-6-113 MCA; Sec. 2, Ch. 633, L. 1989, Eff. 7/1/89 (HB 663)
IMP: Sec. HB 663 MCA; Sec. 1, Ch. 633, L. 1989, Eff. 7/1/89 (HB 663)

(RULE IV) 46.12.1825 REQUIREMENTS, PLAN OF CARE

(1) ~~To be covered, a certification of terminal illness must be completed and hospice services must be reasonable and necessary for the palliation and management of the terminal illness and related conditions. The individual must elect hospice care and a plan of care must be established and reviewed monthly by the basic interdisciplinary assessment group.~~ The plan of care must be maintained by the hospice and available for department review. To be eligible for coverage, services must be consistent with the plan of care. In order to establish a plan of care:

Subsections (1)(a) through (1)(c) remain as proposed.

(d) the entire group must ~~review~~ approve the initial plan within two calendar days following the assessment.

AUTH: Sec. 53-6-113 MCA; Sec. 2, Ch. 633, L. 1989, Eff. 7/1/89 (HB 663).
IMP: Sec. HB 663 MCA; Sec. 1, Ch. 633, L. 1989, Eff. 7/1/89 (HB 663).

(RULE V) 46.12.1827 HOSPICE, CERTIFICATION OF TERMINAL ILLNESS ~~(1)--The hospice must obtain a physician certification of the terminal illness for the individual which is:~~

(1) In order to be eligible to elect hospice care under medicaid, an individual must be certified as being terminally ill in accordance with medicare certification requirements.

~~(a)--signed by:~~

~~(i)----the attending physician;~~

~~(ii)---the hospice medical director;~~ ~~or~~

~~(iii)--a physician who is a member of the basic interdisciplinary assessment group;~~

~~(b)--obtained within two calendar days after the hospice care is initiated;~~

~~(c)--filed with a specific hospice; includes the individual's medical prognosis and states the life expectancy is six (6) months or less.--The hospice must maintain this certification statement;~~

(2) ~~The department has the right to obtain another physician's opinion to verify an individual's medical status;~~ The department hereby adopts and incorporates by reference 42 CFR 418.22, as amended through October 1, 1988, which sets forth medicare conditions for certification of terminal illness to qualify an individual to be eligible to elect hospice care. Copies of 42 CFR 418.22, as amended through October 1, 1988, are available from the Montana Department of Social and Rehabilitation Services, Economic Assistance Division, 111 N. Sanders, P.O. Box 4210, Helena, Montana 59620.

~~(3)--For any subsequent election period, the hospice must obtain another certification under the same requirements described in (1)(b) above, within two calendar days of the beginning of that period.~~

AUTH: Sec. 53-6-113 MCA; Sec. 2, Ch. 633, L. 1989, Eff. 7/1/89 (HB 663)
IMP: Sec. HB 663 MCA; Sec. 1, Ch. 633, L. 1989, Eff. 7/1/89 (HB 663)

(RULE VII) 46.12.1831 HOSPICE, ELECTION AND WAIVER OF OTHER BENEFITS

(1) ~~If an individual elects to receive hospice care, he must file an election statement with a particular hospice.--An election statement may also be filed by a legally authorized representative--or--guardian.~~ An individual eligible for hospice care or his representative must file an election statement with a particular hospice in order to receive that care. The department will follow medicare guidelines in administering this provision.

~~(a)--An election to receive hospice care will be automatically renewed after the initial election periods, without a~~

~~break-in-care-as-long-as-the-individual-remains-in-the-care-of the-designated-hospice-and-does-not-revoke-the-election.~~

~~(b)--An-individual-who-has-previously-revoked-his-hospice election-may-elect-further-periods-when-the-following-conditions-are-met:~~

~~(i)----the-hospice-benefit-period-covered-by-medicaid-did not-exceed-two-hundred-and-ten-(210)-days;~~

~~(ii)---the-individual-did-not-change-hospices-more-than six-(6)-times-during-the-hospice-benefit-period;-and~~

~~(iii)--the--individual--did--not--revoke--hospice--election periods-more-than-six-(6)-times-as-described-in-the-change-of hospice-requirements.~~

~~(c)--An-individual-may-receive-medicaid-covered-hospice services-from-the-first-day-of-hospice-care-or-any-subsequent day-of-hospice-care,-but-a-individual-cannot-designate-an-effective-date-that-is-earlier-than-the-date-the-election-is made.~~

~~(d)--An-individual-must-waive-all-rights-to-medicaid-payments-for-the-duration-of-the-election-period-of-hospice-care with-the-following-exceptions:~~

~~(i)----hospice-care-and-related-services-provided-either directly-or-under-arrangements-by-the-designated-hospice;~~

~~(ii)---any--medicaid-services--that--are--not--related--or equivalent-to-the-treatment-of-the-terminal-condition-or-a related-condition-for-which-hospice-care-was-elected;-and~~

~~(iii)--physician--services--provided--by--the--individual's designated-attending-physician,-if-that-physician-is-not-an employee-of-the-designated-hospice-or-receiving-compensation from-the-hospice-for-those-services.~~

(2) The department hereby adopts and incorporates by reference 42 CFR 418.24(a) through 418.24(d), as amended through October 1, 1988, which set forth requirements for individual election of hospice care and 42 CFR 418.26, as amended through October 1, 1988, which sets forth elements of the election statement. Copies of 42 CFR 418.24(a) through 418.24(d) and 418.26, as amended through October 1, 1988, are available from the Montana Department of Social and Rehabilitation Services, Economic Assistance Division, 111 N. Sanders, P.O. Box 4210, Helena, Montana 59620.

(3) An individual waives all rights to medicaid payments for the duration of the election of hospice care for the following services:

(a) Hospice care provided by a hospice other than the hospice designated by the individual (unless provided under arrangements made by the designated hospice).

(b) Any medicaid services that are related to the treatment of the terminal condition for which hospice care was elected or a related condition or that are equivalent to hospice care except for:

(i) services provided by the designated hospice;

(ii) services provided by another hospice under arrangements made by the designated hospice;

(iii) services provided by the individual's attending physician if that physician is not an employee of the designated hospice or receiving compensation from the hospice for those services; and

(iv) coverage of approved drugs.

~~(2) The election statement must include the following items of information:~~

~~(a) identification of the particular hospice that will provide care to the individual;~~

~~(b) the individual's acknowledgement that the person has been given a full understanding of hospice care;~~

~~(c) the individual's acknowledgement that the person understands that all medicaid services except those identified in subsection (3)(d) are waived by the election during the hospice benefit period;~~

~~(d) the effective date of the election; and~~

~~(e) the signature of the individual and the date of the signature.~~

AUTH: Sec. 53-6-113 MCA; Sec. 2, Ch. 633, L. 1989, Eff. 7/1/89 (HB 663)
IMP: Sec. HB 663 MCA; Sec. 1, Ch. 633, L. 1989, Eff. 7/1/89 (HB 663)

(RULE VIII) 46.12.1833 HOSPICE, REVOCATION OF ELECTION

(1) ~~An individual may revoke the election of hospice care at any time~~. An individual or representative may revoke the individual election of hospice care at any time during an election period. The department will follow medicare guidelines in administering this provision.

~~(a) To revoke the election of hospice care, the individual must file a signed revocation statement with the hospice.~~

~~(b) Upon revocation of the hospice election, other medicaid coverage is reinstated and the individual forfeits coverage for any remaining days in that election period.~~

(2) The department hereby adopts and incorporates by reference 42 CFR 418.28, as amended through October 1, 1988, which sets forth the medicare requirements for revoking the election of hospice care. Copies of 42 CFR 418.28, as amended through October 1, 1988, are available from the Montana Department of Social and Rehabilitation Services, Economic Assistance Division, 111 N. Sanders, P.O. Box 4210, Helena, Montana 59620.

AUTH: Sec. 53-6-113 MCA; Sec. 2, Ch. 633, L. 1989, Eff. 7/1/89 (HB 663)
IMP: Sec. HB 663 MCA; Sec. 1, Ch. 633, L. 1989, Eff. 7/1/89 (HB 663)

(RULE IX) 46.12.1835 HOSPICE, CHANGE OF HOSPICE

(1) ~~An individual may at any time change their designated hospice during election periods for which he is eligible.~~ An individual or representative may change once in each election period the designation of the particular hospice from which hospice care will be received. The department will follow medicare guidelines in administering this provision.

~~(a) An individual may change designated hospices no more than six times during the hospice benefit period.~~

~~(b) The change of the designated hospice is not considered a revocation of the election. To change a hospice an individual must file a dated & signed statement during the monthly election period with the first hospice and the newly designated hospice. This statement must contain the following information:~~

~~(i) the name of the hospice from which the individual has received care;~~

~~(ii) the name of the hospice from which the individual plans to receive care; and~~

~~(iii) the effective date of the change in hospices.~~

~~(c) A change in ownership of a hospice is not considered a change in the designation of a hospice and requires no action on the individual's part.~~

(2) The department hereby adopts and incorporates by reference 42 CFR 418.30, as amended through October 1, 1988, which sets forth the medicare requirements that must be met when another hospice is chosen in an election period. Copies of 42 CFR 418.30, as amended through October 1, 1988, are available from the Montana Department of Social and Rehabilitation Services, Economic Assistance Division, 111 N. Sanders, P.O. Box 4210, Helena, Montana 59620.

AUTH: Sec. 53-6-113 MCA; Sec. 2, Ch. 633, L. 1989, Eff. 7/1/89 (HB 663)

IMP: Sec. HB 663 MCA; Sec. 1, Ch. 633, L. 1989, Eff. 7/1/89 (HB 663)

(RULE X) 46.12.1837 HOSPICE, REIMBURSEMENT

(1) ~~Reimbursement for hospice services is limited to 210 days.~~ Medicaid payment for covered hospice care will be made in accordance with the specific categories of covered hospice care (routine home care day, continuous home care day, inpatient respite care day, and general inpatient care day) and the payment amounts and procedures established by medicare.

~~(2) With the exception of payment for physician services outlined in ARM 46.12.2003, medicaid reimbursement for hospice care will be made at one of four predetermined rates for each day in which an individual receives the respective type and intensity of the service furnished under the care of the hospice. The four rates are prospective rates. There will be~~

~~no retroactive rate adjustments other than the application of the "cap" on overall payments and the limitations on payments for inpatient care, if applicable.~~ The department hereby adopts and incorporates by reference 42 CFR 418.302, as amended through October 1, 1988, which sets forth the medicare payment procedures. Copies of 42 CFR 418.302, as amended through October 1, 1988, are available from the Montana Department of Social and Rehabilitation Services, Economic Assistance Division, 111 N. Sanders, P.O. Box 4210, Helena, Montana 59620.

~~(a) Descriptions of the payments for each level of care are:~~

~~(i) Routine home care, the hospice will be paid the routine home care rate for each day the patient is in residence, under the care of the hospice and not receiving continuous home care. This rate is paid without regard to volume or intensity of routine home care services provided on any given day.~~

~~(ii) Continuous home care, is provided only during a period of crisis. A period of crisis occurs when a patient requires continuous care which is primarily nursing care to achieve palliation and management of acute medical symptoms. Care must be provided by either a registered nurse or a licensed practical nurse and a nurse must provide care for at least half the total period of the care. A minimum of eight hours of care must be provided during a twenty-four day which begins and ends at midnight. This care need not be continuous and uninterrupted. If less skilled care is needed on a continuous basis to enable the person to remain at home, this is covered as routine home care. For every hour or part of an hour of continuous care furnished, the hourly rate will be reimbursed to the hospice up to twenty four hours per day.~~

~~(iii) Inpatient respite care, the hospice will be paid at the inpatient respite care rate for each day that the recipient is in an approved inpatient facility and is receiving respite care. Payment for respite care may be made for a maximum of five days at a time including the date of admission but not counting the date of discharge in any monthly election period. Payment for the sixth and any subsequent day is to be made at the routine home care rate. Respite care may not be provided when the hospice patient is a nursing home resident.~~

~~(iv) General inpatient care, the hospice will be paid at the inpatient rate when general inpatient care is provided. No other fixed payment rates will be applicable for a day on which the recipient receives hospice general inpatient care except for:~~

~~(A) date of discharge from an inpatient unit, payment for that day will be the appropriate home care rate, unless the patient dies as an inpatient. When the individual is discharged as deceased, the inpatient rate, either general or respite, is to be paid for the discharge date.~~

~~(v)----The-medicaid-hospice-payment-rates-are-the-same-as the-medicare-hospice-rates,-adjusted-to-reflect-area-wages-and disregard-cost-offsets-attributable-to-medicare-coinsurance amounts.--Under-the-medicaid-hospice-benefit,-no-cost-sharing may-be-imposed-with-respect-to-hospice-services-rendered-to medicaid-recipients.~~

~~(vi)---Payment-for-nursing-home-services-will-not-be-provided-to-a-fully-eligible-individual-as-provided-for-in-ARM 46.12.1205(1)(b)--when--the--individual--elects--the--medicaid hospice-benefit.~~

(3) The board and room rate to be paid a hospice for a medicaid recipient who resides in a nursing facility (SNF/ICF) will be the medicaid rate established by the department for the individual facility minus the amount the recipient pays toward his own cost of care. Payment for board and room will be made to the hospice and, in turn, the hospice will reimburse the nursing facility. General inpatient care or hospice respite care in a nursing facility will not be reimbursed directly by the medicaid program when a medicaid recipient elects the hospice benefit payment. Under such circumstances payment will be made to the hospice in accordance with this rule.

(a) In this context, the term "room and board" includes performance of personal care services, including assistance in the activities of daily living, socializing activities, administration of medication, maintaining the cleanliness of a resident's room, and supervision and assisting in the use of durable medical equipment and prescribed therapies.

~~(vii)--The-hospice-has-an-obligation-of-continuing-care. After-the--individual's-hospice-benefit-expires,-the-hospice must-continue-to-provide-that-individual's-care-until-he-either-expires-or-revokes-the-election-of-hospice-care.~~

~~(3)--Payments-to-a-hospice-for-inpatient-care-must--be limited-according-to-the-number-of-days-of-inpatient-care-furnished-to-medicaid-patients.---During-the-twelve--(12)--month period-beginning-November-1-of-each-year-and-ending-October-31 of-the-next-year,-the-aggregate-number-of-inpatient-days-(both general-inpatient-days-and-inpatient-respite-care)-may--not exceed-twenty-per-cent-of-the-total-number-of-days-of-hospice care-provided-to-all-medicaid-recipients-during-the-same-period--by-the--designated--hospice--or--its--contracted-agent(s). This-limitation-is-applied-once-each-year,-at-the-end-of-the hospices'-"cap-period".~~

~~(a)--For-the-purposes-of-computation,-if-it-is-determined that-the-inpatient-rate-should-not-be-paid,-any-days-for-which the-hospice-receives-payment-at-a-home-care-rate-will-not-be counted--as--inpatient--days.---The--limitations--on--payment--for inpatient-days-are-as-follows:~~

~~(i)----the--maximum--allowable--number--of--inpatient--days will-be-calculated-by-multiplying-the-total-number-of-medicaid hospice-care-by-twenty-per-cent;~~

~~(ii)---if-the-total-number-of-days-of-inpatient-care-furnished-to-medicaid-hospice-patients-is-less-than-or-equal-to-the-maximum,-no-adjustment-will-be-necessary;-and~~

~~(iii)---if-the-total-number-of-days-of-inpatient-care-furnished-to-medicaid-hospice-patients-exceeded-the-maximum-allowable-number,-the-payment-limitations-will-be-determined-by:~~

~~(A)--calculating-a-ratio-of-maximum-allowable-inpatient-days-to-the-number-of-actual-days-of-inpatient-care,-and-multiplying-this-ratio-by-the-total-reimbursement-for-inpatient-care-that-was-made;~~

~~(B)--multiplying-excess-inpatient-care-days-by-the-routine-home-care-rate;~~

~~(C)--adding-the-amounts-calculated-in-paragraphs-(A)-and-(B);-and~~

~~(D)--comparing-the-amount-in-subsection-(C)-with-interim-payments-made-to-the-hospice-for-inpatient-care-during-the-cap-period;~~

~~(b)--The-amount-by-which-interim-payments-for-inpatient-care-exceed-the-amount-calculated-in-section-(10)(iii)(d)-is-due-from-the-hospice.~~

~~(4) The--basic--rates--for--hospice--care--represent--full-reimbursement-to-the-hospice-for-the-costs-of-all-covered-services-related-to-the-treatment-of-the-individual's-terminal-illness,-including-the-administrative-and-general-supervisory-activities-performed-by-physicians-who-are-employees-of-or-working-under-arrangements-made-with-the-hospice.---These-activities-would-generally-be-performed-by-the-physician-serving-as--the-medical-director--and--the-physician-member-of--the-hospice--interdisciplinary-group.---Group--activities--include-participation-in-the-establishment-of-plans-of-care,-supervision-of-care-and-services,-periodic-review-and-updating-of-plans-of-care,-and-establishment-of-governing-policies.--The-costs-for--these-services-are-included-in-the-reimbursement-rates-for-routine-home-care,-continuous-home-care,-and-inpatient--respite--care.~~ The following services performed by hospice physicians are included in the rates described in subsections (1) and (2) of this rule:

~~(a) Reimbursement--for--a--hospice-employed--physician's-direct-patient-services-which-are-not-rendered-as-a-volunteer-is-made-in-accordance-with-ARM-46.12.2003.---These-services-will-be-billed-by-the-hospice-under-the-hospice-provider-number-and,-the-related-payments-will-be-counted-in-determining-whether-the-overall-hospice-cap-amount-per-ARM-46.12.Rule-III-has-been-exceeded.---The-only-physician-services-to-be-billed-by-a-hospice-for-such-services-are-direct-patient-care-services.---Laboratory-and-x-ray-services-are-included-in-the-hospice-daily-rate.~~ general supervisory services of the medical director; and

~~(b) Volunteer-physician-services-are-excluded-from-medicaid-reimbursement-with-the-following-exceptions:~~ participation in the establishment of plans of care, supervision of

care and services, periodic review and updating of plans of care, and establishment of governing policies by the physician member of the interdisciplinary group.

~~(i)--a hospice may be reimbursed on behalf of a volunteer physician for specific direct patient care services which are not rendered on a volunteer basis. The hospice must have a liability to reimburse the physician for those services rendered. In determining whether a services is provided on a volunteer basis, a physician must not distinguish which services are provided voluntarily on the basis of the patient's ability to pay.~~

~~(ii)--reimbursement for an independent physician's direct patient services which are not rendered as a hospice volunteer is made in accordance with ARM 46.12.2003. These services will not be billed by the hospice under the hospice provider number and they will not be counted in determining whether the overall hospice cap amount defined in ARM 46.12.Rule III has been exceeded.~~

(5) ~~Cap on overall reimbursement. Aggregate payments to each hospice will be limited during a hospice cap period beginning November 1 of one year and ending October 31 of the next year. The total payments made for services furnished to medicaid recipients during this period will be compared to the "cap amount" for this period. Any payments in excess of the cap must be refunded by the hospice.~~ For services not described in subsection (4), medicaid will pay the hospice for those physician services furnished by hospice employees or under arrangements with the hospice in accordance with ARM 46.12.2001 through 46.12.2003. Reimbursement for these physician services is included in the amount subject to the hospice limit described below. Services furnished voluntarily by physicians are not reimbursable.

~~(a)--The overall cap will be compared to reimbursement after the inpatient limitation is computed and subtracted from total reimbursement due the hospice.~~

~~(b)--Total payment made for services furnished to medicaid recipients during this period means all payments for services rendered during the cap year, regardless of when payment is acutally made.~~

~~(c)--The "cap amount" is calculated by multiplying the number of recipients electing certified hospice care during the period by $6500. this amount will be adjusted for each subsequent cap year beginning November 1, 1983, to reflect the percentage increase or decrease in the medical care expenditure category of the consumer price index (CPI) for all urban consumers as published by the bureau of labor statistics. It will also be adjusted per Rules III & IV.~~

~~(d)--The computation and application of the "cap amount" is made by the department after the end of the cap period.~~

~~(e)--The hospice will report the number of medicaid recipients electing hospice care during the period to the~~

~~department.--This must be done thirty (30) days after the end of the cap period as follows:~~

~~(i)--if the individual is transferred to a noncertified hospice, payment will not be made to the noncertified hospice. The certified hospice may then count a complete recipient benefit period in their cap amount.~~

~~(ii)--if a hospice seeks certification in mid-month, a weighted average cap amount based on the number of days falling within each cap period will be used.~~

(6) ~~Adjustment of the overall cap. cap amounts in each hospice's cap period will be adjusted to reflect changes in the cap periods and designated hospices during the individual's election period.--The proportion of each hospice's days of services to the total number of hospice days rendered to the individual during their election period will be multiplied by the cap amounts to determine each hospice's adjusted cap amount.~~ Services of the patient's attending physician, if he or she is not an employee of the hospice or providing services under arrangements with the hospice, are not considered hospice services and are not included in the amount subject to the hospice payment limit.

~~(a)--After each cap period has ended, the department will calculate the overall cap within a reasonable time for each hospice participating in the program.~~

~~(b)--Each hospice's cap amount will be computed as follows:~~

~~(i)--the share of the "cap amount" that each hospice is allowed will be based on the proportion of total covered days provided by each hospice in the "cap period", and~~

~~(ii)--the proportion determined in ARM 46.12.Rule III(5)(b) for each certified hospice will be multiplied by the "cap amount" specified for the "cap period" in which the recipient first elected hospice.~~

~~(c)--the individual must file an initial election during the period beginning September 28 of the previous year through September 27 of the current cap year in order to be counted as an electing medicaid recipient during the current cap year.~~

(7) Medicaid reimbursement to a hospice in a cap period is limited to a cap amount established using medicare principles.

(8) The department hereby adopts and incorporates by reference 42 CFR 418.309, as amended through October 1, 1988, which sets forth medicare's methodology for calculating the hospice cap amount. Copies of 42 CFR 418.309, as amended through October 1, 1988, are available from the Montana Department of Social and Rehabilitation Services, Economic Assistance Division, 111 N. Sanders, P.O. Box 4210, Helena, Montana 59620.

(9) The department will notify the hospice of the determination of program reimbursement at the end of the cap year.

(10) Payments made to a hospice during a cap period that exceed the cap amount are overpayments and must be refunded.

AUTH: Sec. 53-6-113 MCA; Sec. 2, Ch. 633, L. 1989, Eff. 7/1/89 (HB 663)
IMP: Sec. HB 663 MCA; Sec. 1, Ch. 633, L. 1989, Eff. 7/1/89 (HB 663)

5. The Department has amended ARM 46.12.501 as proposed with the following changes:

46.12.501 SERVICES PROVIDED Subsections (1) through (1)(bb) remain as proposed.
(cc) hospice services until June 30, 1991, as specified by THE sunset clause SET BY THE ENACTING LEGISLATION.
Subsection (2) remains as proposed.

AUTH: Sec. 53-2-201 and 53-6-113 MCA
IMP: Sec. 53-6-101, 53-6-103 and 53-6-141 MCA

6. The Department has thoroughly considered all commentary received:

COMMENT: The original notice omitted a part of the statement of reasonable necessity for the proposed rule changes.

RESPONSE: The hospice program is mandated by House Bill 663 passed by the 1989 Montana legislature.

COMMENT: Incorporate as much of the federal Medicare regulations as possible to make the Medicaid program consistent with Medicare. Any hospice who will be serving a Medicaid client must be medicare certified and will already be familiar with and subject to the Medicare regulations.

RESPONSE: The department concurs and has revised the proposed rules to reflect this.

COMMENT: Remove drugs as a covered service under Medicaid. Drug costs, like physician services, should be included as a part of the aggregate cap amount but will not be covered under the daily rate.

RESPONSE: The department concurs and will reimburse outpatient drugs under the provisions of ARM 46.12.701 through 46.12.703. The cost of these drugs will be included in both the aggregate cap amount under the hospice program and in the cost of hospice care when it is evaluated as to whether hospice care was budget neutral as required under HB 663.

COMMENT: The department should set a room and board rate for Medicare or Medicaid beneficiaries residing in a nursing home. This rate should be the same rate nursing homes receive now for a Medicaid patient (the nursing home's Medicaid rate minus the patient's personal payment based on his resources). The hospice will receive this amount and give it to the nursing home who will collect the personal payment from the patient.

RESPONSE: The department will set the board and room rate at the established Medicaid nursing facility rate (SNF or ICF) for the hospice resident less the amount each Medicaid recipient pays toward the cost of care.

COMMENT: The department should implement a pilot project to allow self-directed recipients more flexibility in obtaining personal care.

RESPONSE: The 1989 Legislature authorized such a pilot project in an amendment to HB 100. The department intends to implement such a project within personnel and budget constraints.

COMMENT: The proposed rule should be amended to allow personal attendant care to be reimbursed in addition to the normal hospice benefit. Since personal attendant care is not a covered service under the medicare hospice benefit, it should be reimbursed separately. Recipients will have to be institutionalized if personal attendant care services are not available and this is contradictory to the intent of the personal care attendant program. Personal care attendant and home health aide services are different because of the training and experience requirements for the service providers. Home health aide services were established on a part-time or intermittent basis while personal care attendant was established as a long term care alternative to nursing care. There is currently legislation in Congress that would require Medicaid recipients receiving hospice services to waive rights to only those services available under Medicare.

RESPONSE: The proposed rule indicates that hospices must provide the same services required and defined by Medicare. Medicare hospice regulations require that home health aide and homemaker services be provided or arranged by the hospice as a condition of participation. The duties of the home health aide are defined in 42 CFR 405.1227(a) to include personal care and household services essential to health care at home. It is federal intent that personal care is included as a covered service under the definition of home health aide and homemaker services and must be provided or arranged by the hospice. To provide personal care attendants as a covered Medicaid service in addition to the hospice benefit would be duplication. It is true that some individuals may have to be

institutionalized when their care needs exceed what can be provided safely in the home. This is also the case when a person's personal care needs exceed the program limits. Training and experience requirements are different for home health aides and personal care attendants but the duties are the same and the federal regulations cited above indicate that home health aides will provide for the personal care needs of the recipient. Home health regulations do require home health aides to be provided on a part-time or intermittent basis but the federal Medicare regulations at 42 CFR 418.94 state that the services must be available and adequate in frequency to meet the recipient's needs. Regulations at 42 CFR 418.50(2) also state that the hospice must make covered services available on a 24 hour basis to the extent necessary to meet the needs of recipients. If state legislation is passed to change current requirements, the hospice rule would be amended to incorporate and comply with the new requirements.

Julia E. Robinson

Director, Social and Rehabilitation Services

Certified to the Secretary of State June 19, 1989.

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

In the matter of the amendment of Rules 46.12.204, 46.12.522, 46.12.527, 46.12.537, 46.12.542, 46.12.547, 46.12.582, 46.12.589, 46.12.605, 46.12.805, 46.12.905, 46.12.915 and 46.12.1025 pertaining to a two percent (2%) increase in medicaid fees for provider services	)	NOTICE OF THE AMENDMENT OF RULES 46.12.204, 46.12.522, 46.12.527, 46.12.537, 46.12.542, 46.12.547, 46.12.582, 46.12.589, 46.12.605, 46.12.805, 46.12.905, 46.12.915 AND 46.12.1025 PERTAINING TO A TWO PERCENT (2%) INCREASE IN MEDICAID FEES FOR PROVIDER SERVICES

TO: All Interested Persons

1. On May 11, 1989, the Department of Social and Rehabilitation Services published notice of the proposed amendment of Rules 46.12.204, 46.12.522, 46.12.527, 46.12.537, 46.12.542, 46.12.547, 46.12.582, 46.12.589, 46.12.605, 46.12.805, 46.12.905, 46.12.915 and 46.12.1025 pertaining to a two percent (2%) increase in medicaid fees for provider services at page 563 of the 1989 Montana Administrative Register, issue number 9.

2. The Department has amended Rules 46.12.522, 46.12.527, 46.12.537, 46.12.542, 46.12.547, 46.12.605, 46.12.805 and 46.12.905 as proposed.

2. The Department has amended the following rules as proposed with the following changes:

46.12.204 RECIPIENT REQUIREMENTS, CO-PAYMENTS

Subsections (1) through (1)(o) remain as proposed.

(p) prosthetic devices, durable medical equipment and medical supplies, $.50 per LINE item; ~~for items that do not require prior authorization, and $3.00 per item for items that require prior authorization;~~

Subsections (1)(q) through (4) remain as proposed.

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

46.12.582 PSYCHOLOGICAL SERVICES, REIMBURSEMENT

Subsections (1) through (2)(c) remain as proposed.

(23) ~~$41.46~~42.29 PER HOUR for individual psychological services, family therapy and psychological testing; or

(34) ~~$12.43~~12.686 PER HOUR AND ONE HALF SESSION for group psychological services.

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

46.12.589 LICENSED CLINICAL SOCIAL WORK SERVICES, REIMBURSEMENT Subsections (1) through (3) remain as proposed.

(a) ~~$33.16~~33.880 per hour for individual counseling;

(b) ~~$9.94~~10.14 per HOUR AND ONE HALF session for group counseling; or

(c) ~~$33.16~~33.820 PER HOUR for family therapy.

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

46.12.915 EYEGLASSES, REIMBURSEMENT Subsections (1) through (1)(c) remain as proposed.

(i) EFFECTIVE JULY 1, 1989, THE REIMBURSEMENT RATES LISTED WILL BE INCREASED BY TWO PERCENT (2%). ALL ITEMS PAID BY REPORT WILL REMAIN AT THE RATE INDICATED.

Subsections (2) through (4)(b) code "V0132" remain as proposed.

3-V2715	Prism, per lens	1.88	~~20.00~~
3-V2730	Special base curve, glass or plastic, per lens	20.00	~~1.00~~

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

46.12.1025 AMBULANCE SERVICES, REIMBURSEMENT Subsections (1) through (5)(a) remain as proposed.

(b) the ~~individual provider's January 1982 medicaid rate plus 10 times 112.2 percent.~~ AMOUNT ALLOWABLE FOR THE SAME SERVICE UNDER MEDICARE; OR

(c) THE INDIVIDUAL PROVIDER'S JUNE 1989 MEDICAID RATE PLUS 2%.

(6) ~~The department will pay the lower~~st of the ~~following for ambulance services which are also covered by medicare:~~ BASIC LIFE SUPPORT AND MILEAGE FEES FOR PROVIDERS CERTIFIED AFTER JUNE 30, 1989, WILL BE ESTABLISHED AT 65.2% OF USUAL AND CUSTOMARY FEE.

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

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

~~(c) the individual provider's January 1982 medicaid rate plus 10 times 112.2 percent.~~

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

4. The Department has thoroughly considered all commentary received:

COMMENT: The language for co-payments for prosthetic devices, durable medical equipment and medical supplies would be more precise if paragraph 46.12.204(p) were changed to read ". . . per line item;".

RESPONSE: This change in wording will be included in the final rule.

COMMENT: Under current practice psychologists' services are paid in 15 minute increments.

RESPONSE: The hourly rates as published in the original notice will be adjusted to reflect this practice. The final rates will be:

1. Individual and family therapy, and testing and evaluation - $42.28 per hour;
2. Group therapy - $12.66 per hour and a half session per recipient.

COMMENT: The Montana Psychological Association has recommended that as part of this rule change the department change its policy on psychological testing and evaluation to allow time to be billed other than time actually spent with the patient. The time would include consultation with agencies such as the Department of Family Services and the Developmental Disabilities Division, family members and test scoring, and report writing. The Association has recommended that a maximum of 6 hours per year of the 22 hour limit be allowed for this type of service. The Association believes that the 6 hour cap per year would help keep the change cost neutral.

RESPONSE: The department has accepted this proposal because the use of 6 hours as a sublimit within the 22 hour limit can be managed in such a way as to be budget neutral. Though the change cannot be incorporated under this notice the department will pursue a separate change that may be effective retroactive to July 1, 1989.

COMMENT: The department has noted that under ARM 46.12.589 found on page 4 of the notice, the rate for individual therapy was published as $33.88 per hour.

RESPONSE: This was an error. The hourly rate should be the same as family therapy.

COMMENT: The department has noted that under current practice payments for licensed clinical social workers' services are made in 15 minute units.

RESPONSE: The final rates will be adjusted to reflect this practice. The final rates will be:

1. Individual therapy and family therapy - $33.80 per hourly session; and
2. Group therapy - $10.14 per hour and a half session.

COMMENT: A comment in support of the two percent increase for social workers was received. The commentor also recommended that licensed clinical social workers be reimbursed for evaluations and consultations.

RESPONSE: The addition of evaluations and consultations to the list of covered licensed clinical social workers' services would be a significant program expansion and would require additional funding because evaluation and consultation are not currently a covered licensed clinical social work service.

COMMENT: Why does the department pay licensed clinical social workers less than licensed clinical psychologists?

RESPONSE: The Montana Chapter of the National Association of Social Workers (NASW) argued that social workers charge less than psychologists when the Association promoted legislation to have licensed clinical social workers services covered by Medicaid. The argument was made at that time that the addition of this practitioner group under Medicaid would be cost neutral. The information provided by the Association indicated that a differential in payment levels between two professions was and is justified.

COMMENT: The twenty-two hour limit on licensed clinical psychologists and licensed clinical social workers should be increased.

RESPONSE: An increase in this limit would require legislative authority through additional funding.

COMMENT: In the current rule, the fees for codes 3-V2715 and 3-V2730 were just the opposite of what providers thought they should be.

RESPONSE: The fees for these codes will be changed in the final notice. The fee for code 3-V2715 will be changed from $20 to $1.88 and the fee for code 3-V2730 will be changed from $1.88 to $20.

COMMENT: The notice does not state that the fees for eyeglasses will be increased by two percent.

RESPONSE: Page one of the notice indicates that eyeglasses will be increased by two percent. ARM 46.12.915 will be amended on the final notice to include the two percent increase.

COMMENT: Will ARM 46.12.1025, ambulance services reimbursement, be updated to include a two percent increase?

RESPONSE: ARM 46.12.1025 will be updated on the final notice to include the two percent increase.

COMMENT: Will provider manuals be updated and if so when?

RESPONSE: New manuals should be issued by July 1, 1989.

COMMENT: The two percent increase of provider fees for outpatient physical therapy services should be applied to evaluation procedure and kinetic activity procedures rather than all physical therapy services.

RESPONSE: Due to the lateness of the request, the department is unable to comply with this request. The department, however, is willing to consider this matter at a later date and make fee adjustments based on utilization history.

Julia E. Robinson
Director, Social and Rehabilitation Services

Certified to the Secretary of State June 19, 1989.

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

In the matter of the amendment of Rule 46.12.505 pertaining to diagnosis related groups (DRGs)	))))	NOTICE OF THE AMENDMENT OF RULE 46.12.505 PERTAINING TO DIAGNOSIS RELATED GROUPS (DRGS)

TO: All Interested Persons

1. On May 11, 1989, the Department of Social and Rehabilitation Services published notice of the proposed amendment of Rule 46.12.505 pertaining to diagnosis related groups (DRGs) at page 513 of the 1989 Montana Administrative Register, issue number 9.

2. The Department has amended the following rule as proposed with the following changes:

46.12.505 INPATIENT HOSPITAL SERVICES, REIMBURSEMENT

Subsections (1) through (2)(b) remain as proposed.

(c) The department computes a Montana average base price per case. This average budget neutral base price per case is ~~$1,360.19~~ ~~$1,421.55~~ $1,416.08 for fiscal year ending June 30, ~~1989~~ 1990.

Subsections (2)(d) through (12(c)(i) remain as proposed.

3. The Department has thoroughly considered all commentary received:

COMMENT: After the proposed rule was published, a recalculation was made using the most current data available regarding the base price to update the reimbursement system for the second year of a phased in Disproportionate Share Adjustment. This calculation indicates an add-on to the base price is necessary for hospitals designated as Medicaid Disproportionate Share Providers. The adjustment which results in an add-on of $37.80, will be funded through a set-aside of 4/10ths of one percent of the base price. This results in a base price of $1,416.08, rather than $1,421.55 as originally proposed.

RESPONSE: The department has adjusted the base price according to the recalculation.

COMMENT: How did the department calculate the 4/10ths of 1% set aside for disproportionate share hospitals?

RESPONSE: The amount was calculated by estimating the percentage of inpatient care days provided in disproportionate share (DSH) hospitals and multiplying it by the adjustment of 2.67%. The estimate of inpatient care days was based on 1986-1987 data and showed that 15% of the days were provided in DSH

hospitals. This calculation results in a set aside of 4/10th of 1% (.15 x .0767).

COMMENT: The proposed adjustment to the base price fails to adequately reflect anticipated cost increases for upcoming rate years. The hospital market basket inflation rate reported in the May 8, 1989 Federal Register for Federal Fiscal Year 1990 is 5.8%, rather than 3.9% as proposed by the department. The lack of adequate legislative appropriation to increase the DRG inflation factor does not justify establishment of inadequate rates. The department has previously utilized rate systems which allowed payments in excess of appropriation. The department may seek supplemental appropriation or make other cuts in the program necessary to remain within the appropriation. The department should amend the proposed rule to reflect the updated information available in the May 1989 Federal Register.

RESPONSE: The department finds that the proposed rate of reimbursement for inpatient hospital services will adequately reimburse costs that must be incurred by efficiently and economically operated facilities. Under federal law, the proposed rate may not exceed the amount reasonablely estimated as the amount that would have been paid under Medicare payment principles. The legislative appropriation and the proposed base price are based upon the latest available information regarding Medicare payment principles. This rate information includes the current Federal Fiscal Year end (FYE 9/30/89) TEFRA inflation factor of 3.9%. The department's current policy requires use of the TEFRA update factor in the development of rates. While the 1990 market basket and TEFRA factors are the same, it should be noted that they have differed in the past and may differ in the future. Further, the 5.8% market basket inflation rate has not been finally adopted. This 5.8% rate was only proposed in the May 8, 1989 Federal Register and remains subject to comment and revision. Use of proposed rather than final factors might result in implementation of rates in excess of what could reasonably be estimated to have been paid under Medicare payment principles and might threaten continued federal financial participation (FFP) in inpatient hospital reimbursement. Moreover, the department has not developed rates based upon the appropriation. Rather, the appropriation was based upon the applicable 3.9% TEFRA factor. The department will adopt the rule with the 3.9% factor.

COMMENT: The department has failed to propose any changes to the policies affecting unusually costly outliers. These outliers typically occur in neonate intensive care units where DRG losses are in the tens of thousands of dollars. It is not reasonable for the department to expect that these losses be made up by "profitable DRGs", given a base price of less than

$1,500. The department should amend the proposed rule to provide a stoploss provision for neonate (intensive care) DRGs to at least 80% of charges.

RESPONSE: The department is willing to review the neonate outlier policy with providers and provider organizations and to consider changes. The department recognized the importance of this issue in the development of the DRG system and implemented the 60% of charge floor in reimbursement. The department will not increase reimbursement in this area from 60% of charges to 80% of charges without a thorough review of the policy. Such a change might result in reimbursement in excess of the aggregate amounts allowed by the Health Care Financing Administration (HCFA), resulting in an inability to make satisfactory assurances to HCFA and jeopardizing FFP in the Montana Medicaid Program.

COMMENT: Since implementation of the DRG system, the department has failed to produce quantifiable evidence of the adequacy of DRGs, has failed to perform required utilization review in a timely manner, has failed to evaluate reimbursement policies, and has been unable to maintain a current GROUPER/claims processing system. These failures are the result of decreasing commitment of department resources to the DRG program. The inability of the department to "service" the DRG system is increasing provider costs. The department should revise the Medicaid remittance advice for more effective utilization by hospitals and for consistency with Medicare forms. The department should identify the job position and funds which will be dedicated solely to the DRG system. Alternatively, the department should consider adopting a reimbursement system current staff can administer.

RESPONSE: The department agrees that the DRG project currently is understaffed. However, quantifiable evidence of the adequacy of DRGs is available and has been shared with the Montana Hospital Association (MHA) and providers on numerous occasions. This data does not include direct comparison to cost information in the base year. However, this is a result of the normal time delay inherent in the process of obtaining and auditing cost information. The department is willing to discuss possible solutions to this delay problem. The department is aware that some areas are in need of more timely utilization review and has taken steps to increase the resources available for this review. The department is developing multiple grouper capability, which is projected to be completed in 1990. The department is willing to meet with providers and the MHA to establish priorities for development and maintenance of the prospective DRG system, and to discuss administrative resources and the department's commitment to the DRG system.

COMMENT: The department should consider lowering the disproportionate share hospital utilization thresholds, which would allow more providers to qualify, or should proportionately allocate the adjustment to hospitals. Many hospitals had Medicaid utilization rates in excess of 2% above the mean utilization rate, but received no additional reimbursement unless they exceeded the threshold of one standard deviation above the mean.

RESPONSE: State Medicaid agencies are required by the Health Care Financing Administration (HCFA) to make additional payments to hospitals who serve a disproportionate share of Medicaid or other low income recipients. HCFA has established minimum standards for identifying and reimbursing disproportionate share hospitals. The department has adopted and followed these standards in developing the adjustment and believes this adjustment adequately reimburses qualifying hospitals. The department also believes that the disproportionate share threshold adequately identifies disproportionate share hospitals.

Director, Social and Rehabilitation Services

Certified to the Secretary of State June 19, 1989.

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

In the matter of the amendment of Rules 46.12.525, 46.12.526 and 46.12.527 pertaining to outpatient physical therapy services	)))))	NOTICE OF THE AMENDMENT OF RULES 46.12.525, 46.12.526 AND 46.12.527 PERTAINING TO OUTPATIENT PHYSICAL THERAPY SERVICES

TO: All Interested Persons

1. On May 11, 1989, the Department of Social and Rehabilitation Services published notice of the proposed amendment of Rules 46.12.525, 46.12.526 and 46.12.527 pertaining to outpatient physical therapy services at page 597 of the 1989 Montana Administrative Register, issue number 9.

2. The Department has amended ARM 46.12.525, OUTPATIENT PHYSICAL THERAPY SERVICES, DEFINITION, as proposed.

3. The Department has amended the following rules as proposed with the following changes:

46.12.526 OUTPATIENT PHYSICAL THERAPY SERVICES, REQUIREMENTS Subsections (1) through (6) remain as proposed.

(7) Outpatient physical therapy service is limited per fiscal year to 70 ~~visits~~ hours without prior authorization and an additional 30 ~~visits~~ hours with prior authorization by the department. A maximum of 100 ~~visits~~ hours per fiscal year is allowed.

Subsections (8) through (10) remain as proposed.

(11) THE DESIGN, FABRICATION, FITTING AND INSTRUCTION IN THE USE OF DYNAMIC AND STATIC SPLINTS, BRACES AND SLINGS ARE REIMBURSEABLE UNDER THE PROGRAM ACCORDING TO THE PROVISIONS OF ARM 46.12.801 THROUGH 46.12.806.

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

46.12.527 OUTPATIENT PHYSICAL THERAPY SERVICES, REIMBURSEMENT Subsections (1) through (1)(c) remain as proposed.

(2) Outpatient physical therapy services which are reimbursable under the Montana medicaid program are limited to the ~~following:~~ SERVICES LISTED IN THIS SUBSECTION AND ARE REIMBURSEABLE AT THE PER UNIT PRICE INDICATED. A UNIT IS A FIFTEEN (15) MINUTE PERIOD OF SERVICE.

EVALUATION AND INSTRUCTION

REIMBURSEMENT IS LIMITED TO A MAXIMUM OF 4 UNITS PER VISIT.

9-99080	Physical therapy evaluation..... ~~(15-minute-units-maximum-of 4-units-per-visit)~~	8.32 ~~33.28~~
9-97799	Home instruction ..... ~~(15-minute-units-maximum-of 4-units-per-visit)~~	8.32 ~~33.28~~
9-90600	Initial consultation ..... ~~(15-minute-units-maximum-of 4-units-per-visit)~~	8.32 ~~33.28~~

MUSCLE TESTING

REIMBURSEMENT IS LIMITED TO A MAXIMUM OF 4 UNITS PER VISIT.

9-95831	MANUAL, EXTREMITY OR TRUNK	8.32
9-95832	HAND (WITH OR WITHOUT COMPARISON WITH NORMAL SIDE)	8.32
9-95833	TOTAL EVALUATION OF BODY, EXCLUDING HANDS	8.32
9-95834	TOTAL EVALUATION OF BODY, INCLUDING HANDS	8.32
9-95842	MUSCLE TESTING, ELECTRICAL REACTION OF DEGENERATION, CHRONAXY, GALVANIC/ TETANUS RATIO, ONE OR MORE EXTREMITIES, ONE OR MORE METHODS ..	8.32

ELECTROMYOGRAPHY

SERVICES ARE LIMITED TO A MAXIMUM OF 4 UNITS PER VISIT.

9-95860	ONE EXTREMITY AND RELATED PARA-SPINAL AREAS	16.64
9-95861	TWO EXTREMITIES AND RELATED PARA-SPINAL AREAS	16.64
9-95862	THREE EXTREMITIES AND RELATED PARA-SPINAL AREAS	16.64
9-95864	FOUR EXTREMITIES AND RELATED PARA-SPINAL AREAS	16.64
9-97752	MUSCLE TESTING, TORQUE CURVES DURING ISOMETRIC AND ISOKINETIC EXERCISE (E.G., BY USE OF CYBEX MACHINE) ...	16.64

MODALITIES

~~ONE~~ FIRST MODALITY OR INITIAL UNIT OF SERVICE ~~(initial 15 minutes)~~ 13.31

"9-97010 Hot or cold packs" through "9-97028 Ultraviolet" remain the same.

9-97039 Each additional MODALITY OR UNIT OF SERVICE ~~modality 15 minutes (specify modality)~~. 3.00

PROCEDURES

THE FOLLOWING SERVICES ARE NOT LIMITED TO A SPECIFIED MAXIMUM NUMBER OF UNITS PER OFFICE VISIT. THE FIRST 2 UNITS OF SERVICE FOR A GIVEN PROCEDURE ARE REIMBURSED AT THE HIGHER UNIT PRICE INDICATED. UNITS OF SERVICE AFTER THE FIRST 2 UNITS OF SERVICE OF A GIVEN PROCEDURE ARE REIMBURSED AT THE RATE OF $5.00 PER UNIT OF SERVICE.

ONE PROCEDURE, FIRST 2 UNITS EACH..... 9.99 ~~19.97~~
~~initial 30 15 minutes, each visit (Use these procedure codes for first 30 minutes only -- maximum of 2 unites per visit.)~~

"9-97710 Therapeutic exercises" through "9-97128 Ultrasound" remain as proposed.

9-97260 MANIPULATION

9-97145 Each additional ~~15 minutes~~ UNIT OF SERVICE..... 5.00

~~OTHER PROCEDURES~~

9-97139 Postural drain~~ing~~AGE; 15 minute unit ..... 8.65 ~~17.30~~

9-97220 Isolation tub; FIRST 2 UNITS EACH .... 13.31 ~~26.62~~
~~initial 15 minutes (Use these procedure codes for first 30 minutes only -- maximum of 2 unites per visit.)~~

9-29160 Each additional ~~15 minutes~~ UNIT OF SERVICE..... ..... 5.00

9-97500 Orthotics training (dynamic bracing, splinting); upper extremities; FIRST 2 UNITS EACH..... ..... 9.99 ~~19.97~~
~~initial 30 15 minute (Use these procedure codes for first 30 minutes only -- maximum of 2 unites per visit.)~~

9-97501 Each additional ~~15 minutes~~ UNIT OF SERVICE 5.00

9-97520 Prosthetic training; FIRST 2 UNITS EACH .... 9.99 ~~19.97~~
~~initial 30 15 minutes, each visit (Use these procedure codes for first 30 minutes only --~~

	~~maximum of 2 unites per visit.)~~	
9-97521	Each additional ~~15 minutes~~ UNIT OF SERVICE.....	5.00
9-97530	Kinetic activities to increase coordination, strength or range of motion, one area (any two extremities or trunk); ~~initial 30 15 min~~.. FIRST 2 UNITS EACH ~~(Use these procedure codes for first 30 minutes only-- maximum of 2 units per visit.)~~	9.99 ~~19.97~~
9-97531	Each additional ~~15 minutes~~ UNIT OF SERVICE.....	5.00
ACTIVITIES OF DAILY LIVING (ADL) AND DIVERSIONAL ACTIVITIES		9.99
9-97540	~~Initial 30 15 minutes, each visit~~ .... FIRST 2 UNITS EACH ~~(Use these procedure codes for first 30 minutes only-- maximum of 2 units per visit.)~~	~~19.97~~
9-97541	Each additional ~~15 minutes~~ UNIT OF SERVICE	5.00
POOL THERAPY		7.99
9-97240	~~Initial 30 15 minutes, each visit~~ .... FIRST 2 UNITS EACH ~~(Use these procedure codes for first 30 minutes only-- maximum of 2 units per visit.)~~	~~15.97~~
9-97241	Each additional ~~15 minutes~~ UNIT OF SERVICE	5.00
9-97039	Additional modalities ~~(with~~ whirlpool~~)~~ (specify)	3.00
TESTS AND MEASUREMENTS		
9-97700	Office visit, including one of the following tests or measurements, with report, ~~initial 30 15 minutes, each visit~~ FIRST 2 UNITS EACH ..... ~~(Use these procedure codes for first 30 minutes only-- maximum of 2 units per visit.)~~ Orthotic check-out Prosthetic check-out Activities of daily living check-out	16.64 ~~33.28~~
9-97701	Each additional ~~15 minutes~~ UNIT OF SERVICE	5.00

9-97720 Extremity testing for strength, dexterity or stamina; ~~initial 30 15-minutes, each visit~~ ..... 16.64 ~~33.28~~
FIRST 2 UNITS EACH
~~(Use these procedure codes for first 30 minutes only--maximum of 2 units per visit.)~~

9-97721 Each additional ~~15 minutes~~
UNIT OF SERVICE 5.00

~~MUSCLE TESTING~~

~~REIMBURSEMENT IS LIMITED TO A MAXIMUM OF 4 UNITS PER VISIT~~

~~0.32~~
~~9-95831 Manual, extremity or trunk ..... 33.28~~
~~(15 minute units) maximum of 4 units per visit)~~
~~9-95832 Hand (with or without comparison with normal side) ..... 0.32 33.28~~
~~(15 minute units) maximum of 4 units per visit)~~
~~9-95833 Total evaluation of body, excluding hands ..... 0.32 33.28~~
~~(15 minute units) maximum of 4 units per visit)~~
~~9-95834 Total evaluation of body, including hands ..... 0.32 33.28~~
~~(15 minute units) maximum of 4 units per visit)~~
~~9-95842 Muscle testing, electrical reaction of degeneration, chronaxy, galvanic/tetanus ratio, one or more extremities, one or more methods ... 0.32 33.28~~
~~(15 minute units) maximum of 4 units per visit)~~

~~ELECTROMYOGRAPHY~~

~~SERVICES LIMITED TO A MAXIMUM OF 4 UNITS PER VISIT~~

~~9-95860 One extremity and related para spinal areas ..... 16.64 66.55~~
~~(15 minute units maximum of 4 units per visit)~~
~~9-95861 Two extremities and related para spinal areas ..... 16.64 66.55~~
~~(15 minute units maximum of 4 units per visit)~~
~~9-95862 Three extremities and related para spinal areas ..... 16.64 66.55~~

~~(15-minute-units-maximum-of 4-units-per-visit)~~
~~9-95864---Four-extremities-and-related-para-------16.64~~
~~spinal-areas-.....66.55~~
~~(15-minute-units-maximum-of 4-units-per-visit)~~
~~9-97752---Muscle-testing,-torque-curves-during isometric-and-isokinetic-exercise----16.64~~
~~(e.g.,-by-use-of-cybex-machine)-... 66.55~~
~~(15-minute-units-maximum-of 4-units-per-visit)~~

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

3. The department has thoroughly considered all commentary received:

COMMENT: The fee schedule for modalities, some of which are unattended, are reimbursed at a higher rate than procedures.

RESPONSE: The department has never used a relative value scale for services. Rather, services are fee based. The department agrees that further study needs to be done in this area. In future rule amendments, modality fees will be reconsidered, along with other requests for a different distribution of the 2% increase.

COMMENT: Providers have been informed by the department that a durable medical equipment (DME) number will be assigned to physical therapists that apply and that casting and splinting will be billed under that system with reimbursement at 90% of billed charges. These services will not be a part of the 100-hour limitation.

RESPONSE: This is correct. The department has amended ARM 46.12.526 to provide that fabrication, fitting and instruction in the use of splints and braces are reimburseable under the provisions of ARM 46.12.801 through 46.12.806. This amendment will allow physical therapists to be Medicaid certified as durable medical equipment providers. DME services will be reimbursed according to that service fee schedule, which sets reimbursement at 90% of billed charges by report items. DME services will not be counted towards the physical therapy limitation.

COMMENT: We request that the department and the Montana Chapter of the American Physical Therapy Association (The Association) each year review the full year of service and its

reimbursement to establish a factual history of the delivery of physical therapy care to Medicaid recipients.

RESPONSE: The department concurs and is presently developing data for mutual review.

COMMENT: Why was the maximum treatment time changed from 200 to 100 hours?

RESPONSE: This change was made in a 1987 rule amendment and is outside of the scope of this rule change. However, the department will address the issue in writing with the individual at a later time.

COMMENT: Pool therapy that is different from whirlpool therapy is also a one to one procedure and should be reimbursed at the same rate as other procedures.

RESPONSE: The department will consider this proposal for possible adoption in later rule amendments.

COMMENT: Why are home health agency services being removed from the physical therapy limitation?

RESPONSE: The department considers the current limitations on home health services to be adequate to limit physical therapy services provided by home health agencies. Home health services are limited to 200 visits per year. This limit applies to nursing visits, home health aid visits, physical therapy, occupational therapy and speech visits. These visits are subject to a $400 monthly prior authorization cap.

COMMENT: Based upon negotiations with the Association the department limited physical therapy services to 100 visits per year. The proposed rule changes the term from visits to hours. Is this change inconsistent with the prior agreement?

RESPONSE: The agreement was based upon 100 visits or contacts with the therapist, not upon 100 procedures or modalities. Prior to the rule hearing, the department representative discussed with the provider representative changing the term "visits" to "hours" and weighting each procedure and modality based upon 15 minute units of service. These changes were acceptable to the provider representative. The objective was to accomplish an adjustment which is cost neutral, and which

will not reduce reimbursement to providers or benefits to recipients.

COMMENT: The department should not attempt to set the fee schedule using parenthetical phrases as interpretive guidelines. The parenthetical phrases are ambiguous and confusing.

RESPONSE: The department agrees and has amended the language in ARM 46.12.527 deleting parentheses and clarifying language.

COMMENT: The 2% increase in provider fees for outpatient physical therapy services should be applied to evaluation procedures and kinetic activity procedures rather than all physical therapy services.

RESPONSE: Due to the lateness of the request, the department is unable to comply with this request at this time. The department will consider basing fee adjustments on utilization history for possible inclusion at a later date.

Director, Social and Rehabilitation Services

Certified to the Secretary of State June 19, 1989.

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

In the matter of the amendment of Rule 46.12.532 pertaining to reimbursement for speech therapy services	))))	NOTICE OF THE AMENDMENT OF RULE 46.12.532 PERTAINING TO REIMBURSEMENT FOR SPEECH THERAPY SERVICES

TO: All Interested Persons

1. On May 11, 1989, the Department of Social and Rehabilitation Services published notice of the proposed amendment of Rule 46.12.532 pertaining to reimbursement for speech therapy services at page 596 of the 1989 Montana Administrative Register, issue number 9.

2. The Department has amended Rule 46.12.532 as proposed.

3. The Department has thoroughly considered all commentary received:

COMMENT: Does the department intend to increase the speech therapy evaluation fee?

RESPONSE: Yes. ARM 46.12.532 has been revised to increase the evaluation services fee from $26.01 to $29.50 as directed by House Bill 100.

COMMENT: A Legislative Council staff person commented that the rationale on the first notice did not clearly set forth a statement of reasonable necessity for the rule change.

RESPONSE: The 1989 Legislature clearly specified their intent in House Bill 100 to increase the Medicaid reimbursement fee for speech therapy services. The department believes this statement of legislative intent is sufficient to establish the reasonable necessity for this rule change.

Director, Social and Rehabilitation Services

Certified to the Secretary of State June 19, 1989.

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

In the matter of the amendment of Rules 46.12.570, 46.12.571, 46.12.572 and 46.12.573 pertaining to clinic services covered by Medicaid	)))))	NOTICE OF THE AMENDMENT OF RULES 46.12.570, 46.12.571, 46.12.572 and 46.12.573 PERTAINING TO CLINIC SERVICES COVERED BY MEDICAID

TO: All Interested Persons

1. On May 11, 1989, the Department of Social and Rehabilitation Services published notice of the proposed amendment of Rules 46.12.570, 46.12.571, 46.12.572 and 46.12.573 pertaining to clinic services covered by Medicaid at page 522 of the 1989 Montana Administrative Register, issue number 9.

2. The Department has amended 46.12.571 and 46.12.573 as proposed.

3. The Department has amended ARM 46.12.570 and 46.12.572 as proposed with the following changes:

46.12.570 CLINIC SERVICES, DEFINITIONS Subsections (1) through (4) remain as proposed.

(5) "Individuals with clinic privileges" means those persons who are either employed by or under contract to a mental health center who meet the criteria developed by the state mental health authority to provide AND BILL FOR one or more of the mental health services purchased by the department.

Subsection (5)(a) remains as proposed.

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

46.12.572 CLINIC SERVICES, COVERED PROCEDURES

Subsections (1)(k)(iv) remain as proposed.

(2) Mental health clinic services provided by a mental health center are limited to:

(a) individual therapy INCLUDING PSYCHOLOGICAL TESTING AND EVALUATION;

Subsections (2)(b) through (4) remain as proposed.

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

4. The Department has thoroughly considered all commentary received:

COMMENT: In section 46.12.570(5), the proposed rule incorrectly states that clinical privileges defines individuals who have the "authority to provide" various mental health services. The Department of Institutions' use of clinical privileges is only for the purpose of defining whose services may be billed to the Department. It does not prevent others from providing the service if the Department does not pay.

RESPONSE: The Department concurs. The language in ARM 46.12.570(5) has been adjusted to reflect that the clinically privileged criteria are used to determine when a service can be billed to Medicaid.

COMMENT: The Medicaid contracts have always included "emergency services" as a separate service in calculating the clinical rate. The Department of Institutions no longer reimburses for emergency therapy as a separate service; this is now considered part of what is included under individual therapy.

RESPONSE: The base year for establishing mental health center rates is 1985. Until we establish a more recent base year we will not be able to incorporate the changes adopted by the Department of Institutions.

COMMENT: The Department has consistently allowed coverage of psychological testing and evaluation under individual therapy.

RESPONSE: The final version of ARM 46.12.572(2) has been modified to reflect this coverage.

Julia E. Roberts

Director, Social and Rehabilitation Services

Certified to the Secretary of State June 19, 1989.

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

In the matter of the amendment of Rule 46.12.703 pertaining to reimbursement for outpatient drugs	)))	NOTICE OF THE AMENDMENT OF RULE 46.12.703 PERTAINING TO REIMBURSEMENT FOR OUTPATIENT DRUGS

TO: All Interested Persons

1. On May 11, 1989, the Department of Social and Rehabilitation Services published notice of the proposed amendment of Rule 46.12.703 pertaining to reimbursement for outpatient drugs at page 515 of the 1989 Montana Administrative Register, issue number 9.

2. The Department has amended Rule 46.12.703 as proposed.

4. The Department has thoroughly considered all commentary received:

COMMENT: The proposed increase of $.25 in the maximum dispensing fee is inadequate to cover the actual costs incurred by providers.

RESPONSE: The department believes the increase adequately reimburses providers, but will continue to monitor and study the adequacy of reimbursement.

COMMENT: A representative of the Montana Department of Institutions (DI) indicates that DI contracts with a single pharmaceutical provider to provide drugs to all state hospitals and institutions. Will the contractor be required to submit survey forms for each facility served or will submission of one survey form be sufficient?

RESPONSE: The reimbursement rule is designed primarily to address reimbursement for providers serving individual recipients or facilities. The system used by DI is unique. The department will study this question and will meet with representatives of DI in determining the appropriate approach to this problem.

Julia E. Bolen
Director, Social and Rehabilitation Services

Certified to the Secretary of State June 19, 1989.

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

In the matter of the amendment of Rules 46.12.2003 pertaining to reimbursement for physician services	))))	NOTICE OF THE AMENDMENT OF RULE 46.12.2003 PERTAINING TO REIMBURSEMENT FOR PHYSICIAN SERVICES

TO: All Interested Persons

1. On May 11, 1989, the Department of Social and Rehabilitation Services published notice of the proposed amendment of Rule 46.12.2003 pertaining to reimbursement for physician services at page 520 of the 1989 Montana Administrative Register, issue number 9.

2. The Department has amended Rule 46.12.2003 as proposed.

3. The Department has thoroughly considered all commentary received:

COMMENT: The published notice of public hearing indicates that the department adopts and incorporates by reference the procedure code report (PCR) as amended through July 1, 1989. The public hearing is scheduled for May 31, 1989. Is the adopted version of the PCR available for examination prior to the hearing, and will the department amend the PCR after the hearing but prior to the July 1, 1989 effective date?

RESPONSE: The adopted version of the PCR has been available from the department for examination since the date of publication of the notice of public hearing. No further amendments to the PCR have been made since that date and none are contemplated prior to the July 1, 1989 effect date.

Julia E. Robinson
Director, Social and Rehabilitation Services

Certified to the Secretary of State June 19, 1989.

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

In the matter of the amendment of Rules 46.12.2003 pertaining to updating of procedures codes for physician services	))))	NOTICE OF THE AMENDMENT OF RULE 46.12.2003 PERTAINING TO UPDATING OF PROCEDURES CODES FOR PHYSICIAN SERVICES

TO: All Interested Persons

1. On May 11, 1989, the Department of Social and Rehabilitation Services published notice of the proposed amendment of Rule 46.12.2003 pertaining to updating of procedure codes for physician services at page 548 of the 1989 Montana Administrative Register, issue number 9.

2. The Department has amended Rule 46.12.2003 as proposed.

3. No written comments or testimony were received.

Director, Social and Rehabilitation Services

Certified to the Secretary of State June 19, 1989.

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

In the matter of the adoption of Rule (I) 46.12.3208 pertaining to a bona fide effort to sell non-home real property for medicaid eligibility purposes	)))))	NOTICE OF THE ADOPTION OF RULE (I) 46.12.3208 PERTAINING TO A BONA FIDE EFFORT TO SELL NON-HOME REAL PROPERTY FOR MEDICAID ELIGIBILITY PURPOSES

TO: All Interested Persons

1. On May 11, 1989, the Department of Social and Rehabilitation Services published notice of the proposed adoption of rule (I) 46.12.3208 pertaining to a bona fide effort to sell non-home real property for medicaid eligibility purposes at page 561 of the 1989 Montana Administrative Register, issue number 9.

2. The Department has adopted Rule (I) 46.12.3208, BONA FIDE EFFORT TO SELL NON-HOME REAL PROPERTY, as proposed.

3. No written comments or testimony were received.

Julia E. Kotwa
Director, Social and Rehabilitation Services

Certified to the Secretary of State June 19, 1989.

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

In the matter of the amendment of Rule 46.12.3401 pertaining to Medicaid coverage of eligible pregnant women and infants	)))))	NOTICE OF THE AMENDMENT OF RULE 46.12.3401 PERTAINING TO MEDICAID COVERAGE OF ELIGIBLE PREGNANT WOMEN AND INFANTS

TO: All Interested Persons

1. On May 11, 1989, the Department of Social and Rehabilitation Services published notice of the proposed amendment of Rule 46.12.3401 pertaining to Medicaid coverage of eligible pregnant women and infants at page 550 of the 1989 Montana Administrative Register, issue number 9.

2. The Department has amended Rule 46.12.3401 as proposed.

3. The Department has thoroughly considered all commentary received:

COMMENT: Legislative Council staff commented that 53-4-212 MCA should be inserted as an additional statutory authority.

RESPONSE: The Department agrees. The insertion will be made on replacement pages.

Director, Social and Rehabilitation Services

Certified to the Secretary of State June 19, 1989.

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

In the matter of the adoption of Rule I and amendment of Rules 46.25.101, 46.25.711, 46.25.720, 46.25.722, 46.25.725, 46.25.727, 46.25.728, 46.25.732, 46.25.733, 46.25.742 and 46.25.744 pertaining to General Relief	))))))))))	NOTICE OF THE ADOPTION OF RULE I AND AMENDMENT OF RULES 46.25.101, 46.25.711, 46.25.720, 46.25.725, 46.25.727, 46.25.728, 46.25.732, 46.25.733, 46.25.742 and 46.25.744 PERTAINING TO GENERAL RELIEF

TO: All Interested Persons

1. On May 11, 1989, the Department of Social and Rehabilitation Services published notice of the proposed adoption of Rule I and amendment of Rule 46.25.101, 46.25.711, 46.25.720, 46.25.722, 46.25.725, 46.25.727, 46.25.728, 46.25.732, 46.25.733, 46.25.742 and 46.25.744 pertaining to General Relief at page 602 of the 1989 Montana Administrative Register, issue number 9.

2. The Department has amended Rules 46.25.101, 46.25.711, 46.25.720, 46.25.722, 46.25.725, 46.25.727, 46.25.728, 46.25.732, 46.25.733, 46.25.742 as proposed.

3. The Department has amended ARM 46.25.744 as proposed with the following changes:

46.25.744 INCOME FOR GENERAL RELIEF MEDICAL

Original subsections (1) through (1)(b) remain interlined as proposed.

(2) Covered medical services will be provided to the eligible person when their household's average monthly income, LESS EARNED INCOME DISREGARDS REQUIRED BY ARM 46.25.728 (3), ~~including presumptive income,~~ is ~~above the monthly income standard found in ARM 46.25.727 but~~ below the monthly income level found in this rule after the following computations are followed:

(a) Average monthly income is determined by computing income reasonably certain to be received in a twelve (12) month period~~, and less applicable earned income disregards as provided for in ARM 46.25.720 (1)(c)~~ and dividing by 12.

Subsections (1)(a)(i) through (5) remain as proposed.

AUTH: Sec. 53-2-201, 53-2-803 and 53-3-114 MCA; Sec. 2, Ch. 603, L. 1989, Eff. 4/21/89 (SB 134); Sec. 6, Ch. 451, L. 1989, Eff. 7/1/89 (HB 723); Sec. 2. Ch. 585, L. 1989, Eff. 7/1/89 (HB 742)

IMP: Sec. 53-3-205 and 53-3-206 MCA; Sec. 4, Ch. 603, L. 1989, Eff. 4/21/89 (SB 134); Sec. 11, Ch. 451, L. 1989, Eff. 7/1/89 (HB 723); Sec. 4, Ch. 585, L. 1989, Eff. 4/20/89 (HB 742)

4. The Department has adopted Rule (I), 46.25.714, FORM OF RELIEF, as proposed.

5. In this final notice, the department has corrected a typographical error in ARM 46.25.744, changing a cross reference from ARM 46.25.728(1)(c) to (3), and has phrased the rule for better clarity. In addition, legislative council staff pointed out that section 53-3-102 MCA was listed incorrectly as one of the authorities for the proposed change to ARM 46.25.101.

Julia E. Robins
Director, Social and Rehabilitation Services

Certified to the Secretary of State June 19, 1989.

VOLUME NO. 43 OPINION NO. 20

POLICE - Officers' eligibility for retirement benefits before age 50;
RETIREMENT SYSTEMS - Eligibility of municipal police officers for retirement benefits before age 50;
MONTANA CODE ANNOTATED - Sections 19-9-801, 19-9-802;
MONTANA LAWS OF 1989 - Chapter 196, section 15.

HELD: A police officer hired after July 1, 1975, who completes 20 years of service before reaching the age of 50 must continue serving as a police officer until he reaches age 50 in order to be eligible for retirement benefits.

June 5, 1989

Charles W. Jardine
City Attorney
201 South Seventh Street
Miles City MT 59301

Dear Mr. Jardine:

You have requested my opinion on the following question:

> May a police officer whose eligibility for service retirement depends on section 19-9-801(2), MCA, retire before reaching age 50 if he has completed 20 or more years of aggregate service and waits until he reaches age 50 to receive his benefits, or must he continue serving as a police officer until he reaches age 50 in order to be eligible for the benefits?

Section 19-9-801, MCA, which was amended by House Bill 89 (1989 Mont. Laws, ch. 196, § 15), effective March 20, 1989, now provides:

> Members are eligible for retirement and shall retire as provided in this section:
>
> (1) A member who was employed by an employer as a police officer on July 1, 1975, is eligible to receive a service retirement allowance when he has completed 20 years or more in the aggregate as a probationary officer, a regular officer, or a special officer, in any capacity or rank and has terminated covered employment.

(2) A member who was or is first employed by an employer as a police officer after July 1, 1975, is eligible to receive a service retirement allowance when he has reached the age of 50, has completed 20 years or more in the aggregate as a probationary officer, a regular officer, or a special officer, in any capacity or rank, and has terminated covered employment.

(3) (a) Except as provided in subsection (3)(b), the retirement allowance may commence on the first day of the month following the member's last day of membership service or, if requested by the terminated member in writing, on the first day of the month following receipt of the written application.

(b) The retirement allowance for an eligible terminated member must commence no later than the first day of the month following the member's 55th birthday.

Standing alone, subsection (2) of the statute clearly requires that a police officer hired after July 1, 1975, reach age 50 before he is eligible for his service retirement, but it is ambiguous concerning whether the officer must remain employed as a police officer until he reaches age 50. However, the next section of the act, section 19-9-802, MCA, clarifies the matter. That section states:

(1) A police officer who is eligible for service retirement under 19-9-801(1) or (2) may retire as of the time he becomes eligible or may elect to serve an additional 1 to 10 years as an active police officer.

(2) A police officer whose eligibility depends on 19-9-801(2) and who completes 20 years of service before reaching the age of 50 is considered to have elected to serve an additional year for each year between the completion of his 20th year of service and his 50th birthday and shall be paid the additional 1%, as prescribed in 19-9-804(2), for each such year. [Emphasis added.]

§ 19-9-802, MCA.

The language of section 19-9-802(2), MCA, requires an officer hired after July 1, 1975, to remain a police officer each additional year between his twentieth year and his reaching the age of 50, in order to be eligible for service retirement.

A section of an act must be interpreted in such a manner as to ensure coordination with other sections of the act and fulfill legislative intent. Hotstetter v. Inland Development Corp. of Montana, 172 Mont. 167, 171, 561 P.2d 1323, 1326 (1977). When section 19-9-801(2), MCA, is read in conjunction with section 19-9-802, MCA, the intent of the Legislature that police officers hired after July 1, 1975, work until age 50 is clear.

THEREFORE, IT IS MY OPINION:

> A police officer hired after July 1, 1975, who completes 20 years of service before reaching the age of 50 must continue serving as a police officer until he reaches age 50 in order to be eligible for retirement benefits.

Sincerely,

Marc Racicot

MARC RACICOT
Attorney General

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. 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, 1989. This table includes those rules adopted during the period April 1, 1989 through June 30, 1989 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, 1989, 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 1989 Montana Administrative Register.

ADMINISTRATION, Department of, Title 2

I	Exempt Compensatory Time - Workweek, p. 2609
2.21.8001	and other rules - Grievances, p. 2055, 2559

AGRICULTURE, Department of, Title 4

I	Inspection Fee for Commercial Feeds, p. 2467, 13
I-XXVI	and other rules - Standards and Procedures for Implementation of the Montana Environmental Policy Act, p. 1606, 2692
4.5.203	Designation of Noxious Weeds, p. 628
4.12.3011	Regulation of Noxious Weed Seeds, p. 248, 394
4.12.3501	and other rules - Grading of Certified Seed Potatoes, p. 2062, 2562

STATE AUDITOR, Title 6

I-II	Unethical Practices by Investment Advisers and Broker-dealers, p. 2065, 221
I-VII	Emergency Rules - Implementation of the Medicare Catastrophic Coverage Act of 1988, p. 2563
6.10.121	Registration of Securities Salesmen and Broker-dealers, p. 2071, 220

COMMERCE, Department of, Title 8

I-XXVI	and other rules - Standards and Procedures for

Implementation of the Montana Environmental Policy Act, p. 1606, 2692

(Board of Athletics)

8.8.2803 and other rules - Prohibitions - Boxing Contestants - Physician Requirements - Weights and Classes - Scoring - Down - Equipment - Judges - Inspectors - Appeals - Appeal of Decisions of Officials, p. 630

(Board of Cosmetologists)

8.14.603 School Requirements, p. 1943, 2479

(Board of Hearing Aid Dispensers)

8.20.401 and other rules - Traineeship Requirements and Standards - Fees - Notification of Address Change - Record Retention - Code of Ethics - Disciplinary Actions - Fines - Hearings - Minimum Testing and Recording Procedures, p. 694

(Board of Horse Racing)

8.22.501 and other rules - Definitions - Parimutuel Exercise Persons - Jockeys - Pony Persons - Trainers - Veterinarians - General Requirements - Medication, p. 635

(Board of Landscape Architects)

8.24.403 and other rules - Applications - Seals - Examinations - Reciprocity - Suspensions and Revocations - Complaint Process - Disciplinary Actions - Fines, p. 698

(Board of Medical Examiners)

8.28.418 and other rule - Annual Registration and Fees - Fee Schedule, p. 172, 395

(Board of Morticians)

8.30.701 Unprofessional Conduct - Narcotics Law Violations - Felony, p. 2535, 225

(Board of Nursing)

8.32.305 and other rules - Educational Requirements - Licensure - Conduct - Disciplinary Procedures - Standards - General Welfare - Reports - Definitions, p. 1629, 2720

(Board of Nursing Home Administrators)

8.34.414 and other rule - Examinations - Fee Schedule, p. 2269, 2567, 14

(Board of Optometrists)

8.36.404 Examinations, p. 1947, 318

(Board of Outfitters)

8.39.504 and other rules - Licensure -- Approved Operations Plan - Conduct -- Standards of Outfitter and Professional Guide - Conduct -- Additional Required Outfitter Procedures - Outfitter Records, p. 460

(Board of Pharmacy)

8.40.415 and other rule - Suspension or Revocation - Gross Immorality and Dangerous Drugs, p. 703

(Board of Physical Therapy Examiners)

8.42.601 and other rules - Unprofessional Conduct -

(Montana Agriculture Development Council)
I-VI Growth Through Agriculture Program, p. 2026, 2481
(Montana State Lottery Commission)
8.127.605 and other rules - Licenses - License Renewal - Electronic Funds Transfer - Prizes, p. 2342, 19

EDUCATION, Title 10

(Superintendent of Public Instruction)
I-VII Traffic Education, p. 2074A, 438
10.13.301 and other rules - Program Standards and Course Requirements for Traffic Education, p. 2537, 438
(Board of Public Education)
I-CLXXXVI and other rules - Accreditation, p. 2075, 2271, 342
10.57.301 and other rules - Endorsement Information - Class 2 Teaching Certification, p. 312, 662
10.58.302 and other rules - Teacher Education Programs Leading to Interstate Reciprocity of Teacher Certification, p. 2629, 397
10.65.201 Policy Statement on Kindergarten Accreditation and Schedule Variances, p. 311, 662
(Montana Arts Council)
10.111.705 Challenge Grants for Permanent Endowment Development, p. 649

FAMILY SERVICES, Department of, Title 11

11.12.211 and other rules - Payment Rates for Residential Foster Care Providers, p. 2344, 20

FISH, WILDLIFE AND PARKS, Department of, Title 12

I-XXVI and other rules - Standards and Procedures for Implementation of the Montana Environmental Policy Act, p. 1606, 2692
12.6.701 Personal Flotation Devices and Life Preservers, p. 1960, 267
12.6.707 Definition of "Vessel", p. 1959, 269
12.6.903 Helena Valley Equalizing Regulations, p. 506

HEALTH AND ENVIRONMENTAL SCIENCES, Department of, Title 16

I Food and Consumer Safety - Temporary Licensing of Tourist Homes During the Montana Centennial Cattle Drive, p. 720
I-XV Licensure Standards for Medical Assistance Facilities, p. 2349, 479, 663
I-XXVI and other rules - Standards and Procedures for Implementation of the Montana Environmental Policy Act, p. 1606, 226, 398
16.8.921 and other rules - Air Quality Permitting of New or Altered Sources of Air Contamination, p. 181,

STATE LANDS, Department of, Title 26

I-V Department of State Lands' Responsibility to Maintain State Land Ownership Records, p. 2546, 667
I-XXVI and other rules - Standards and Procedures for Implementation of the Montana Environmental Policy Act, p. 1606, 28
26.4.301 and other rules - Regulation of Strip and Underground Coal and Uranium Mining, p. 1317, 30, 399

LIEUTENANT GOVERNOR, Title 30

(Statehood Centennial Office)
I and other rule - Grants to the Counties or Organization of Counties - Application Review Procedure, p. 2360, 2743

LIVESTOCK, Department of, Title 32

I Notice of Change of Agent Employment Status, p. 511
32.6.712 State Meat and Poultry Inspection Program, p. 186, 612

NATURAL RESOURCES AND CONSERVATION, Department of, Title 36

I-XXVI and other rules - Standards and Procedures for Implementation of the Montana Environmental Policy Act, p. 1606, 2692, 228
I-XLV Safety of Dams Program, p. 1137, 2489
(Board of Natural Resources and Conservation)
36.15.101 and other rules - Floodplain Management, p. 727
(Board of Water Well Contractors)
I-IX Monitoring Well Construction Standards, p. 1868, 2503
36.21.650 and other rules - Casing Perforations - Intermixing of Aquifers - Sealing of Casing - General, p. 2475, 229

PUBLIC SERVICE REGULATION, Department of, Title 38

I-IX Pipeline Safety, p. 2207, 2569
I-XXIII and other rule - Establishing Certain Minimum Standards for the Adequacy of Telecommunications Services, p. 377
38.5.301 Filing Requirements for Municipal Water and Sewer Utilities, p. 743

REVENUE, Department of, Title 42

I Keylock or Cardtrol Statements, p. 745