MONTANA ADMINISTRATIVE REGISTER

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MONTANA ADMINISTRATIVE REGISTER

ISSUE NO. 9

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 The notice section contains state agencies' proposed new, amended or repealed rules, the rationale for the change, date and address of public hearing and where written comments may be submitted.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

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NOTICE SECTION

STATE OF MONTANA
DEPARTMENT OF COMMERCE
BEFORE THE BOARD OF MILK CONTROL

In the matter of amendment of rule 8.86.504(1)(g) and 8.86.506(13) as it relates to quota plans	))))))	NOTICE OF PROPOSED AMENDMENT OF RULE 8.86.504(1)(g), AND 8.86.506(13) -- QUOTA RULES NO PUBLIC HEARING CONTEMPLATED DOCKET #92-89

TO: ALL LICENSEES UNDER THE MONTANA MILK CONTROL ACT (SECTION 81-23-101, MCA, AND FOLLOWING), AND ALL INTERESTED PERSONS:

1. On June 29, 1989, the Board of Milk Control proposes to amend ARM 8.86.504(1)(g) and 8.86.506(13). The amendments are proposed as a result of a petition filed by the Meadow Gold quota committee and on the Board's own motion.

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

"8.86.504 TRANSFER OF QUOTA

(1) through (f) remain the same.

(g) Transfers which do not qualify as intrafamily or are not the result of a bona fide sale and purchase by a person ~~not now a quota holder~~ in the market ~~of the entire farm~~, including the herd, and production facilities ~~and substantially all of the land associated with the production of milk~~ (subject to the judgment of the producer committee that the purchaser will be substantially standing in the shoes of the seller and continuing the production operation without interruption) shall only be made as follows:

(i) . . ."

AUTH: 81-23-302, MCA IMP: 81-23-302, MCA

"8.86.506 PRODUCER COMMITTEE

(1) through (12) remain the same.

(13) When an aggrieved person files an appeal to the board from a decision of the quota committee, the appeal will be heard as follows:

(a) The aggrieved party will be given the opportunity to make an oral presentation and submit written justification in support of reversal or modification of the quota committee's decision.

(b) Members of the quota committee will be given the opportunity to make an oral presentation and submit written material in opposition to reversal or modification of the quota committee's decision.

(c) The decision of the board will be based on the record of the quota committee hearing as supplemented by oral argument and written submissions to the board. However, the hearing before the board will not be a trial de novo. New material that could not reasonably be submitted to the quota committee will be accepted if it relates to the grounds set forth in subsection 13(d) hereof.

(d) In ruling on the appeal from the quota committee decision the board will not overrule or modify the decision of the quota committee unless:

(i) there was collusion affecting the committee members decision; or

(ii) the board determines that actual bias or prejudice on the part of one or more committee members affected the decision; or

(iii) the committee decision was the result of an incorrect interpretation of a statute or rule applicable to the decision; or

(iv) the committee decision was clearly erroneous in view of the reliable, probative, and substantial evidence on the whole record.

(e) On review of a quota committee's decision, the board shall not substitute its judgement (second guess) for that of the quota committee as to the weight of the evidence on question of fact.

(f) The board of milk control shall hear an appeal at their next scheduled regular board meeting or within 90 days of its filing at bureau offices.

~~(13)~~(14) The administrator shall maintain records of all requests of the producer committee and the disposition thereof. Such files shall be open for inspection by any interested persons during the regular office hours of the Montana milk control bureau."

AUTH: 81-23-302, MCA IMP: 81-23-302, MCA

3. The purpose of the amendment to 8.86.504(1)(g) is to clarify the subsection in the light of ambiguities brought to light in actual appeals of quota committee decisions. (Full text of the rule is located at pages 8-2557 through 8-2558, Administrative Rules of Montana.)

The purpose of the amendment to 8.86.506(13) is to provide rules for handling appeals from quota committee decisions. (Full text of the rule is located at pages 8-2559 through 8-2561, Administrative Rules of Montana.)

4. Interested persons may submit their data, views or arguments concerning the proposed amendments in writing to the

Milk Control Bureau, 1520 E. 6th Ave. - Rm 50, Helena, MT 59620-0512 no later than June 12, 1989.

5. If a person who is directly affected by the proposed amendment wishes to express their data, views or arguments orally or in writing at a public hearing, they must make written request for a hearing and submit this request along with any written comments they have to the above address no later than June 12, 1989.

6. If the agency receives requests for a public hearing on the proposed amendment from either 10 percent (10%) or twenty five (25), whichever is less, of the persons who are directly affected by the proposed amendment; 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 (10%) of those persons directly affected has been determined to be 12 persons based on an estimate of 125 resident and nonresident Meadow Gold and Black Hills Milk producers and distributors.

MONTANA BOARD OF MILK CONTROL
MILTON OLSEN, CHAIRMAN

BY: William E. Ross
WILLIAM E. ROSS, Bureau Chief

Certified to the Secretary of State May 1, 1989.

STATE OF MONTANA
DEPARTMENT OF COMMERCE
BEFORE THE BOARD OF HOUSING

In the matter of the proposed amendment of 8.111.305 pertaining to lending institutions	))))	NOTICE OF PROPOSED AMENDMENT OF 8.111.305 QUALIFIED LENDING INSTITUTIONS

NO PUBLIC HEARING CONTEMPLATED

TO: All Interested Persons:

1. On June 10, 1989, the Board of Housing proposes to amend the above-stated rule.

2. The proposed amendment will read as follows: (new matter underlined, deleted matter interlined) (full text of the rule is located at pages 8-3950 and 8-3951, Administrative Rules of Montana)

"8.111.305 QUALIFIED LENDING INSTITUTIONS (1) through (2)(e) will remain the same.

(f) evidence of current corporate and ownership structure demonstrating more than one year of existence. This also applies to existing approved lending institutions which are restructured by the institution's regulatory agency or corporate reorganization.

(3) through (6) will remain the same."

Auth: Sec. 90-6-104, 90-6-106, MCA; IMP, Sec. 90-6-106, 90-6-108, MCA

3. REASON: The Board of Housing published a notice of proposed amendment of this rule at page 2625, 1988 Montana Administrative Register, issue number 24. This amendment was adopted as proposed at page 266, 1989 Montana Administrative Register, issue number 3.

When the original notice was proposed the word "also" under subsection (2)(f) was inadvertently omitted.

The statement of reasonable necessity in the original notice was "The rule amendment and adoption is proposed in order to establish and clarify the (i) type and amount of insurance coverage required; (ii) financial reporting requirements; and (iii) standards of financial condition for institutions which participate in the board's programs as lending institutions and servicers of mortgage loans. The establishment of reporting requirements and standards of financial conditions for lending institutions and servicers will provide greater assurance of financial responsibility to the board from those institutions participating in the board's programs."

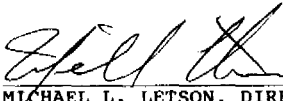
4. Interested persons may submit their data, views or arguments concerning the proposed amendment in writing to Richard A. Kain, Administrator, Montana Board of Housing,

2001 Eleventh Avenue, Helena, Montana 59620, no later than June 8, 1989.

5. If a person who is directly affected by the proposed amendment 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 Richard A. Kain, Administrator, Montana Board of Housing, 2001 Eleventh Avenue, Helena, Montana 59620, no later than June 8, 1989.

6. If the Board receives requests for a public hearing on the proposed amendment from either 10% or 25, whichever is less, of those persons who are directly affected by the proposed amendment, 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 eight based on the number of qualified lending institutions.

MONTANA BOARD OF HOUSING

BY: 

MICHAEL L. LETSON, DIRECTOR
DEPARTMENT OF COMMERCE

Certified to the Secretary of State May 1, 1989.

BEFORE THE FISH AND GAME COMMISSION
OF THE STATE OF MONTANA

In the matter of the amendment of Rule 12.6.903 pertaining to Helena Valley Equalizing Reservoir Regulations.	))))	NOTICE OF THE PUBLIC HEARING ON PROPOSED AMENDMENT OF RULE 12.6.903 PERTAINING TO HELENA VALLEY EQUALIZING REGULATIONS

TO: All interested persons

1. On June 1, 1989, at 7:00 o'clock p.m., a public hearing will be held in the Commission Room at Montana Department of Fish, Wildlife, and Parks headquarters in Helena, Montana to consider the amendment of rule 12.6.903 pertaining to Helena Valley Equalizing Reservoir Regulations.

2. The proposed amendment replaces present rule 12.6.903 found in the Administrative Rules of Montana. The proposed amendment would add windsurfers to the regulations at the Helena Valley Reservoir.

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

12.6.903 HELENA VALLEY EQUALIZING RESERVOIR REGULATIONS

(1) Remains the same.

(2) The main purpose of the equalizing reservoir is to impound the waters for irrigation and for domestic water supply for the city of Helena. Accordingly, any person at any time going in or upon the lands or waters thereof, whether as a visitor, hunter, ~~or~~ fisherman or windsurfer, shall assume all risks arising or resulting in injury or death to himself or damage to or destruction of property, resulting directly or indirectly, wholly or in part, and from use of said reservoir and lands or appurtenant structures or their construction, operation, and control by the United States or by the commission.

Subsections (3) through (5) remain the same.

(6) No swimming or wading is permitted in the reservoir except those persons windsurfing and wearing a wet suit or dry suit in designated areas. Designated areas as posted are closed to all windsurfing near the water outlets.

Subsections (7) through (10) remain the same.

AUTH: Sec. 87-1-303 MCA
IMP: Sec. 87-1-303 MCA

4. The department is proposing this amendment to its rule in response to requests from windsurfers who wish use the Helena Valley Reservoir.

5. Interested parties may submit their data, views or arguments concerning the proposed rule in writing at the hearing. Written data, views or arguments may also be submitted to Fred Robinson, Staff Attorney, Department of Fish, Wildlife and Parks, 1420 East Sixth, Helena, Montana, 59620, no later than June 8, 1989.

6. Fred Robinson, Staff Attorney, has been designated to preside over and conduct the hearing.

7. The authority of the agency to make the proposed amendment is based on section 87-1-303, MCA, and the rule implements section 87-1-303, MCA.

K. L. Cool, Director
Montana Department of Fish
Wildlife, and Parks

Certified to the Secretary of State May 1, 1989.

BEFORE THE DEPARTMENT OF HIGHWAYS
OF THE STATE OF MONTANA

In the matter of the adoption of a Rule classifying certain types of actions as categorical exclusions	NOTICE OF PROPOSED ADOPTION OF A RULE CLASSIFYING CERTAIN TYPES OF ACTIONS AS CATEGORICAL EXCLUSIONS NO PUBLIC HEARING CONTEMPLATED

TO: All Interested Persons:

1. On June 16, 1989, the Department of Highways proposes to adopt a rule which classifies certain types of actions as categorical exclusions from the requirements of preparing an environmental impact statement or an environmental assessment under the Montana Environmental Policy Act and department regulations 18.2.235 through 18.2.260.

2. The proposed rule provides as follows: RULE I ACTIONS THAT QUALIFY FOR A CATEGORICAL EXCLUSION (1) The following types of actions do not individually, collectively, or cumulatively require the preparation of an environment assessment or an environmental impact statement unless the action involves one or more of the extraordinary circumstances stated in (2) below.

(a) Approval of utility installations, road approaches, and railroad crossings.

(b) Construction or improvement of bicycle and pedestrian lanes, paths and facilities and facilities for access for the handicapped.

(c) The installation of noise barriers, landscaping, fencing, signs, pavement markings, traffic signals, and railroad warning devices.

(d) Construction of, reconstruction of, or improvements to rest areas and truck weigh stations.

(e) Modernization of an existing highway by resurfacing, restoration, rehabilitation, reconstruction, adding shoulders or adding auxiliary lanes for parking, turning or climbing.

(f) Highway safety or traffic operations improvement projects.

(g) Bridge rehabilitation, reconstruction, or replacement or the construction of grade separations.

(h) Changes in access control.

(i) Alterations to existing buildings.

(j) Emergency replacement or reconstruction of a highway facility after a natural disaster or catastrophic failure in order to restore the highway for the welfare and safety of the public.

(2) The preparation of an environmental assessment or an environmental impact statement will be required if the

project involves any of the following extraordinary circumstances:

(a) Significant impact on publicly owned parklands, recreation areas, wildlife or waterfowl refuges or any significant historic site.

(b) Significant impact on wetlands or prime farmlands.

(c) Significant impact on the human environment that may result from large acquisitions of right-of-way, relocations of persons or businesses, changes in traffic patterns, changes in grade, or other types of changes.

(d) Significant impact on air, noise, or water quality.

(e) Substantial controversy on environmental grounds.

(f) Any other kind of significant environmental impact.

3. The department is proposing this rule because the types of actions included in the rule are also categorical exclusions under the National Environmental Policy Act. The Department's experience with these types of projects and compliance with 23 C.F.R. section 771.117 have indicated that these types of action normally have no significant impact on the environment. Whenever projects have significant impact or where the Department is not certain of the impact, the Department will comply with all requirements under MEPA and prepare either an environmental assessment or an environmental impact statement in compliance with Rules 18.2.235 through 18.2.260.

4. Interested parties may submit their data, views, or arguments concerning the proposed rule in writing to Thomas J. Barnard, P.E., Administrator of the Engineering Division, Department of Highway, 2701 Prospect Avenue, Helena, Montana, 59620 no later than June 9, 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 Thomas J. Barnard, P.E., Administrator of the Engineering Division, Department of Highways, 2701 Prospect Avenue, Helena, Montana, 59620, no later than June 9, 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 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 more than 25 persons based on the population of Montana.

7. The authority of the department to make the proposed rule is based on section 2-4-201, MCA, and the rule implements section 75-1-201, MCA.

Larry W. Larsen, P.E.
Director of Highways

By: Larry W. Larsen

Certified to the Secretary of State May 1, 1989

BEFORE THE DEPARTMENT OF LIVESTOCK
OF THE STATE OF MONTANA

In the matter of a proposed rule regulating livestock	))	NOTICE OF PROPOSED ADOPTION OF RULE I Relative to requiring notice of change of Agent Employment status

(NO PUBLIC HEARING CONTEMPLATED)

TO: All Interested Persons:

1. On June 13, 1989, the Board of Livestock acting through the department of livestock proposes to adopt Rule I requiring notification to the department of any change of employment status for all listed agents.

2. The rule, as proposed, provides as follows:

RULE I NOTICE OF CHANGE OF EMPLOYMENT STATUS (1) All livestock dealers who employ agents must immediately notify the department of livestock of any changes in employment status relative to those agents.

(a) Failure to notify the department of livestock of any change in employment status may constitute a violation serious enough to initiate and invoke the provisions of 81-8-273 and 81-8-274, MCA.

AUTH 81-8-231 IMP 81-8-231

3. The Board of Livestock proposes to adopt this rule pursuant to the mandate of 81-8-231, MCA which requires that the department "adopt rules necessary to carry out this part".

4. Interested parties may submit their data, views or arguments concerning the proposed rules in writing to Les Graham, Executive Secretary to the Board of Livestock, Capitol Station, Helena, Montana 59620 no later than June 12, 1989.

5. If a person who is directly affected by the proposed rule 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 Les Graham, Executive Secretary to the Board of Livestock, no later than June 12, 1989.

6. If the Board receives requests for a public hearing on the proposed rules from either 10% or 25, whichever is less, of those persons who are directly affected by the proposed rules, 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 Hearing will be published in the Montana Administrative Register.

Nancy Espy
NANCY ESPY, CHAIRMAN
Board of Livestock

BY: Lon Mitchell
LON MITCHELL, STAFF ATTORNEY
Department of Livestock

Certified to the Secretary of State May 1, 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 PUBLIC HEARING ON THE PROPOSED AMENDMENT OF RULE 46.12.505 PERTAINING TO DIAGNOSIS RELATED GROUPS (DRGS)

TO: All Interested Persons

1. On June 2, 1989, at 1:30 p.m., a public hearing will be held in the auditorium of the Social and Rehabilitation Services Building, 111 Sanders, Helena, Montana to consider the proposed amendment of Rule 46.12.505 pertaining to diagnosis related groups (DRGs).

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

46.12.505 INPATIENT HOSPITAL SERVICES, REIMBURSEMENT

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

(c) The department computes a Montana average base price per case. This average budget neutral base price per case is ~~$1,368.19~~ $1,421.55 for fiscal year ending June 30, ~~1989~~ 1990.

Subsections (2)(d) through (12(c)(i) remain the same.

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

3. The medicaid prospective payment diagnostic related group (DRG) system creates incentives for hospitals to contain the cost of services. Under the DRG system hospitals are paid a set price per service provided. If hospitals are able to provide the service at a cost less than the DRG payment, the hospital may retain the savings. The proposed amendment increases reimbursement to hospital providers.

The budget neutral base price per case has been developed by the department to maintain aggregate medicaid inpatient hospital expenditures at a level equal to what would have been expended under the previous reimbursement system based upon medicare cost reimbursement principles. The base price has been calculated by inflating forward the most recent audited cost data available for inpatient hospital services. For the rate year beginning July 1, 1989, the base price is calculated by multiplying the previous year's base price by 3.9%, the rural hospital inflation index set by the Tax Equity and Fiscal Responsibility Act of 1986 (TEFRA).

For the initial year of the DRG system, the federal fiscal year ending September 30, 1987, the system was designed to be budget neutral, i.e., medicaid would pay no more and no less for inpatient hospital services in the aggregate than

would have been paid under a cost-based system of reimbursement. Cost growth in future years is limited by utilization increase indexes set by TEFRA.

4. Interested parties may submit their data, views, or arguments either orally or in writing at the hearing. Written data, views, or arguments may also be submitted to the Office of Legal Affairs, Department of Social and Rehabilitation Services, P.O. Box 4210, Helena, Montana 59604, no later than June 8, 1989.

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

Julia E. Bolinger

Director, Social and Rehabilitation Services

Certified to the Secretary of State May 1, 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 PUBLIC HEARING ON THE PROPOSED AMENDMENT OF RULE 46.12.703 PERTAINING TO REIMBURSEMENT FOR OUTPATIENT DRUGS

TO: All Interested Persons

1. On June 2, 1989, at 10:30 a.m., a public hearing will be held in the auditorium of the Social and Rehabilitation Services Building, 111 Sanders, Helena, Montana to consider the proposed amendment of Rule 46.12.703 pertaining to reimbursement for outpatient drugs.

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

46.12.703 OUTPATIENT DRUGS, REIMBURSEMENT

Subsection (1) remains the same.

(2) The dispensing fee for filling prescriptions shall be determined for each pharmacy provider annually. The dispensing fee shall include the average sum of the individual provider's direct and indirect costs which can be allocated to the filling of prescriptions, plus an additional sum as an incentive factor, which shall be 7 1/2% of the average of all Montana pharmacy prescription charges for the year the cost survey is conducted. If the individual provider's usual and customary average dispensing fee for filling prescriptions is less than the foregoing method of determining the dispensing fee, then the lesser dispensing fee shall be applied in the computation of the payment to the pharmacy provider. The cost of filling a prescription shall be determined from the Montana dispensing cost survey. A copy of the Montana dispensing cost survey form is available upon request from the department. This Montana dispensing cost survey shall outline the information used in determining the actual average cost of filling a prescription for each pharmacy. A provider's ~~F~~failure to submit the cost survey form properly completed will result in the assignment of the minimum dispensing fee offered. ~~Out-of-state providers will be assigned the average of dispensing fee offered to in-state providers.~~ The average cost of filling a prescription will be established on the basis of a determination of all direct and indirect costs that can be allocated to the cost of the prescription department and that of filling a prescription. ~~If there is questionable information supplied on the cost survey form, the current "Hilly Digest" will be used in determining reasonableness of this information.~~ The dispensing fees assigned shall range

between a minimum of $2.00 and a maximum of ~~$3,754~~.00. Out-of-state providers will be assigned a $3.50 dispensing fee.

(3) Notwithstanding subsection (2) above, effective ~~December~~ July 1, 1989, ~~the dispensing fee for filling prescriptions shall be maintained at the amount participating pharmacies have in effect on November 30, 1986.~~ All in-state ~~and out of state~~ pharmacies which became or become providers after November 30, 1986, will be assigned an interim $3.50 dispensing fee until a dispensing fee survey, as provided for in subsection (2) above, can be completed for six months of operation. At that time, a new dispensing fee will be assigned which will be the lower of the dispensing fee calculated in accordance with subsection (2) for the pharmacy or the ~~$3,504~~.00 dispensing fee. Failure to comply with the six months dispensing fee survey requirement will result in a dispensing fee of $2.00 being assigned.

Subsection (4) remains the same.

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

3. The Administrative Rules on Medicaid outpatient drug services are being amended in accordance with the appropriation bill for the next biennium, HB 100. In addition, the reference to the current "Lilly Digest" is being eliminated as this process has not been used for over seven (7) years and is no longer applicable.

4. Interested parties may submit their data, views, or arguments either orally or in writing at the hearing. Written data, views, or arguments may also be submitted to the Office of Legal Affairs, Department of Social and Rehabilitation Services, P.O. Box 4210, Helena, Montana 59604, no later than June 8, 1989.

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

6. This rule change will be effective July 1, 1989.

Julia E. Robinson
Director, Social and Rehabilitation Services

Certified to the Secretary of State May 1, 1989.

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

In the matter of the amendment of Rules 46.12.555, 46.12.556, and 46.12.557 pertaining to personal care services	))))	NOTICE OF PUBLIC HEARING ON THE PROPOSED AMENDMENT OF RULES 46.12.555, 46.12.556, and 46.12.557 PERTAINING TO PERSONAL CARE SERVICES

TO: All Interested Persons

1. On June 1, 1989, at 10:30 a.m., a public hearing will be held in the auditorium of the Social and Rehabilitation Services Building, 111 Sanders, Helena, Montana to consider the proposed amendment of Rules 46.12.555, 46.12.556 and 46.12.557 pertaining to personal care services.

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

46.12.555 PERSONAL CARE SERVICES, DEFINITION

Subsection (1) remains the same.

(2) Personal care services include, but are not limited to, assistance with ~~personal care functions~~ activities of daily living such as bathing, grooming, transferring, walking, eating, dressing, toileting, self-administered medications, meal preparation, escort and home management.

Subsection (2)(a) remains the same.

(b) Escort services are limited to trips to obtain medical diagnosis or treatment or to shop for items specifically required for the recipient's health care and ~~maintenance~~ nutritional needs.

(c) Home management and escort services must be provided only in conjunction with direct personal care and must be directly related to a recipient's medical needs.

(3) Personal care services are delivered by attendants supervised by registered nurses.

(4) Personal care services ~~can~~ do not include the following ~~specialized~~ skilled services ~~only if the services are provided by a licensed practical or registered nurse~~ that require professional medical training:

Subsections (4)(a) through (4)(f) remain the same.

~~(i) Provision of these specialized services must be prior authorized by the department.~~

Subsections (5) through (5)(e) remain the same.

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

46.12.556 PERSONAL CARE SERVICES, REQUIREMENTS

(1) To qualify for personal care, a person must be medicaid eligible and demonstrate a medical need for personal care.

~~(2)--Personal-care-services-are-available-only-to-recipients-who-reside-at-home.~~

(32) Personal care services may be provided only in the recipient's home. An attendant may accompany a recipient to receive medical care or shop for items essential to the recipient's health ~~and-maintenance~~ care or nutritional needs.

Subsections (4) through (7) remain the same in text but will be recategorized as subsections (3) through (6).

(87) Personal care services must be prescribed at least annually by a physician and must be supervised at least every ~~sixty~~ ninety (690) days by a registered nurse.

Subsections (9) through (16) remain the same in text but will be recategorized as subsections (8) through (15).

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

46.12.557 PERSONAL CARE SERVICES, REIMBURSEMENT

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

(c) Additional assistance is required for a short term during a post-hospitalization period.

(d) ~~There--are--no--feasible~~ The available alternatives ~~arrangements~~ are not appropriate for meeting the recipient's additional personal care needs. Other alternatives to be considered include provision of personal care services in combination with other formal services or in combination with contributions of informal caregivers.

Subsections (2) and (2)(a) remain the same.

(3) Reimbursement for personal care services is based on contracted unit rates. The rates are for units of attendant, and nurse supervision, ~~overtime-and-travel~~ services.

Subsections (3)(a) and (3)(b) remain the same.

~~(c)--A-unit-of-overtime-service-is-one-hour-and-means services-provided-by-an-attendant-in-excess-of-40-hours-per week.~~

(dc) ~~Travel-time-is~~ Reimbursement is available for time spent in travel by an attendant as part of his principal activity, such as travel time between recipient home visits. Travel time does not include time from the attendant's home to the first recipient or from the last recipient home visit back to the attendant's home.

(4) Reimbursement is not available to attendants for mileage to and from recipient homes.

(5) The department will contract, except as provided for under ARM 46.12.557(2)(ba), with only a provider or providers chosen after request for proposals and competitive consideration of those submitting proposals. A person retained

personally by a recipient to deliver personal care services will not be considered a provider of personal care services for the purposes of this rule and therefore will not be reimbursed by the department.

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

3. These proposed rules incorporate several changes needed to bring the program into conformity with federal guidelines and to make the program more effective in delivery. Beginning July 1, 1989, specialized attendant services will be covered by the home health program. For this reason, specialized attendant services will be removed from personal care services. The definitions of escort and home management for services have been clarified to comply with guidelines issued in the Federal Medical Assistance Manual. The nurse supervision requirements have been reduced to improve program efficiency.

4. Interested parties may submit their data, views, or arguments either orally or in writing at the hearing. Written data, views, or arguments may also be submitted to the Office of Legal Affairs, Department of Social and Rehabilitation Services, P.O. Box 4210, Helena, Montana 59604, no later than June 8, 1989.

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

6. This rule change will be effective July 1, 1989.

Julia E. Robinson
Director, Social and Rehabilitation Services

Certified to the Secretary of State May 1, 1989.

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

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

TO: All Interested Persons

1. On May 31, 1989, at 1:30 p.m., a public hearing will be held in the auditorium of the Social and Rehabilitation Services Building, 111 Sanders, Helena, Montana to consider the proposed amendment of Rule 46.12.2003 pertaining to reimbursement for physician services.

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

46.12.2003 PHYSICIAN SERVICES, REIMBURSEMENT/GENERAL REQUIREMENTS AND MODIFIERS (1) The department hereby adopts and incorporates by reference the procedure code report (PCR) as amended through ~~June 10~~July 1, 1989. The PCR is published by the Montana department of social and rehabilitation services and lists medicaid-payable physician procedure codes and descriptions as delineated in the CPT4 and/or the Health Care Financing Administration's common procedure coding system (HCPCS), fees assigned to relevant procedures and effective dates of fees assigned. A copy of the PCR may be obtained from the Economic Assistance Division, Department of Social and Rehabilitation Services, P.O. Box 4210, Helena, Montana 59604.

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

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

3. The proposed rule change will implement the two percent physician service fee increases authorized by the 1989 legislature.

ARM 46.12.2003 incorporates by reference the Physicians Procedure Code Report (PCR), which describes and lists procedure codes for physician services reimburseable by Medicaid. The PCR is developed by the department from the Physicians' Current Procedural Terminology, Fourth Edition (CPT4) and the Health Care Financing Administration's procedure coding system (HCPCS). Revising the PCR and updating the incorporation by reference date will implement the legislative changes.

The estimated financial impact of the increases in reimbursement for physician services for the state fiscal year beginning July 1, 1989, is a total of $360,627. This figure

includes $100,000 per year for obstetrics and gynecology fees and $260,627 for those physician services demonstrating high usage and for which there is a wide disparity between billed charges and the present Medicaid reimbursement.

Copies of this notice are available at all local human services offices and county welfare offices statewide.

4. Interested parties may submit their data, views, or arguments either orally or in writing at the hearing. Written data, views, or arguments may also be submitted to the Office of Legal Affairs, Department of Social and Rehabilitation Services, P.O. Box 4210, Helena, Montana 59604, no later than June 8, 1989.

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

6. This rule change will be effective July 1, 1989.

Julia E. Robinson
Director, Social and Rehabilitation Services

Certified to the Secretary of State May 1, 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 PUBLIC HEARING ON 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

TO: All Interested Persons

1. On June 6, 1989, at 9:00 a.m., a public hearing will be held in the auditorium of the Social and Rehabilitation Services Building, 111 Sanders, Helena, Montana to consider the proposed amendment of Rules 46.12.570, 46.12.571, 46.12.572, and 46.12.573 pertaining to clinic services covered by Medicaid.

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

46.12.570 CLINIC SERVICES, DEFINITIONS Subsections (1) through (4) remain the same.

(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 one or more of the mental health services purchased by the department.

(a) These criteria are included in contracts between the department and each mental health center.

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

46.12.571 CLINIC SERVICES, REQUIREMENTS Subsections (1) through (4)(d) remain the same.

(5) Services specified in ARM 46.12.572(2) are provided by those individuals with clinical privileges except that day treatment is provided by or under the supervision of individuals with clinical privileges.

(6) Family counseling will be covered only when a medicaid eligible member of the family has been determined to be in need of mental health services and is involved in the family therapy.

(7) Diagnostic clinic services shall not exceed the amount, duration and scope of the covered services outside of a clinic setting.

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) through (1)(k)(iv) remain the same.

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

(a) individual therapy;

(b) family therapy;

(c) group therapy;

(d) emergency services; and

(e) day treatment.

(3) Mental health clinic services provided by a mental health center do not include community living support services, transitional living services or services provided by telephone.

(4) Diagnostic clinic services are limited to speech therapy, audiology, hearing aids, psychologist services, social work services, physical therapy, occupational therapy and medical and dental evaluation, diagnosis and treatment services.

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

46.12.573 CLINIC SERVICES, REIMBURSEMENT Subsection (1) remains the same.

(a) group I procedures ~~$227~~232.00;

(b) group II procedures ~~$270~~275.00;

(c) group III procedures ~~$291~~297.00; and

(d) group IV procedures ~~$331~~338.00.

Subsection (2) remains the same.

(3) Reimbursement for mental health center clinic services shall be by negotiated rate for each center.

(4) The negotiated rate for each mental health center shall be based on the allowable rate for each service for the state fiscal year 1985 established by the department of institutions plus two (2) per cent.

(a) The allowable rates per each fifteen (15) minute unit are:

(i) individual therapy - $14.30;

(ii) day treatment - $1.87;

(iii) group therapy and family therapy - $3.58; and

(iv) emergency services - $14.49.

(b) The negotiated rate for each center shall be the total allowable payments divided by the total allowable units. The total allowable units are the sum of the allowable units for each service specified in (4)(a) for the state fiscal year prior to the calendar year in which the rates are negotiated. The total allowable payments are the total of allowable units for each service specified in (4)(a) times the rate for the same service specified in (4)(a).

(c) The rates for mental health centers new to the medicaid program shall be the average of rates paid to participating mental health centers in the month when the mental health center becomes a Montana medicaid provider.

(i) The rate for newly participating mental health centers shall be in effect for at least twelve (12) months.

(5) Reimbursement for diagnostic clinic services shall be negotiated rates not to exceed the cost of the same services outside of a clinic setting.

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

3. The primary purpose of this rule is to implement 2% increase for clinic services as provided for in House Bill 100. Reimbursement for surgical centers and diagnostic centers has not been adjusted since 1982. The allowable rates for mental health centers were established in 1985. The 2% increase will address a primary problem, which is outdated rates for all clinic services. The rule will indicate that the payment to diagnostic centers will not exceed the payment level for the same services outside of the diagnostic centers. The 2% increase to the diagnostic centers will be contained in the rule changes for the specific services (e.g., physical therapy, ARM 46.12.527). The method for establishing rates for mental health centers will also be specified.

The rules on limits and covered services are needed to establish clear authority beyond current contracts for the services covered in diagnostic clinics and mental health centers.

The impact of the 2% increase for mental health centers for state fiscal year 1990 will be $151,000. The impact of the 2% increase for surgical centers for state fiscal year 1990 will be $33,000. The impact of the 2% increase for diagnostic centers for state fiscal year 1990 will be $1,000.

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

4. Interested parties may submit their data, views, or arguments either orally or in writing at the hearing. Written data, views, or arguments may also be submitted to the Office of Legal Affairs, Department of Social and Rehabilitation Services, P.O. Box 4210, Helena, Montana 59604, no later than June 8, 1989.

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

Julia E. Robinson
Director, Social and Rehabilitation Services

Certified to the Secretary of State May 1, 1989.

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

In the matter of the amendment of Rules 46.12.1201, 46.12.1202, 46.12.1203, 46.12.1204, 46.12.1205, 46.12.1206, 46.12.1207, 46.12.1208, and 46.12.1209 pertaining to reimbursement for skilled nursing and intermediate care services	)))))))))	NOTICE OF PUBLIC HEARING ON PROPOSED AMENDMENT OF RULES 46.12.1201, 46.12.1202, 46.12.1203, 46.12.1204, 46.12.1205, 46.12.1206, 46.12.1207, 46.12.1208, AND 46.12.1209 PERTAINING TO REIMBURSEMENT FOR SKILLED NURSING AND INTERMEDIATE CARE SERVICES

TO: All Interested Persons

1. On June 6, 1989, at 1:00 p.m., a public hearing will be held in the auditorium of the Social and Rehabilitation Services Building, 111 Sanders, Helena, Montana to consider the proposed amendment of Rules 46.12.1201, 46.12.1202, 46.12.1203, 46.12.1204, 46.12.1205, 46.12.1206, 46.12.1207, 46.12.1208, and 46.12.1209 pertaining to reimbursement for skilled nursing and intermediate care services.

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

46.12.1201 TRANSITION FROM RULES IN EFFECT SINCE JULY 1 ~~1987~~ 1988 (1) These rules shall be effective July 1, ~~1988~~ 1989.

(2) Includable costs for periods prior to July 1, ~~1987~~ 1988 will be determined in accordance with rules for includable costs then in effect.

(3) The payment rate for nursing facilities other than ICF/MR providers, is a result of computing the formula:

R=RO+RP, where:

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

RO=T, if A-T is less than 0

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

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

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

RP=S(2) for providers delivering services in ~~long-term care~~ nursing facilities extensively remodeled after July 1, 1984 where M_1-S is less than or equal to 0

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

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

~~(i) the addition or substitution of a partner having a substantial interest in the partnership as permitted by applicable state law;~~

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

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

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

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

RO=A

RP=M

~~where:~~

(c) R is the payment rate for the current year,

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

(e) S(1) = [(V x S) + (Y x ~~8.14~~ 8.38)] divided by (V + Y)

where:

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

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

(f) S(2) = the lower of ~~8.14~~ 8.38 or S + (((F x 12) divided by 365) x ~~1.0716~~ 1.1037)

where:

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

D is the number of licensed beds in the facility.

B is the total allowable remodeling costs.

(g) T is the interim operating rate plus estimated incentive factor in effect on June 30, 1982.

(h) A is the operating rate effective July 1 of the current year in accordance with ARM 46.12.1204(2) and 46.12.1204(5), and revised as of the effective date of a change which results in a change in operating rate. ~~or, at least annually, in accordance with ARM 46.12.1204(5).~~ Operating Rrate revisions, including increases or decreases, effective as of a date other than July 1 may occur only under the following circumstances: ~~a change in the number of licensed beds or a change in provider.~~

(i) a change in the number of licensed beds, a change in provider, or due to a retroactive adjustment of the patient assessment score resulting from the first monitor of a new provider occurring after the new provider has been in the medicaid program for three months and has had its interim rate set by using the statewide average patient assessment score;

(ii) a provider whose operating rate effective July 1, is computed with a deficient patient assessment monitor score, as determined in accordance with ARM 46.12.1206(4), will be allowed to have a new monitor performed and a revised rate computed effective January 1. The provider must not have a significant difference (10%) in the new monitor, of a month in the survey period May through October, in order to have a revised rate computed effective January 1 using the provider's average patient assessment computation. If a significant difference still exists there will be no change in rate effective January 1. If there is no significant difference the provider must use the new six month average patient assessment score for the period May through October to compute the rate effective January 1. Providers who acquire a new patient assessment score must staff in relation to the new patient assessment score and in accordance with ARM 46.12.1206(2); or

(iii) with respect to light care or heavy care patients according to the provisions of ARM 46.12.1204(2)(b).

(i) M is the property rate effective July 1 of the current year in accordance with ARM 46.12.1204(3) and 46.12.1204(5), and revised as of the effective date of a change which results in a change in property rate ~~or, at least annually, in accordance with ARM 46.12.1204(5).~~ Property Rrate revisions effective as of a date other than July 1 may occur only under the following circumstances: certification of newly constructed beds or completion of an extensive remodeling project, as defined in ARM 46.12.1202(2)(s), or a change in provider or refinancing of a mortgage or renegotiation of a lease.

(j) M_1 = the M calculated under ARM 46.12.1204(3) in effect on 6/30/85 times ~~1.0716~~ 1.1037.

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

(i) the addition or substitution of a partner having a substantial interest in the partnership as permitted by applicable state law;

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

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

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

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

46.12.1202 PURPOSE AND DEFINITIONS (1) The purpose of the following rules is to define the basis and procedures the department will use to pay for ~~long-term-care~~ nursing facility services provided to medicaid recipients from July 1, 1989 forward.

(a) These rules meet the requirements of Title XIX of the Social Security Act including 42 CFR 447 et seq and allow the department to pay for ~~long-term-care~~ nursing facility services through the use of rates that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable Montana and federal laws, regulations, and quality and safety standards.

(b) Efficiently and economically operated providers are those providers who provide adequate ~~long-term-care~~ nursing facility services at a cost that is less than or equal to the payment rate determined in ARM 46.12.1204.

(c) Adequate ~~long-term-care~~ nursing facility services are those provided in conformity with applicable Montana and federal laws, regulations, quality and safety standards, by providers having no deficiencies as determined ~~in~~ according to ARM 46.12.1206(9).

(d) The rules for determining rates and the rate-setting methodology may be amended or revised from time to time as determined by the department and according to procedures established under Montana ~~state~~ law.

(2) As used in these rules governing ~~long-term--care~~ nursing facility services, the following definitions apply:

(a) "~~long-term--care~~ Nursing facility services" means skilled nursing facility services provided in accordance with 42 CFR 405 Subpart K, intermediate care facility services provided in accordance with 42 CFR 442 Subpart F, and intermediate care facility services for the mentally retarded provided in accordance with 42 CFR 442 Subpart G. The department hereby adopts and incorporates herein by reference 42 CFR 405 Subpart K, and 42 CFR 442 Subparts F and G, which define the participation ~~standards~~ conditions for providers, copies of which may be obtained through the Department of Social and Rehabilitation Services, P. O. Box 4210, 111 Sanders, Helena, Montana 59604. The term "nursing facility services" includes the term "long care facility services". These services include, but are not limited to, a medically necessary room, dietary services including dietary supplements used for tube feeding or oral feeding such as high nitrogen diet, nursing services, minor medical and surgical supplies, and the use of equipment and facilities. The services and examples of service listed in this subsection are included in the rate determined by the department under ARM 46.12.1201 and ARM 46.12.1204 and no additional reimbursement is provided for such services. Examples of ~~long-term-care~~ nursing facility services are:

(i) all general nursing services including but not limited to administration of oxygen and related medications, hand-feeding, incontinent care, tray service, nursing rehabilitation services, ~~and~~ enemas~~,~~, and decubitus treatment;

(ii) services necessary to provide for residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life;

(~~ii~~iii) items furnished routinely and ~~relatively uniformly~~ to all patients without charge, such as patient gowns, water pitchers, basins and bed pans;

(~~iii~~iv) items distributed or used individually in small quantities including but not limited to:

(A) anti-bacterial/bacteriostatic solutions, including betadine, hydrogen peroxide, 70% alcohol, merthiolate, zepherin solution;

(B) cotton;

(C) denture cups;

(D) deodorizers (room-type);

(E) disposable diapers~~;~~, cloth diapers if requested;

Original subsections (2)(a)(iii)(F) through (2)(a)(vii) remain the same in text but will be recategorized as (2)(a)(iv)(F) through (2)(a)(viii).

(b) "Provider" means any person, agency, corporation, partnership or other entity that furnishes ~~long-term--care~~ nursing facility services and has entered into an agreement with the department for providing those services.

(c) "Department" means the Montana department of social and rehabilitation services or its agents.

(d) "Medicaid recipient" means a person who is eligible and receiving assistance through Title XIX of the Social Security Act for ~~long-term-care~~ nursing facility services.

Subsection (2)(e) remains the same.

(f) "Average nursing care hourly wage" means the weighted sum of the hourly wages, including benefits for nursing aides employed by providers, identified by the department in its ~~March 1987~~ most recent survey of providers, divided by the ~~total number of facilities surveyed.~~ hours included in the survey.

(g) ~~"Average nursing care time"~~ "Statewide average patient assessment score" means the sum of management hours of care for medicaid recipients identified by the department in its ~~fiscal year 1987~~ most recent patient assessment survey, divided by the total number of medicaid recipients surveyed.

(h) "Provider's average ~~nursing care time~~" patient assessment score" means the sum of management hours of care expressed in nursing aide hours for medicaid recipients ~~in a~~ served by a specific ~~facility~~ provider as identified by the department in its ~~fiscal year 1987~~ most recent patient assessment survey, divided by the number of medicaid recipients ~~in that facility~~ served by that provider and included in the survey subject to the provisions of ARM 46.12.1206(4). ~~For facilities new to the medicaid program, 3.157 will be used because there was no fiscal year 1987 survey performed.~~ The most recent survey shall include a survey period of not less than three months nor more than six months.

(i) ~~"Average wage" means 50% of the sum of starting salaries for job openings in the 300 series in the dictionary of occupational titles identified by the department in its most recent survey of jobs opened in Montana's job service offices during a twelve month or more period, divided by the number of job openings surveyed, plus 50% of the sum of the average starting nursing care salaries identified by the department in its fiscal year 1987 wage survey, divided by the number of facilities surveyed.~~ "Licensed to non-licensed ratio" means that ratio computed when the weighted sum of the hourly wages, including benefits for RN's and LPN's employed by providers, identified by the department in its January 1989 wage survey of providers, divided by the hours included in the survey is divided by the average nursing care hourly wage. This ratio is used to convert licensed hours into equivalent non-licensed hours for staffing and patient assessment computations provided for in ARM 46.12.1206(3). This factor is updated each time a wage survey is compiled.

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

~~locations.~~ "Medically necessary room" means a double occupancy room. Services provided in private rooms will be reimbursed by the department at the same rate as services provided in a double occupancy room.

(i) A provider must provide a private room at no additional charge when it is medically necessary and the provider may not bill recipients extra for a medically necessary private room. A medicaid resident may pay an additional amount on a voluntary basis for a private room when such a room is not medically necessary. The resident must be clearly informed that additional payment is strictly voluntary.

(k) "Owner" means any person, agency, corporation, partnership or other entity which has an ownership interest, including a leasehold or rental interest, in assets used to provide ~~long-term-care~~ nursing facility services pursuant to an agreement with the department.

(l) "Administrator" means the person licensed by the state, including an owner, salaried employee, or other provider, with day-to-day responsibility for the operation of the facility. In the case of a facility with a central management group, the administrator, for the purpose of these rules, may be some person (other than the titled administrator of the facility), with day-to-day responsibility for the long-term care portion of the facility. In such cases, this other person must also be a licensed nursing home administrator.

(m) "Related parties" for purposes of interpretation hereunder, shall include the following:

(i) A person or entity shall be deemed a related party to his spouse, ancestors, descendants, brothers and sisters, or the spouses of any of the above, and also to any corporation, partnership, estate, trust, or other entity in which he or a related party has a substantial interest or in which there is common ownership.

(ii) For purposes of determining whether parties are related within the meaning of this rule, A a substantial interest shall be deemed an interest directly or indirectly, in excess of five percent (5%) of the control, voting power, equity, or other beneficial interest of the entity concerned.

Subsections (2)(m)(iii) through (2)(q) remain the same.

(r) "Nonemergency routine transportation" means ~~routine~~ transportation for routine activities such as facility scheduled outings, nonemergency visits to physicians, dentists, optometrists, etc. Such transportation will be considered routine when provided within the community served by the facility or within 20 miles of the facility, whichever is greater.

(s) "Extensive remodeling" means a renovation or refurbishing of all or part of a provider's physical facility, in accordance with certificate of need requirements, when the projects total cost depreciable under generally acceptable accounting principles exceeds, in a twelve month period,

$2,400 times the number of total licensed beds in the facility. "Extensive remodeling" does not include the construction of additional new beds, but may include construction of additional square feet, or conversion of existing hospital beds to nursing facility beds.

(t) "Total allowable remodeling costs" means those costs which are supported by adequate documentation. These costs include, but are not limited to, all costs of construction. Costs of moveable equipment, supplies, furniture, appliances, etc. are specifically excluded. ~~Also excluded are those remodeling costs related to certification of additional nursing home beds as required by the department of health and environmental sciences.~~

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

Subsections (2)(v) and (2)(w) remain the same.

(x) "Substantial interest" as referred to in ARM 46.12.1201(3)(k) is defined as twenty five percent interest or greater.

Subsection (2)(y) remains the same.

(z) The laws and regulations and federal policies cited in this sub-chapter shall mean those laws and regulations which are in effect as of July 1, 1989.

(aa) "Heavy care" patient means a medicaid recipient with a patient assessment score of 7.10 or above for any month.

(bb) "Light care" patient means a medicaid recipient with a patient assessment score of 1.15 or below for any month.

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

46.12.1203 PARTICIPATION REQUIREMENTS (1) ~~The~~ Nursing facility providers participating in the Montana medicaid program shall, in addition to the regulations set forth in ARM 46.12.301, meet the following basic requirements to receive payments for services:

(~~1~~a) maintain a current license under the rules of the department of health and environmental sciences for the category of care being provided;

(~~2~~b) maintain a current certification for Montana medicaid under the ~~rules of the department~~ applicable state and federal laws and regulations for the category of care being provided;

Subsections (3) and (4) remain the same in text but will be recategorized as (1)(c) and (d).

(~~5~~e) accept, as payment in full for all operating and property costs, the amounts calculated and paid in accordance with the reimbursement method set forth in these rules; ~~and~~

(~~6~~f) for providers maintaining patient trust accounts, insure that any funds maintained in those accounts are used

only for those purposes for which the patient, legal guardian, or personal representative of the patient has given written delegation. A provider may not borrow funds from these accounts for any purpose. The provider must maintain resident funds in excess of $50 in an interest bearing account separate from the facility funds with credit for all interest earned. The facility must maintain other personal funds in a non-interest bearing account or petty cash fund. The provider must notify each medicaid resident when their account reaches $200 less than the applicable resource eligibility guideline set forth in the department's rules and that an increased balance could result in loss of eligibility for medicaid benefits;

(g) Nursing facilities must meet the participation requirements regarding training of nurses aides at the times and in the manner required under 42 U.S.C. section 1395i-3(b)(5) and (f)(2) and 42 U.S.C. section 1396r(b)(5) and (f)(2) (as amended by public law 100-203, known as the Omnibus Budget Reconciliation Act of 1987 [OBRA 87]), which the department hereby adopts and incorporates by reference. A copy of these statutes may be obtained from the Department of Social and Rehabilitation Services, P.O. Box 4210, Helena, Montana 59604;

(h) protect and promote resident rights including freedom of choice; freedom from restraint, physical or chemical unless necessary for resident safety; right to privacy; right to receive notice before change of a room or roommate; confidentiality of personal and clinical records; right to examine survey results; and right to voice grievances. The provider must provide notice orally and in writing of these rights upon admission and apprise the resident of items and services covered by the medicaid rate for which the resident may not be charged;

(i) provide for transfer and discharge notice 30 days in advance except if health or safety is endangered due to medical needs. The provider must notify the resident and a family member in advance of a transfer or discharge, chart in the resident's record the reason for discharge, identify the resident's right to appeal and provide the resident with the name, address and telephone number of the state long term care ombudsman; and

(j) maintain admission policies which do not discriminate on the basis of diagnosis or handicap or violate federal or state laws prohibiting discrimination against the handicapped, including persons infected with Acquired Immunity Deficiency Syndrome/Human Immunodeficiency Virus (AIDS/HIV).

AUTH: Sec. 53-6-113 MCA; Sec. 2, Ch. 152, L. 1989, Eff. 10/1/89 (SB 124)

IMP: Sec. 53-6-141 MCA; Sec. 1, Ch. 152, L. 1989, Eff. 10/1/89 (SB 124)

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

(2) The calculated operating rate A, in dollars per patient day, is given by the following effective July 1, 1988~~9~~:

A=A(1), if T_1 is equal to or greater than A(1), or
A=A(2), if T_1 is equal to or less than A(2), or
A=T_1, if T_1 is less than A(1) and greater than A(2), or
A=A(3) if the facility was constructed after 6/30/82
where:
A(1) = ~~B times~~ ((C times (($27.77 + ($54,627 divided by D)) divided by .9)) + E) + ~~$1.23~~ the OBRA increment.
A(2) = ~~B times~~ ((C times (($27.09 + ($54,627 divided by D)) divided by .9)) + E) + ~~$1.23~~ the OBRA increment.
A(3) = ~~B times~~ ((C times ((27.43 + ($54,627 divided by D)) divided by .9)) + E) + ~~$1.23~~ the OBRA increment.
~~B is the area wage adjustment for a provider,~~
C is the inflation factor used to compute the per diem rates. The inflation factor is the factor necessary to calculate increases in R(1) such that, effective July 1, 1987~~9~~, R(2) = R(1) x 1.02~~3~~.
D is the number of licensed beds for a provider times 366 days,
or D is either the number of licensed beds for a provider or 25, whichever is greater or is the number of licensed beds for a provider or 120 whichever is smaller, times 366 for facilities newly constructed after June 30, 1985 or not in the program on June 30, 1985 or participating in the program with greater than 25 licensed beds on June 30, 1985.
E is the patient care adjustment for a provider,
T_1 is C times the interim operating rate in effect on June 30, 1982, indexed to December 31, 1982.

R(1) = The statewide weighted average per diem rate for R as of June 1, 1987~~9~~.

R(2) = The statewide weighted average per diem rate for R indexed from R(1) by 1.02~~3~~ effective July 1, 1987~~9~~.

The OBRA 87 cost increment effective July 1, 1989 is $2.00.

~~(a) The area wage adjustment for a provider is the result of computing the following formula:~~
~~B=1 + ((F-G) divided by G) times the ratio of total labor costs to total operating costs, based on the fiscal year 1987 information) if F is equal to or greater than one standard deviation from the average wage, or~~
~~B=1.0 if F is less than one standard deviation from the average wage,~~
~~where:~~
~~F is the average wage for a provider's wage area,~~

~~G--is--the--average--wage--for--all--wage--areas--plus--one standard--deviation,--if--P--is--more--than--one--standard deviation-above-the-average-wage,-or~~

~~G--is--the--average--wage--for--all--wage--areas--minus--one standard--deviation,--if--P--is--more--than--one--standard deviation-below-the-average-wage.~~

(ba) The patient care adjustment for a provider is the result of computing the following formula:

E= L times (J-K)

where:

E is the patient care adjustment for a provider.

J is the provider's average nursing care time.

K is the average nursing care time for all providers.

L is the average nursing care hourly wage including benefits.

(b) The operating rate P for individual medicaid recipients who meet the definition of "heavy care" in ARM 46.12.1201(2)(aa) or "light care" in 46.12.1202(2)(bb) is the result of computing the following:

P= A + ((Q - J) ÷ J) x L)

where:

P is the operating rate adjustment attributable to heavy care or light care medicaid recipients.

A is the operating rate calculated for the provider.

Q is the individual patient assessment score for the heavy care or light care recipient.

J is the provider's average patient assessment score.

L is the average nursing care hourly wage including benefits.

The operating rate P is to be billed for services provided to heavy care and light care recipients for every month in which the recipient meets the definition of heavy care or light care. This operating rate is subject to retroactive adjustment.

(3) The calculated property rate is the result of computing the formula:

(a) M = N x Z except for facilities extensively remodeled or with new beds constructed after July 1, 1984.

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

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

where:

M is the property rate per day of service,

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

N is $7.60.

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

N(1) = the lower of ~~8.14~~ 8.38 or (((A x D) + (B x 7.60)) divided by (A + B)) x ~~1.0716~~ 1.1037

N(2) = the lower of ~~8.14~~ 8.38 or D x ~~1.0716~~ 1.1037 + ((F x 12) divided by 365).

where:

A is the total square footage of the original structure.

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

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

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

H is the total number of licensed beds in the facility after extensive remodeling.

G is total allowable remodeling costs.

Z is ~~1.0716~~ 1.1037.

(4) The payment rate to providers of intermediate care facility services for the mentally retarded is the actual includable cost incurred by the provider as determined in ARM 46.12.1207 divided by the total patient days of service during the provider's fiscal year. ~~, except that~~ The payment rate will not exceed ~~total allowable costs per day for the 12 month period ended June 30, 1989, with increases in subsequent years indexed to June 30 of the rate year by 9% per year beginning July 1, 1989~~ the final rate in effect on June 30, 1982, as indexed to the mid-point of the rate year by 9% per 12 month year for fiscal years ending on or before June 30, 1987, and 5.1% per year indexed to June 30 of the rate year for the fiscal years ending after July 1, 1987, and on or before June 30, 1988. The payment rate will not exceed total allowable costs per day for the 12 month period ended June 30, 1989, with increases in subsequent years indexed to June 30 of the rate year by an index not to exceed the medicare market basket index beginning July 1, 1990. Providers having a 1989 cost reporting period ending on a date other than June 30, 1989, must submit detailed cost information supplemental to the cost report. This cost information must be for the period July 1, 1988 through June 30, 1989, and include, at a minimum, worksheet A and the medicaid long term care facility trial balance (form MFB-2), which are standard cost report forms.

Subsections (4)(a) and (b) remain the same.

(c) Following the sale of an intermediate care facility for the mentally retarded after April 5, 1989, the new provider's property costs will be computed at the lesser of historical costs or the rate used for all other intermediate care facilities subject to the limitations in 42 U.S.C. 1396(A)(13)(C).

(5) The averages, standard deviations, or prorating for additions ~~or area wage adjustments~~ are recalculated once a year, using the ~~fiscal year 1987~~ most currently available data

prior to June 1. Revised rates based on the new calculations are issued by July 1 of each year.

(6) The payment rate to out-of-state nursing facilities for eligible Montana medicaid individuals will be at the facility's established medicaid rate as set by that state's medicaid authority.

(a) Payment will be made only when one of the following conditions is met:

(i) there is a medical emergency and the client's health would be endangered if he or she was to return to Montana for medical services;

(ii) the services required are not provided in Montana;

(iii) the required services and all related expenses are less costly than if those services were provided in Montana;

(iv) the recipient is a child in another state for whom Montana makes adoption assistance or foster care assistance payments; or

(v) it is determined by the state that it is general practice for recipients in a particular locality to use medical resources in another state.

(b) To receive payment for nursing facility services, the out-of-state facility must submit the following information to the department:

(i) physician order's identifying the Montana resident and the purpose, cause and expected duration of the stay;

(ii) a copy of the letter establishing the facility's medicaid rate as issued by that state's medicaid authority for the period the services were provided;

(iii) a Level I screening must be performed prior to entry into the nursing facility to determine if there is a diagnosis of mental illness or mental retardation and if so, to conduct assessments which determine the applicant's need for active treatment. This screening form may be obtained from the department;

(iv) a copy of the preadmission-screening determination for the client. The preadmission-screening determines the level of care and may be obtained from the Montana-Wyoming Foundation for medical care. A telephone, post-admission screening determination may be acceptable;

(v) the Montana resident's full name, medicaid ID number and dates of service;

(vi) a copy of the certification notice from that state's survey agency showing certification for medicaid during the period services were provided;

(vii) a statement or other assurance that the facility was not operating under sanctions imposed by medicare or medicaid during the period services were provided which would preclude payment; and

(viii) the provider's federal identification number.

(c) When the above information is received by the department, it will be evaluated to determine whether or not

payment is approved and the rate and dates of service which can be authorized.

(d) The out-of-state provider must enroll in the Montana medicaid program by contacting the state's fiscal intermediary, Consultec, at P.O. Box 4286, Helena, MT 59604.

AUTH: Sec. 53-6-113 MCA; Sec. 1, Ch. 457, L. 1989, Eff. 4/5/89 (SB 399)
IMP: Sec. 53-6-141 MCA; Sec. 1, Ch. 457, L. 1989, Eff. 4/5/89 (SB 399)

46.12.1205 PAYMENT PROCEDURES (1) The department pays providers amounts determined under these rules on a monthly basis upon receipt of an appropriate billing which represents the number of patient days of ~~long-term-care~~ nursing facility services provided to authorized medicaid recipients times the payment rate applicable to each recipient minus the amount each medicaid recipient pays toward the cost of care. Authorized medicaid recipients are those residents who have been determined eligible for medicaid and have been authorized for either skilled or intermediate level of care as a result of the screening process described in ARM 46.12.1101.

(a) Reimbursement for medicare co-insurance days will be limited to the payment rates as determined under ARM 46.12.1204 or the medicare co-insurance rate, whichever is lower, minus the amount each medicaid recipient pays toward the cost of care.

(b) In accordance with section 9435(b) of P.L. 99-509, the Omnibus Budget Reconciliation Act of 1986, payment may not be made for services provided to a fully eligible individual when the individual elects the medicare hospice benefit. This denial of payment is required when the hospice and the provider have made a written agreement under which the hospice is responsible for the professional management of the individual's hospice care and the provider agrees to provide room and board to the individual. Payment under such circumstances will be made to the hospice for room and board services in accordance with the rates established under section 1902(a)(13) of the Social Security Act. In this context, the term "room and board" includes performance of personal care services, including assistance in the activities of daily living, in 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.

(2) The payments made according to ARM 46.12.1205(1) represent full payment for the patient days of ~~long-term-care~~ nursing facility services represented on a billing. A provider shall not bill or collect any additional amount from medicaid recipients or the department for these services,

except that the department may be billed additionally as allowed below:

(a) A provider may bill additionally at direct cost, with no indirect charges or mark-up added, on a per-patient basis, for the following items, if such items are medically necessary, in accordance with ARM 46.12.306 which are prescribed by a physician:

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

(cviii) nutrient solutions for parenteral and enteral nutrition therapy when such solutions are the only source of nutrition for patients who, because of chronic illness or trauma, cannot be sustained through oral feeding. These solutions will be allowable only if they are determined medically appropriate and prior authorized by the director of the medicaid bureau; and

(cviv) routine nursing supplies used in extraordinary amounts and prior authorized by the department.

(b) If the above items are also covered by the medicare program and provided to medicaid recipients who are also medicare recipients, reimbursement will be limited to the lower of the medicare prevailing charge or the provider's direct cost. Medicare Part A is all inclusive. No ancillary services can be billed to the medicaid program for days of service for which medicare Part A coverage is in effect.

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

(d) Physical, occupational, and speech therapies may be billed additionally by the licensed therapist providing the service. Maintenance therapy and rehabilitation services reimbursed as ~~long-term-care~~ nursing facility services under the per diem rate shall not be billed additionally by either the therapist or the provider. If the therapist is employed by or under contract with the provider, the provider shall bill under a separate therapy provider number. Department rules related to physical therapy (ARM 46.12.527), occupational therapy (ARM 46.12.547), and speech pathology (ARM 46.12.532) shall apply.

(e) ~~Medically necessary motorized or customized wheelchairs with special design for a unique condition; helmets; shoulder braces; sacroiliac, lumbro sacral, and dorso-lumbral supports; hinged joint steel knee cap; wrist supports; orthopedic braces; elastic stockings; other anatomical supports; and oxygen may be billed additionally by the provider of medical supplies or equipment in accordance with ARM 46.12.801 802 and ARM 46.12.805 806.~~ Durable medical equipment and medical supplies which are intended to treat a unique condition of the recipient which cannot be met by routine nursing care may be billed separately by the medical supplier in accordance with ARM 46.12.801 to 802 and ARM 46.23.805 to 806.

Subsections (2)(f) and (g) remain the same.

(h) Providers may contract with any qualified person or agency, including home health agencies, to provide required ~~long-term-care~~ nursing facility services. However, except as allowed in this subsection, none of the contracted services may be billed additionally.

Subsection (3) remains the same.

(4) Any medical services and supplies for medicaid recipients in ~~long-term-care~~ nursing facilities not included under ~~long-term-care~~ nursing facility services may be billed by the provider of those services according to applicable department rules.

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

met. The bed may not be filled unless prior approval is obtained from the department. In situations where conditions of billing for holding a bed are not met, providers must hold the bed and may not bill medicaid for the hold bed day until all conditions of billing are met.

Subsection 6 remains the same.

(7) Before a nursing facility resident is transferred for hospitalization or therapeutic leave, the facility must provide written notice to the resident and a family member or legal representative on the expected duration of the transfer and written information concerning state plan provisions regarding the period during which the resident will be permitted to return and resume residency in the facility. Facilities must have a written return policy under which medicaid eligible residents will be readmitted as soon as a semi private bed is available, should a transfer from the facility for a hospitalization or therapeutic leave exceed the bed-hold period as specified under the state plan.

(8) The following items or services are not included in the payment benefit for services rendered by a nursing facility in the medicaid program. These items are considered to be items which may be charged to the nursing facility resident:

(a) vitamins, multivitamins;

(b) calcium supplements;

(c) nasal decongestants and antihistamines;

(d) special requests by a nursing home resident for a specific item or brand that is different from that which the facility routinely stocks or provides as a requirement or condition of participation which is covered under the medicaid routine per diem rate (i.e. special lotion, powder, diapers);

(e) shaving soap;

(f) toothpaste, toothbrush;

(g) cosmetics;

(h) hair combs;

(i) brushes;

(j) tobacco products and accessories;

(k) personal dry cleaning;

(l) beauty shop services;

(m) television rental;

(n) less-than-effective drugs (exclusive of stock items);

(o) over-the-counter drugs (exclusive of the following routine stock items: acetaminophen, aspirin, milk of magnesia, mineral oil, suppositories for evacuation, maalox and mylanta).

Subsection (7) remains the same in text but will be recategorzed as subsection (9).

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

46.12.1206 PATIENT ASSESSMENTS, STAFFING REPORTS AND DEFICIENCIES (1) Each provider will report to the department each month the care requirements for each medicaid patient in the facility on the forms provided and ~~according to~~ in accordance with the patient assessment manual and instructions supplied by the department. The patient assessment manual dated February 1985 is hereby adopted and incorporated by reference. A copy of this manual is available from the Department of Social and Rehabilitation Services, P.O. Box 4210, 111 Sanders, Helena, MT 59604.

Subsection (2) remains the same.

(3) Completed patient assessment forms and staffing report forms must be received by the department within ten days following the end of each calendar month. The administrator or his designee must certify that these reports, to the best of his knowledge and belief, are complete, accurate, and prepared consistent with all applicable rules and departmental instructions. If the complete, accurate and certified forms are not received within the ten-day period, the first available payment for ~~long-term-care~~ nursing facility services will be withheld until such time as the forms are received. The use of the department's forms is mandatory. The reports as submitted shall be complete and accurate. Incomplete reports or reports containing inconsistent data will be returned to the provider for completion or correction.

(4) At least once annually the monthly patient assessment abstracts will be monitored for accuracy and consistency with medical records maintained by the provider. If the department's monitor team findings indicate that abstracts verified by chart documentation are significantly different than the abstracts submitted by the provider for the same month, the provider's average patient assessment score will be computed from the abstracts monitored by the monitor team.

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

Subsection (4)(b) remains the same.

(i) The provider may request a monitor of 100% of the monthly patient assessment abstracts for the month originally monitored. This appeal must be made within thirty (30) days of receipt of the monitor findings. If the 100% monitor indicates that the patient assessment abstracts submitted by the

provider remain significantly different from the abstracts monitored, the provider will reimburse the department for the cost of the additional monitor and the provider's average patient assessment score will be computed from abstracts verified by chart documentation during the 100% monitor. Reimbursement for the costs of the monitor must be made within 30 days after receipt of notification of the costs of the monitor, or the department will recover the cost by set-off against amounts paid for ~~long-term-care~~ nursing facility services. If the 100% monitor indicates that provider patient assessment abstracts submitted are not significantly different from the abstracts verified by chart documentation by the monitor team the cost of the additional monitor will be borne by the department and the provider's average patient assessment score will be determined in accordance with ARM 46.12.1202(2)(h).

Subsection (4)(c) through (4)(e) remain the same.

(f) The department will conduct periodic monitoring of the abstracts for recipients reported as meeting the definitions of heavy care and light care as defined in ARM 46.12.1202(2)(i) and (j). Individual patient assessment scores will be recalculated based upon the monitor findings without regard to the definition of "significantly different" in ARM 46.12.1206(4)(e). Operating rates will be recalculated retroactively based upon the monitor findings. Objections to the monitor findings, recalculation of the patient assessment score or retroactive adjustment of the operating rate may be pursued in accordance with ARM 46.12.1210.

(5) Upon admission and as frequently thereafter as the department may deem necessary, the department will evaluate the necessity of nursing home care for each medicaid patient, in accordance with 42 CFR 456.250 through 456.522, which specify utilization review criteria for ~~long-term-care~~ nursing facilities and which are federal regulations which the department hereby adopts and incorporates by reference. A copy of the cited regulations may be obtained from the Department of Social and Rehabilitation Services, P.O. Box 4210, 111 Sanders, Helena, Montana 59604.

(6) As frequently as the department deems necessary, the quality of medical care that each medicaid patient is receiving shall be evaluated by the department, in accordance with 42 CFR 456.600 through 456.614, which specify medical review criteria for ~~long-term-care~~ nursing facilities and which are federal regulations which the department hereby adopts and incorporates by reference. A copy of the cited regulations may be obtained from the Department of Social and Rehabilitation Services, P. O. Box 4210, 111 Sanders, Helena, Montana 59604.

Subsections (7) through (8)(a) remain the same.

(b) Determine includable costs as specified in ARM 46.12.1207 through audit procedures and may recover, in

accordance with ARM 46.12.1209, all amounts paid in excess of includable costs. Amounts recovered will be not less than 10% of amounts paid to the facility for the period for ~~long-term care~~ nursing facility services.

Subsections (9) through (9)(d) remain the same.

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

46.12.1207 INCLUDABLE COSTS Subsections (1) through (1)(a) remain the same.

(b) Cost incurred in the provision of ~~long-term care~~ nursing facility services to the extent such costs are reasonable and necessary are includable.

Subsections (1)(c) through (1)(d)(ii)(A) remain the same.

(B) employee benefits excluding employer contributions required by state or federal law--FICA, Workers' Compensation Insurance (WCI), Federal Unemployment Insurance (FUI), State Unemployment Insurance (SUI). ~~For a self-employed administrator, an amount equal to what would have been the employer's contribution for FICA and WCI may be excluded from such employee benefits;~~

Subsections (1)(d)(ii)(C) through (1)(e)(iii) remain the same.

(iv) For purposes of this subsection, an employee is one from whose salary or wages the employer is required to withhold FICA. Stockholders who are related parties to the corporate providers, officers of a corporate provider, sole proprietors and partners owning or operating a facility are not employees even if FICA is withheld for them.

Subsections (1)(e)(v) through (1)(l) remain the same.

(m) Costs, including attorney's fees, in connection with court or administrative proceedings shall be includable only to the extent that the provider prevails in the proceeding. Where such proceedings are tied to specific reimbursement amounts, the proportion of costs which are includable shall equal the same percentage as is derived by dividing ~~the total reimbursement at issue by~~ the total reimbursement in which the provider prevailed by the total reimbursement at issue.

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

46.12.1208 COST REPORTING The procedures and forms for maintaining cost information and reporting are as follows:

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

(3) Cost Finding. Cost finding means the process of allocating and prorating the data derived from the accounts ordinarily kept by a provider to ascertain its costs of the various services provided. In preparing cost reports, all providers shall utilize the methods of cost finding described

at 42 CFR ~~405.453~~ 413.24 which the department hereby adopts and incorporates herein by reference. 42 CFR ~~405.453~~ 413.24 is a federal regulation setting forth methods for allocating costs. A copy of the regulation may be obtained from the Department of Social and Rehabilitation Services, P.O. Box 4210, 111 Sanders, Helena, Montana 59604. Notwithstanding the above, distinctions between skilled nursing and intermediate care need not be made in cost finding.

Subsections (4) through (6)(b) remain the same.

(c) On conclusion of a review of a cost report, the department shall send the provider the results of the review. Failure of the department to complete desk reviews within any particular time shall not entitle the provider to retain any overpayment discovered at any time.

Subsections (6)(d) and (7) remain the same.

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

46.12.1209 OVERPAYMENT AND UNDERPAYMENT Subsection (1) remains the same.

(2) In the event of an overpayment the department will, within 30 days of the day the department notifies the provider that an overpayment exists, arrange to recover the overpayment by set-off against amounts paid for ~~long-term-care~~ nursing facility services or by repayments by the provider.

(3) If an arrangement for repayment cannot be worked out within 30 days after notification of the provider, the department will make deductions from rate payments with full recovery to be completed within sixty (60) days from the date of the initial request for payment. The sixty (60) day recovery period coincides with requirements of section 1903(d)(2) of the Social Security Act, as amended. This section requires states to repay the federal share of medicaid payments within sixty (60) days of determination of a medicaid overpayment. Recovery will be undertaken even though the provider disputes in whole or in part the department's determination of the overpayment. ~~In the discretion of the department such recovery may be delayed in whole or in part if a request for fair hearing under ARM 46.12.1210 has been made.~~ A request for administrative review or fair hearing shall not entitle a provider to delay repayment of any overpayment determined by the department.

Subsections (4) through (6) remain the same.

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

3. The proposed rule change will allow for a one year nursing facility reimbursement rule for fiscal year 1990 (7/1/89 - 6/30/90) which will provide for an aggregate total increase

in reimbursement to providers of 3%. Incorporated in the total increase will be a 3% property rate increase. An add-on component to the computed operating rate will be incorporated to reimburse for projected Omnibus Budget Reconcilation Act of 1987 (OBRA) costs in addition to the 3% aggregate increase.

This rule change will eliminate the geographic wage component of the operating formula which serves little purpose and benefits very few facilities, and will serve to simplify the formula. In addition a maximum ceiling of 120 licensed beds used in the formula will be considered the point where economies of scale or size are no longer effective in reducing operating costs for a provider. This ceiling will coincide with the 25 bed minimum that already is in place.

A three-tier heavy care reimbursement system will be implemented to cover costs of providing care for patients with exceptional care needs. Separate rates will be developed, based on patient assessment information, to provide for higher reimbursement to patients whose assessment score exceeds a certain level. Conversely a lower reimbursement rate will be computed for patients with little or no care needs based on individual patient assessment data and a minimum level of care. This system will be implemented at the request of providers that feel the current one rate system does not reimburse adequately for exceptional patients with very heavy care needs.

A twice-a-year monitoring system will be developed for providers whose July 1 reimbursement rate has been computed with a deficient monitor score. This change will allow providers with documentation problems in the initial survey period the opportunity to prove documentation is now acceptable and will not penalize them for a full year if problems have been subsequently corrected.

The impact is estimated to be an increase to aggregate long term care provider reimbursement rates of 3% or $1,523,880. The OBRA 87 incremental add-on is projected to be $2.00 per day or $2,725,930. The budgetary impact of other proposed changes is expected to be minimal.

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

4. Interested parties may submit their data, views, or arguments either orally or in writing at the hearing. Written data, views, or arguments may also be submitted to the Office of Legal Affairs, Department of Social and Rehabilitation Services, P.O. Box 4210, Helena, Montana 59604, no later than June 8, 1989.

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

6. These rules changes will be effective July 1, 1989.

Julia E. Rothman
Director, Social and Rehabilitation Services

Certified to the Secretary of State May 1, 1989.

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

In the matter of the amendment of Rule 46.12.2003 pertaining to updating of procedure codes for physician services	)))))	NOTICE OF PUBLIC HEARING ON THE PROPOSED AMENDMENT OF RULE 46.12.2003 PERTAINING TO UPDATING OF PROCEDURE CODES FOR PHYSICIAN SERVICES

TO: All Interested Persons

1. On May 31, 1989, at 2:30 p.m., a public hearing will be held in the auditorium of the Social and Rehabilitation Services Building, 111 Sanders, Helena, Montana to consider the proposed amendment of Rule 46.12.2003 pertaining to updating of procedure codes for physician services.

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

46.12.2003 PHYSICIAN SERVICES, REIMBURSEMENT/GENERAL REQUIREMENTS AND MODIFIERS (1) The department hereby adopts and incorporates by reference the procedure code report (PCR) as amended through ~~June 10~~ April 1, 1989. The PCR is published by the Montana department of social and rehabilitation services and lists medicaid-payable physician procedure codes and descriptions as delineated in the CPT4 and/or the Health Care Financing Administration's common procedure coding system (HCPCS), fees assigned to relevant procedures and effective dates of fees assigned. A copy of the PCR may be obtained from the Economic Assistance Division, Department of Social and Rehabilitation Services, P.O. Box 4210, Helena, Montana 59604.

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

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

3. ARM 46.12.2003 incorporates by reference the department's procedure code report (PCR), which is based upon the Health Care Financing Administration's common procedure coding system (HCPCS) and the Physicians' Current Procedural Terminology, Fourth Edition (CPT4). HCPCS is updated annually and provides billing codes and service descriptions used by fiscal intermediaries and claims payment agents under both the Medicare and Medicaid programs. It is essential that the annual HCPCS changes, which became effective April 1, 1989, be incorporated into the PCR as soon as possible to facilitate the billing and payment of Medicaid and Medicare claims.

The proposed amendment would incorporate by reference the PCR as updated through April 1, 1989, to include changes to

HCPCS, including revisions of service descriptions and addition or deletion of various billing codes through the PCR.

Another primary purpose of the amendment is to increase reimbursement levels to cover providers' acquisition costs for Paraguard or Progestesert intrauterine devices (IUDs). These IUDs are designed to avoid unplanned pregnancies which create negative complications for patients and unnecessary costs for the Medicaid program. Present reimbursement rates are below providers' actual costs of acquiring these IUDs.

The total estimated increase in reimbursement for IUD acquisition costs is $24,700, which includes $17,200 for reimbursement to family planning clinics and $7,500 to physicians. The federal government participates financially in the costs of family planning services at a 90% matching rate.

Because family planning service providers are reimbursed through individual contractual agreements with the Montana Department of Health and Environmental Sciences, the PCR provides separate IUD billing codes for each provider group. The use of separate billing codes also allows the department to collect more specific information regarding costs of medical supplies within the physician services program.

This amendment will apply retroactively to April 1, 1989, because it is essential that Medicaid physician billing codes be consistent with Medicare billing codes, which were revised effective April 1, 1989, in accordance with the HCPCS 1989 annual revision.

Copies of this notice are available at all local human services offices and county welfare offices statewide.

4. Interested parties may submit their data, views, or arguments either orally or in writing at the hearing. Written data, views, or arguments may also be submitted to the Office of Legal Affairs, Department of Social and Rehabilitation Services, P.O. Box 4210, Helena, Montana 59604, no later than June 8, 1989.

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

Julia E. Robinson
Director, Social and Rehabilitation Services

Certified to the Secretary of State May 1, 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 PUBLIC HEARING ON THE PROPOSED AMENDMENT OF RULE 46.12.3401 PERTAINING TO MEDICAID COVERAGE OF ELIGIBLE PREGNANT WOMEN AND INFANTS

TO: All Interested Persons

1. On June 5, 1989, at 9:00 a.m., a public hearing will be held in the auditorium of the Social and Rehabilitation Services Building, 111 Sanders, Helena, Montana to consider the proposed amendments of Rule 46.12.3401 pertaining to medicaid coverage of eligible pregnant women and infants.

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

46.12.3401 GROUPS COVERED, NON-INSTITUTIONALIZED AFDC-RELATED FAMILIES AND CHILDREN Subsections (1) through (1)(b) remain the same.

(i) those individuals who are not receiving and AFDC check solely because the ~~grant~~ check amount is less than $10;

(ii) ~~--an--otherwise--eligible--pregnant--woman--with--no other--children--receiving--AFDC--when--the--pregnancy--has--been--verified--by--a--physician--or--his--designee;~~ participants in a work supplementation program under title IV-A and any child or relative of such individual (or other individual living in the same household as such individuals) who would be eligible for AFDC if there were no work supplementation program.

(iii) individuals whose AFDC is terminated because the family becomes ineligible because of collection or increased collection of child support. These individuals will continue to receive medicaid for four (4) months.

(iv) individuals whose AFDC is terminated because of loss of the $30 and one-third (1/3) disregard at the end of four (4) months or the $30 disregard at the end of eight (8) months. These individuals will continue to receive medicaid for nine (9) months.

~~(iii)~~ (v) individuals under age 21 who currently reside in Montana and are receiving foster care or adoption assistance under Title IV-E of the Social Security Act, whether or not such assistance originated in Montana. Eligibility requirements for Title IV-E foster care and adoption assistance are found in ARM 46.10.307;

~~(iv)--those--who--do--not--receive--AFDC--because--of--the--receipt--of--an--extra--periodic--paycheck;~~

~~(c)---families--with--dependent--children--who--are--not--receiving--AFDC.--This--coverage--is--limited--to:~~

~~(i) individuals who would be eligible for AFDC had they applied within the prior three months;~~

~~(ii) individuals under age 19 who would be eligible for AFDC if they met the school attendance requirements which are found in ARM 46.10.301;~~

~~(iii) needy caretaker relatives as defined in ARM 46.10.302 who have in their care an individual under age 19 who is eligible for medicaid under subsection (b);~~

(c) individuals whose AFDC is terminated solely because of increased income from employment or increased hours of employment. Those individuals will continue to receive medicaid for four (4) months, providing:

(i) the household received an AFDC grant in at least three (3) of the six (6) months prior to the month the household became ineligible; and

(ii) a member of the household continues to work during the four (4) months.

(A) this four (4) month period of continued medicaid coverage begins the month following the date of AFDC closure, or, if AFDC eligibility ends prior to the month of closure, with the first month in which AFDC was erroneously paid.

(d) individuals under age 19 who would be eligible for AFDC if they met the school attendance requirements which are found in ARM 46.10.301.

(e) individuals who would be eligible for AFDC except for failure to meet the WIN participation requirements found in ARM 46.10.308.

(f) a pregnant woman whose pregnancy has been verified and whose family income and resources meet the requirements listed in 46.10.403 and 406.

(i) the unborn child shall be considered as an additional member of the assistance unit for purposes of determining eligibility.

(g) a pregnant woman whose pregnancy has been verified and whose family income does not exceed 100% of the federal poverty guidelines.

(i) the unborn child shall be considered as an additional member of the assistance unit for purposes of determining eligibility.

(h) a child born on or after October 1, 1983, whose family income and resources meet the requirements listed in ARM 46.10.403 and 46.10.406.

(i) an infant through the month of the first birthday whose family income does not exceed 100% of the federal poverty guidelines.

(j) individuals under the age of 21 who are receiving foster care or subsidized adoption payments through child welfare services.

(i) these individuals must have full or partial financial responsibility assumed by public agencies and must have

been placed in foster homes, private institutions or private homes by a non-profit agency.

~~(iv)~~ k) a child of a minor custodial parent when the custodial parent is living in the child's grandparent's home ~~of his or her parent (the child's grandparent)~~, and the grandparent's income is the sole reason rendering the child ineligible for AFDC;

~~(v) individuals who would be eligible for AFDC except for failure to meet the WIN participation requirements found in ARM 46.10.308;~~

~~(vi) individuals who, in August 1972, were eligible for OASDI and who were also receiving AFDC or would have been receiving AFDC had they applied, providing:~~

~~(A) they meet all current AFDC non financial requirements except those identified as inapplicable to medicaid eligibility in ARM 46.12.3402;~~

~~(B) they meet the current AFDC resource limitations found in ARM 46.10.406; and~~

~~(C) they would currently be eligible for an AFDC grant if the increase in OASDI benefits on July 1, 1972 had not raised family income over the AFDC income standards found in ARM 46.10.403;~~

~~(vii) individuals who would be eligible for AFDC except that income and resources of a sibling must be used to determine eligibility.~~

~~(2) Individuals whose AFDC is terminated solely because of increased income from employment, increased hours of employment or as a result (in whole or in part) of the start of or an increase in the amount of child or spousal support payments will continue to receive medicaid for four (4) months, providing:~~

~~(a) the household received an AFDC grant in at least three (3) of the six (6) months prior to the month the household became ineligible; and~~

~~(b) if the grant terminates because of increased hours of employment or increased income from employment, a member of the household continues to work during the extension.~~

~~(i) this four (4) month period of continued medicaid coverage begins the month following the date of AFDC closure, or, if AFDC eligibility ends prior to the month of closure, with the first month in which AFDC is erroneously paid.~~

~~(3) Individuals whose AFDC is terminated because of loss of $30 and one third (1/3) disregard at the end of four (4) months or $30 disregard at the end of eight (8) months will continue to receive medicaid for nine (9) months, providing any private insurance coverage is disclosed.~~

~~(4) Medicaid will be provided to individuals under age 21 who are not eligible for foster care or adoption assistance under Title IV-E or do not qualify as dependent children. Such individuals under 21 are limited to:~~

~~(a) individuals for whom public agencies are assuming full or partial financial responsibility and who are placed in~~

~~foster homes or in private institutions by either public or private, nonprofit agencies;~~

~~(b) individuals in adoptions subsidized in full or part by a public agency;~~

~~(5) Medicaid will be provided to children born after October, 1983 to two parent families who meet the AFDC income and resource requirements. This provision applies through October, 1988;~~

~~(6) Medicaid will continue for two months after the month pregnancy ends (except if pregnancy ends because of a non-medicaid funded abortion) whether or not all financial and non-financial criteria continue to be met so long as she is medicaid eligible when the pregnancy ends;~~

~~(a) if the individual applies for retroactive medicaid coverage after the date pregnancy ends, the two month extended coverage is not available;~~

(l) needy caretaker relatives as defined in ARM 46.10.302 who have in their care an individual under age 19 who is eligible for medicaid.

(m) individuals who would be eligible for, but are not receiving, AFDC.

(2) Medicaid will continue for two months for pregnant women after the month pregnancy ends as long as the pregnant woman was eligible for and receiving medicaid on the date pregnancy ends.

(3) Medicaid will continue for one year for newborn children providing:

(a) the mother was eligible for and receiving medicaid at the time of the newborn's birth;

(b) the mother of the newborn remains eligible; and

(c) the child remains in the same household as the mother.

(4) Medicaid may be provided for up to three months prior to the date of application for individuals listed in 1(a), 1(b)(i), 1(b)(v), 1(d), (e), (f), (g), (h), (i), (j), (k), and (l) if all financial and non-financial criteria are met for any of those months. For individuals listed in 1(g) and (i) retroactive eligibility cannot begin prior to July 1, 1989.

AUTH: Sec. 53-6-113 MCA
IMP: Sec. 53-6-131 and 53-4-231 MCA

3. The amendments to ARM 46.12.3401 are necessary to implement the poor pregnant women and poor infants coverage mandated by the federal Catastrophic Care Act of 1988, Section 301. The federally required implementation deadline is July 1, 1989.

The new program will result in projected expenditures of $591,906 in State Fiscal Year 1990 and $753,746 in State Fiscal Year 1991. These figures were taken from HB 100 and are based on Department projections.

Serving this new group should lessen adverse impacts on local general relief and general relief medical. No resource test will be imposed at this time because of the complexity of the administration of the resource criteria. Because of this complexity, there is potential for increase in quality control errors and federal sanctions. However, should the caseload increase beyond projection, a resource test will be implemented.

4. Interested parties may submit their data, views, or arguments either orally or in writing at the hearing. Written data, views, or arguments may also be submitted to the Office of Legal Affairs, Department of Social and Rehabilitation Services, P.O. Box 4210, Helena, Montana 59604, no later than June 8, 1989.

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

6. This rule change will be implemented July 1, 1989, pursuant to federal requirements.

Julia E. Robinson
Director, Social and Rehabilitation Services

Certified to the Secretary of State May 1, 1989.

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

In the matter of the amendment of Rules 46.10.403 and 46.12.3803 pertaining to income and benefit standards for medically needy assistance and the Aid to Families with Dependent Children (AFDC) programs	))))))	NOTICE OF PUBLIC HEARING ON THE PROPOSED AMENDMENT OF RULES 46.10.403 and 46.12.3803 PERTAINING TO INCOME AND BENEFIT STANDARDS FOR MEDICALLY NEEDY ASSISTANCE AND THE AID TO FAMILIES WITH DEPENDENT CHILDREN (AFDC) PROGRAMS.

TO: All Interested Persons

1. On June 5, 1989, at 10:00 a.m., a public hearing will be held in the auditorium of the Social and Rehabilitation Services Building, 111 Sanders, Helena, Montana to consider the proposed amendment of Rules 46.10.403 and 46.12.3803 pertaining to income and benefit standards for medically needy assistance and the Aid to Families with Dependent Children (AFDC) programs.

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

46.10.403 TABLE OF ASSISTANCE STANDARDS Subsections (1) and (2) remain the same.

(a) Gross monthly income standards to be used when adults are included in the assistance unit are compared with gross monthly income defined in ARM 46.10.505.

GROSS MONTHLY INCOME STANDARDS TO BE USED WHEN ADULTS ARE INCLUDED IN THE ASSISTANCE UNIT

No. Of Persons in Household	With Shelter Obligation Per Month	Without Shelter Obligation Per Month
1	~~474~~ $ 473	$ 170
2	~~640~~ 637	~~276~~ 274
3	~~803~~ 799	~~379~~ 377
4	~~968~~ 962	481
5	~~1,132~~ 1,123	~~577~~ 583
6	~~1,295~~ 1,285	~~668~~ 686
7	~~1,462~~ 1,449	~~755~~ 790
8	~~1,624~~ 1,610	~~838~~ 892
9	~~1,702~~ 1,774	~~916~~ 997
10	~~1,776~~ 1,935	~~990~~ 1,099
11	~~1,844~~ 2,095	~~1,058~~ 1,201
12	~~1,909~~ 2,259	~~1,123~~ 1,306
13	~~1,970~~ 2,420	~~1,184~~ 1,408
14	~~2,026~~ 2,582	~~1,240~~ 1,511
15	~~2,078~~ 2,743	~~1,291~~ 1,613
16	~~2,124~~ 2,907	~~1,338~~ 1,717

(b) Gross monthly income standards to be used when no adults are included in the assistance unit are compared with gross monthly income defined in ARM 46.10.505.

GROSS MONTHLY INCOME STANDARDS TO BE USED WHEN NO ADULTS ARE INCLUDED IN THE ASSISTANCE UNIT

No. of Children in Household	With Shelter Obligation Per Month	Without Shelter Obligation Per Month
1	~~165~~ $ 163	~~63~~ $ 59
2	~~331~~ 326	~~168~~ 163
3	~~494~~ 490	~~272~~ 268
4	~~657~~ 653	~~374~~ 372
5	~~823~~ 817	~~470~~ 477
6	~~988~~ 981	~~561~~ 581
7	~~1,151~~ 1,145	~~640~~ 686
8	~~1,220~~ 1,308	~~731~~ 790
9	~~1,302~~ 1,471	~~800~~ 894
10	~~1,371~~ 1,635	~~882~~ 999
11	~~1,436~~ 1,797	~~951~~ 1,103
12	~~1,499~~ 1,961	~~1,010~~ 1,208
13	~~1,552~~ 2,124	~~1,077~~ 1,312
14	~~1,604~~ 2,288	~~1,132~~ 1,417
15	~~1,650~~ 2,452	~~1,184~~ 1,521
16	~~1,696~~ 2,616	~~1,230~~ 1,626

(c) Net monthly income standards to be used when adults are included in the assistance unit are compared with net monthly income defined in ARM 46.10.505.

NET MONTHLY INCOME STANDARDS TO BE USED WHEN ADULTS ARE INCLUDED IN THE ASSISTANCE UNIT

No. Of Persons in Household	With Shelter Obligation Per Month	Without Shelter Obligation Per Month
1	$ 256	$ 92
2	~~346~~ 344	~~149~~ 148
3	~~434~~ 432	~~205~~ 204
4	~~523~~ 520	260
5	~~612~~ 607	~~312~~ 315
6	~~700~~ 695	~~361~~ 371
7	~~790~~ 783	~~408~~ 427
8	~~878~~ 870	~~453~~ 482
9	~~920~~ 959	~~495~~ 539
10	960 1,046	~~535~~ 594
11	~~997~~ 1,132	~~572~~ 649
12	~~1,032~~ 1,221	~~607~~ 706
13	~~1,065~~ 1,308	~~640~~ 761
14	~~1,095~~ 1,396	~~670~~ 817
15	~~1,123~~ 1,483	~~698~~ 872
16	~~1,148~~ 1,571	~~723~~ 928

(d) Net monthly income standards to be used when no adults are included in the assistance unit are compared with net monthly income defined in ARM 46.10.505.

NET MONTHLY INCOME STANDARDS TO BE USED WHEN NO ADULTS ARE INCLUDED IN THE ASSISTANCE UNIT

No. of Children in Household	With Shelter Obligation Per Month	Without Shelter Obligation Per Month
1	~~89~~ $ 88	~~34~~ $ 32
2	~~179~~ 176	~~91~~ 88
3	~~267~~ 265	~~147~~ 145
4	~~355~~ 353	~~202~~ 201
5	~~445~~ 442	~~254~~ 258
6	~~534~~ 530	~~303~~ 314
7	~~622~~ 619	~~350~~ 371
8	~~664~~ 707	~~395~~ 427
9	~~704~~ 795	~~437~~ 483
10	~~741~~ 884	~~477~~ 540
11	~~776~~ 971	~~514~~ 596
12	~~810~~ 1,060	~~550~~ 653
13	~~839~~ 1,148	~~582~~ 709
14	~~867~~ 1,237	~~612~~ 766
15	~~892~~ 1,325	~~640~~ 822
16	~~917~~ 1,414	~~665~~ 879

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

(a) Benefit standards to be used when adults are included in the assistance unit are compared with net monthly income defined in ARM 46.10.505.

BENEFIT STANDARDS TO BE USED WHEN ADULTS ARE INCLUDED IN THE ASSISTANCE UNIT

No. Of Persons in Household	With Shelter Obligation Per Month	With Shelter Obligation Per Day	Without Shelter Obligation Per Month	Without Shelter Obligation Per Day
1	~~212~~ $ 209	~~7.07~~ $ 6.97	~~76~~ $ 75	~~2.53~~ $ 2.50
2	~~286~~ 281	~~9.53~~ 9.37	~~123~~ 121	~~4.10~~ 4.03
3	~~359~~ 352	~~11.97~~ 11.73	~~170~~ 166	~~5.67~~ 5.53
4	~~433~~ 424	~~14.43~~ 14.13	~~215~~ 212	~~7.17~~ 7.07
5	~~507~~ 495	~~16.90~~ 16.50	~~258~~ 257	~~8.60~~ 8.57
6	~~580~~ 566	~~19.33~~ 18.87	~~299~~ 302	~~9.97~~ 10.07
7	~~654~~ 638	~~21.80~~ 21.27	~~338~~ 348	~~11.27~~ 11.60
8	~~727~~ 709	~~24.23~~ 23.63	~~375~~ 393	~~12.50~~ 13.10
9	~~762~~ 781	~~25.40~~ 26.03	~~410~~ 439	~~13.67~~ 14.63
10	~~795~~ 852	~~26.50~~ 28.40	~~443~~ 484	~~14.77~~ 16.13
11	~~826~~ 923	~~27.53~~ 30.77	~~474~~ 529	~~15.80~~ 17.63
12	~~854~~ 995	~~28.47~~ 33.17	~~503~~ 575	~~16.77~~ 19.17
13	~~882~~ 1,066	~~29.40~~ 35.53	~~530~~ 620	~~17.67~~ 20.67
14	~~907~~ 1,138	~~30.23~~ 37.93	~~555~~ 666	~~18.50~~ 22.20
15	~~930~~ 1,209	~~31.00~~ 40.30	~~578~~ 711	~~19.27~~ 23.70
16	~~951~~ 1,280	~~31.70~~ 42.67	~~599~~ 756	~~19.97~~ 25.20

(b) Benefit standards to be used when no adults are included in the assistance unit are compared with net monthly income defined in ARM 46.10.505.

BENEFIT STANDARDS TO BE USED WHEN NO ADULTS ARE INCLUDED IN THE ASSISTANCE UNIT

No. Of Persons in Household	With Shelter Obligation Per Month	With Shelter Obligation Per Day	Without Shelter Obligation Per Month	Without Shelter Obligation Per Day
1	~~74~~ $ 72	~~2.47~~ $ 2.40	~~28~~ $ 26	~~.93~~ $ 0.87
2	~~148~~ 144	~~4.93~~ 4.80	~~75~~ 72	~~2.50~~ 2.40
3	~~221~~ 216	~~7.37~~ 7.20	~~122~~ 118	~~4.07~~ 3.93
4	~~294~~ 288	~~9.80~~ 9.60	~~167~~ 164	~~5.57~~ 5.47
5	~~368~~ 360	~~12.27~~ 12.00	210	7.00
6	~~442~~ 432	~~14.73~~ 14.40	~~251~~ 256	~~8.37~~ 8.53
7	~~515~~ 504	~~17.17~~ 16.80	~~290~~ 302	~~9.67~~ 10.07
8	~~550~~ 576	~~18.33~~ 19.20	~~327~~ 348	~~10.90~~ 11.60
9	~~583~~ 648	~~19.43~~ 21.60	~~362~~ 394	~~12.07~~ 13.13
10	~~614~~ 720	~~20.47~~ 24.00	~~395~~ 440	~~13.17~~ 14.67
11	~~643~~ 792	~~21.43~~ 26.40	~~426~~ 486	~~14.20~~ 16.20
12	~~671~~ 864	~~22.37~~ 28.80	~~455~~ 532	~~15.17~~ 17.73
13	~~695~~ 936	~~23.17~~ 31.20	~~482~~ 578	~~16.07~~ 19.27
14	~~718~~ 1,008	~~23.93~~ 33.60	~~507~~ 624	~~16.90~~ 20.80
15	~~739~~ 1,080	~~24.63~~ 36.00	~~530~~ 670	~~17.67~~ 22.33
16	~~759~~ 1,152	~~25.30~~ 38.40	~~551~~ 716	~~18.37~~ 23.87

AUTH: Sec. 53-4-212 MCA
IMP: Sec. 53-4-211 and 53-4-241 MCA

46.12.3803 MEDICALLY NEEDY INCOME STANDARDS Subsections (1) through (2) remain the same.

(3) The following table lists the amounts of adjusted income, based on family size, which may be retained for the maintenance of SSI and AFDC-related families. Since families are assumed to have a sheltered obligation, an amount for shelter obligation is included in level.

MEDICALLY NEEDY INCOME LEVELS
FOR SSI and AFDC-RELATED INDIVIDUALS
AND FAMILIES

Family Size	One Month Net Income Level	Two Month Net Income Level	Three Month Net Income Level
1	~~$ 368~~	~~$ 736~~	~~$1,104~~
2	~~303~~ 375	~~766~~ 750	~~1,149~~ 1,125
3	~~408~~ 400	~~816~~ 800	~~1,224~~ 1,200
4	~~433~~ 424	~~866~~ 848	~~1,299~~ 1,272
5	~~507~~ 495	~~1,014~~ 990	~~1,521~~ 1,485
6	~~580~~ 566	~~1,160~~ 1,132	~~1,740~~ 1,698
7	~~654~~ 638	~~1,308~~ 1,276	~~1,962~~ 1,914
8	~~727~~ 709	~~1,454~~ 1,418	~~2,181~~ 2,127
9	~~762~~ 781	~~1,524~~ 1,562	~~2,286~~ 2,343
10	~~795~~ 852	~~1,590~~ 1,704	~~2,385~~ 2,556
11	~~826~~ 923	~~1,652~~ 1,846	~~2,478~~ 2,769
12	~~854~~ 995	~~1,708~~ 1,990	~~2,562~~ 2,985
13	~~882~~ 1,066	~~1,764~~ 2,132	~~2,646~~ 3,198
14	~~907~~ 1,138	~~1,814~~ 2,276	~~2,721~~ 3,414
15	~~930~~ 1,209	~~1,860~~ 2,418	~~2,790~~ 3,627
16	~~951~~ 1,280	~~1,902~~ 2,560	~~2,853~~ 3,840

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

3. In House Bill 100, the General Appropriations bill, the 51st Montana Legislature changed the base used to calculate AFDC payment levels from a state estimate of the upcoming year's federal poverty index (FPI) to the current calendar year's FPI. Thus, the tables are being changed to reflect legislative intent that 42% of the published FPI for calendar 1989 be used for calculating the fiscal year 1990 payment level and 42% of the FPI published for calendar 1990 be used to calculate the state fiscal year 1991 levels.

4. Interested parties may submit their data, views, or arguments either orally or in writing at the hearing. Written data, views, or arguments may also be submitted to the Office of Legal Affairs, Department of Social and Rehabilitation Services, P.O. Box 4210, Helena, Montana 59604, no later than June 8, 1989.

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

6. These rule changes will be effective July 1, 1989.

Julia E. Rodriguez
Director, Social and Rehabilitation Services

Certified to the Secretary of State May 1, 1989.

9-5/11/89 MAR Notice No. 46-2-562

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

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

TO: All Interested Persons

1. On May 31, 1989, at 9:00 a.m., a public hearing will be held in the auditorium of the Social and Rehabilitation Services Building, 111 Sanders, Helena, Montana to consider the proposed adoption of rule I pertaining to a bona fide effort to sell non-home real property for Medicaid eligibility purposes.

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

RULE I BONA FIDE EFFORT TO SELL NON-HOME REAL PROPERTY

(1) Definitions used in this section include:

(a) "Bona fide effort to sell" means a continuing attempt to sell real property at a price no higher than the fair market value.

(b) "Knowledgeable source" means an individual who is an expert in real property values in the geographical area in which the property is located.

(c) "Reasonable offer" means an offer that is equal to or greater than two thirds of fair market value.

(2) Non-home real property owned by an individual (or spouse) is an exempt resource while either one is making a bona fide effort to sell it.

(a) A bona fide effort to sell exists if:

(i) On a yearly basis, two different knowledgeable sources in the geographic area agree that the property is not salable because of a specific condition; or

(ii) Actual sale attempts at a price no higher than fair market value, as estimated by a knowledgeable source:

(A) have been made within the geographic area since the last determination of eligibility; and

(B) the property continues to be for sale; and

(C) no reasonable offer to purchase has been received.

AUTH: Sec. 53-6-113 MCA
IMP: Sec. 53-6-131, 53-6-141 and 53-6-142 MCA

3. Montana generally follows Supplemental Security Income (SSI) eligibility criteria. In 1983, due to a change in SSI eligibility criteria, Montana adopted a "bona fide effort to sell non-home real property" policy. This policy: (1) allows individuals to establish medical assistance eligibility as long as a good faith effort to sell the property at fair market value is being made; (2) includes property in small communities where there is no real estate market; and (3) eliminates sale of property at a minimal or nominal price. This proposal will implement the policy as a rule.

4. Interested parties may submit their data, views, or arguments either orally or in writing at the hearing. Written data, views, or arguments may also be submitted to the Office of Legal Affairs, Department of Social and Rehabilitation Services, P.O. Box 4210, Helena, Montana 59604, no later than June 8, 1989.

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

6. This rule change will be applied retroactively to January 1, 1989.

Julia E. Robinson
Director, Social and Rehabilitation Services

Certified to the Secretary of State May 1, 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 46.12.1205 pertaining to a two per cent (2%) increase in medicaid fees for provider services	)	NOTICE OF PUBLIC HEARING ON THE PROPOSED AMENDMENTS 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 46.12.1205 PERTAINING TO A TWO PER CENT (2%) INCREASE IN MEDICAID FEES FOR PROVIDER SERVICES

TO: All Interested Persons

1. On June 6, 1989, at 11:00 a.m., a public hearing will be held in the auditorium of the Social and Rehabilitation Services Building, 111 Sanders, Helena, Montana to consider the proposed amendment of Rules 46.12.204, 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 46.12.1205 pertaining to a two per cent (2%) increase in medicaid fees for provider services.

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

46.12.204 RECIPIENT REQUIREMENTS, CO-PAYMENTS

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

(i) home health services not including durable medical equipment and medical supplies, $1.00 per service;

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

(p) prosthetic devices, durable medical equipment and medical supplies, $.50 per 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 the same.

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

46.12.522 PODIATRY SERVICES, REIMBURSEMENT/GENERAL REQUIREMENTS AND MODIFIERS (1) The department will pay the lowest of the following for podiatry services not also covered by medicare:

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

(b) the department's fee schedule found in Rule 46.12.573.

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

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

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

(c) the department's fee schedule found in Rule 46.12.523.

(3) For ~~S~~services paid by report (BR) the department will ~~be paid at at the lower of~~ pay 70% of the provider's usual and customary charges.~~, or fees which are comparable to usual and customary charges established by the provider in 1980.~~

(4) Effective July 1, 1989, the reimbursement rates listed in ARM 46.12.523 and 46.12.524 will be increased by two percent (2%). All items paid by report will remain at the rate indicated.

Original Subsection (2) remains the same in text but will be recategorized as subsection (5).

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

46.12.527 OUTPATIENT PHYSICAL THERAPY SERVICES, REIMBURSEMENT Subsection (1) remains the same.

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

Subsections (1)(b) through (1)(c) remain the same.

(2) 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.

Original subsection (2) remains the same in text but will be recategorized as subsection (3).

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

46.12.537 AUDIOLOGY SERVICES, REIMBURSEMENT (1) The department will pay the lowest of the following for audiology services not also covered by medicare:

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

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

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

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

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

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

(3) 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.

Original subsection (2) will remain the same in text but will be recategorized as subsection (4).

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

46.12.542 HEARING AID SERVICES, REIMBURSEMENT (1) The department will pay the lowerst of the following for hearing aid services:

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

Subsection (1)(b) remains the same.

(2) 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.

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

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

46.12.547 OUTPATIENT OCCUPATIONAL THERAPY SERVICES, REIMBURSEMENT (1) The department will pay the lowest of the following for outpatient occupational therapy services not also covered by medicare:

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

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

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

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

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

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

(3) 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.

Original subsection (3) remains the same in text but is recategorized as subsection (4).

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

46.12.582 PSYCHOLOGICAL SERVICES, REIMBURSEMENT (1) The department will pay the lowest of the following for psychological services not also covered by medicare:

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

(b) the department's fee schedule found in this rule.

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

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

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

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

(~~2~~3) ~~$41.46~~42.29 for individual psychological services, family therapy and psychological testing; or

(~~3~~4) ~~$12.43~~12.68 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 (1) The department will pay the lowerst of the following for licensed clinical social work services not also covered by medicare:

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

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

(a) ~~$33.16~~33.88 per hour for individual counseling;

(b) ~~$9.94~~10.14 per session for group counseling; or

(c) ~~$33.16~~33.82 for family therapy.

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

46.12.605 DENTAL SERVICES, REIMBURSEMENT Subsection (1) remains the same.

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

Subsections (1)(b) through (1)(c) remain the same.

(2) 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.

Original subsections (2) through (15) remain the same in text but will be recategorized as subsections (3) through (16).

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

46.12.805 PROSTHETIC DEVICES, DURABLE MEDICAL EQUIPMENT, AND MEDICAL SUPPLIES, REIMBURSEMENT REQUIREMENTS Subsection (1) remains the same.

(a) The department will pay the lowerst of the following for prosthetic devices, durable medical equipment, and medical supplies not also covered by medicare:

(i) the provider's actual ~~(submitted)~~ charge for the item; or

(ii) the medicaid fee schedule.

(b) the department will pay the lowest of the following for prosthetic devices, durable medical equipment and medical supplies which are also covered by medicare:

(i) the provider's actual ~~(submitted)~~ charge for the item;

(ii) the medicaid fee schedule; or

(iii) the amount allowable for the same item under medicare.

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

(2) Effective July 1, 1989, the reimbursement rates listed in ARM 46.12.806 will be increased by two percent (2%). All items paid by report will remain at the rate indicated.

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

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

46.12.905 OPTOMETRIC SERVICES, REIMBURSEMENT

Subsection (1) remains the same.

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

Subsections (1)(b) through (1)(c) remain the same.

(2) 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.

Original subsections (2) through (18) remain the same in text but will be recategorized as subsections (3) through (19).

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

46.12.915 EYEGLASSES, REIMBURSEMENT Subsection (1) remains the same.

(a) the laboratory cost of a lens to the provider for the service;

(i) the laboratory cost of a lens is the cost of a finished lens ready for insertion in a frame.

Subsections (1)(b) through (4)(b) code "V2218" remain the same.

V2220	Add ons for bifocal lenses ~~bifocal add~~ for each full diopter over ~~3.~~252.00D ~~(maximum of one unit~~ per lens~~)~~	2.00

Codes "V2300" through "V2318" remain the same.

V2320	Add ons for trifocal lenses ~~trifocal add~~ for each full diopter over ~~3.~~252.00D ~~(maximum of one unit~~ per lens~~)~~	2.00

Codes "V2410" through "V2740" remain the same.

V2742	Tint, glass, rose 1 or 2, per lens	1.88

Codes "Z9638" through "V0132" remain the same.

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 (4) remain the same.

(5) The department will pay the lowest of the following for ambulance services not also covered by medicare:

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

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

(6) The department will pay the lowerst of the following for ambulance services which are also covered by medicare:

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

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

(c) the 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

3. The reimbursement rates for the services in this proposed rule have not had a general rate increase since July of 1982. House Bill 100, providing for general appropriations, authorized the proposed increase for services which have fixed rates established for specific services. These proposed rules implement those rate increases. The estimated total increase in expenditures for fiscal year 1990 is $446,546. Other proposed changes are to clarify the rules and provide for uniformity.

4. Interested parties may submit their data, views, or arguments either orally or in writing at the hearing. Written data, views, or arguments may also be submitted to the Office of Legal Affairs, Department of Social and Rehabilitation Services, P.O. Box 4210, Helena, Montana 59604, no later than June 8, 1989.

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

Julia E. Robinson
Director, Social and Rehabilitation Services

Certified to the Secretary of State May 1, 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 PUBLIC HEARING ON THE PROPOSED ADOPTION OF RULES AND 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 June 5, 1989, at 1:30 p.m., a public hearing will be held in the auditorium of the Social and Rehabilitation Services Building, 111 Sanders, Helena, Montana to consider the proposed 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.

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

RULE I MEDICAID COVERAGE FOR QUALIFIED MEDICARE BENEFICIARIES (1) Rules II through XVI implement medicaid coverage, as provided for in Section 301 of the Medicare Catastrophic Coverage Act of 1988 and House Bills 452 and 453 of the 51st Montana legislature for the costs of medicare Parts A and B insurance premiums, deductibles, and coinsurance for persons who are categorically entitled to medicaid and meet certain financial and other criteria.

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 II QUALIFIED MEDICARE BENEFICIARIES, DEFINITIONS (1) "Assignment" means an agreement by a medicare provider 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 claims and issue payments to physicians and other providers covered under medicare Part B insurance.

(3) "Chiropractic services" means the manipulation of the spine by a licensed chiropractor to correct a subluxation. Chiropractic services do not include x-rays or other diagnostic or therapeutic services provided by a licensed chiropractor.

(4) "Coinsurance" means an amount of medical and other costs incurred by an eligible person that are the financial responsibility of that person rather than of the medicare Parts A or B insurance. The amount of coinsurance is the difference between the medicare allowable rate and the actual medicare payment.

(5) "Copayment" means a cost sharing fee imposed upon a qualified medicare beneficiary recipient for a medical service paid for by medicaid.

(6) "Customary charge" means the charge most frequently used by the provider for the service or item.

(7) "Deductible" means a set amount of medical and other costs designated by medicare as the person's financial responsibility. Medicare coverage begins with costs in excess of the deductibles.

(8) "Department" means the department of social and rehabilitation services as provided for at 2-15-2201, MCA.

(9) "Full medicaid" means medicaid coverage other than that provided to qualified medicare beneficiaries.

(10) "Hospice care" are those services providing pain relief, symptom management, respite care, and support services to terminally ill persons.

(11) "Intermediary" means the private insurance company contracted with by the United States health care financing administration to make coverage and payment decisions on services covered by medicare Part A insurance in hospitals, skilled nursing facilities, home health agencies and hospices.

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

(a) the provider's customary charge;

(b) the medicare prevailing charge; or

(c) the provider's actual or billed charge.

(13) "Medicare" means the health insurance programs under Title XVIII of the Social Security Act.

(14) "Medicare Part A Insurance" means the insurance program under medicare that covers inpatient hospital care, inpatient care in a skilled nursing facility, home health care, and hospice care.

(15) "Medicare Part B Insurance" means the insurance program under medicare that covers outpatient hospital services, physician services, home health care services, and other medical services not covered by medicare Part A insurance.

(16) "Premiums" means the monthly amounts that are charged for a person to receive medicare Part B insurance coverage and that may be charged for a person to receive

medicare Part A coverage when the person is not eligible for premium-free coverage.

(17) "Prevailing charge" means a level equal to at least three-fourths of the average of all the charges for the same service billed by all the physicians or suppliers in the state.

(18) "Qualified medicare beneficiary" means a person eligible for the program provided for in Rules I through XVI.

(19) "Respite care" is a short term inpatient hospital stay necessary to temporarily relieve the person who regularly provides hospice care to a person.

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 III QUALIFIED MEDICARE BENEFICIARIES, APPLICATION AND ELIGIBILITY FOR MEDICAID (1) A person is a qualified medicare beneficiary eligible for medicaid, as provided for in Rules I, II, and V through XVI, if the person:

(a) is entitled to medicare Part A benefits as provided for in 42 USC 1395c et seq.;

(b) meets the nonfinancial criteria in subsection (2) of this rule;

(c) has countable resources not in excess of two times the resource limitation applicable to the federal supplemental security income (SSI) resource limitation at 42 USC 1382a. The department hereby incorporates 42 USC 1382a as amended through April 1, 1989, which sets forth the resource limitation applicable to the federal (SSI) program. Copies of 42 USC 1382a, as amended through April 1, 1989, are available from the Economic Assistance Division, Department of Social and Rehabilitation Services, P.O. Box 4210, Helena, Montana 59620; and

(d) has countable income not in excess of:

(i) in 1989, 85% of the current federal poverty income standard;

(ii) in 1990, 90% of the federal poverty income standard;

(iii) in 1991, 95% of the federal poverty income standard; and

(iv) in 1992 and each succeeding year, 100% of the federal poverty income standard.

(2) The non-financial criteria for determining eligibility of a medicaid qualified medicare beneficiary are that the person:

(a) is categorically eligible under the federal social security act as being:

(i) age 65 or older,

(ii) blind, or

(iii) disabled;

(b) has a social security number;

(c) meets the citizenship or alienage requirements of ARM 46.12.3201; and

(d) meets the residency requirements of ARM 46.12.3202.

(3) A person in applying for and receiving medicaid as a qualified medicare beneficiary is subject to the following provisions:

(a) ARM 46.12.304 concerning third party liability;

(b) ARM 46.12.3001 concerning application requirements;

(c) ARM 46.12.3002 concerning determinations of eligibility, except as to the effective date provided for at Rule IV;

(d) ARM 46.12.3003 concerning redetermination;

(e) ARM 46.12.3204 concerning limitation on the financial responsibility of relatives;

(f) ARM 46.12.3205 concerning application for other benefits; and

(g) ARM 46.12.3206 concerning assignment of rights to benefits.

(4) Countable income and resources will be determined using SSI criteria incorporated by reference in ARM 46.12.3603 (2).

(5) No retroactive coverage is available to a person for medicaid services provided to the person as a qualified medicare beneficiary. If otherwise eligible for medicaid under another category, a person may receive retroactive coverage for medicaid services received through that other eligibility.

(6) A person receiving medicaid as a qualified medicare beneficiary must report within 10 days any changes in circumstances that may affect eligibility.

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 IV QUALIFIED MEDICARE BENEFICIARIES, EFFECTIVE DATE OF ELIGIBILITY (1) A person is eligible for the receipt of medicaid benefits at the beginning of the following month after the department determines that the person is a qualified medicare beneficiary.

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

(a) ARM 46.12.216 concerning prior approval and restrictions on provider; and

(b) ARM 46.12.3004 concerning the provisions of assistance.

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 VI QUALIFIED MEDICARE BENEFICIARIES, PAYMENT OF MEDICARE PREMIUMS (1) Medicaid will cover the medicare Part B insurance premium for a qualified medicare beneficiary.

(2) Medicaid will cover the medicare Part A insurance premium for a qualified medicare beneficiary who is not eligible for premium-free medicare Part A insurance coverage.

(3) The department will enroll all qualified medicare beneficiaries in medicare Part B insurance. Persons who are not eligible for premium free medicare Part A insurance, will not be enrolled by the department in medicare Part A insurance. Those persons must enroll themselves through the United States social security administration.

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 QUALIFIED MEDICARE BENEFICIARIES, COVERAGE AND REIMBURSEMENT OF DEDUCTIBLES AND CO-INSURANCE FOR MEDICARE SERVICES (1) For a qualified medicare beneficiary, medicaid will participate in the deductibles and coinsurance for the following medicare services also covered by medicaid:

(a) inpatient hospital services;

(b) outpatient hospital services;

(c) home health services;

(d) skilled nursing home care;

(e) outpatient physical therapy services;

(f) outpatient speech therapy services;

(g) outpatient occupational therapy services;

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

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

(j) dental services which are oral surgery services.

(2) Medicaid requirements governing the services in subsection (1) are found in Title 46, chapter 12 of the administrative rules of Montana (ARM). Medicare requirements

prevail when medicare requirements as to the availability and delivery of services differ from those for medicaid.

(3) Reimbursement for services of:

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

(i) the medicare deductibles and coinsurance; or

(ii) the medicaid fee or rate.

(b) (1)(e) through (j) 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 medicaid to be greater than the medicare allowable charge.

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 VIII QUALIFIED MEDICARE BENEFICIARIES, PAYMENT FOR HOSPICE AND RESPITE CARE AS MEDICARE SERVICES NOT COVERED BY FULL MEDICAID (1) Hospice care and related respite care services are a covered medicaid service for a qualified medicare beneficiary when a physician certifies that the person is terminally ill and the person chooses to receive hospice care and related respite care rather than the standard medicare benefits for terminal illness.

(2) Hospice services may only be provided by a medicare certified private organization or public agency.

(3) Hospice care is limited to 210 days per calendar year. Unlimited hospice services are available after 210 days if a physician recertifies that the person is terminally ill.

(4) Respite care is limited to five (5) days per inpatient hospital stay.

(5) Reimbursement for hospice services is the:

(a) entire cost of medicare deductibles and coinsurance;

(b) 5% of the cost of outpatient drugs or $5.00 toward each prescription; and

(c) 5% of the respite care costs up to a total of $540.

(6) These requirements are in addition to those in Title 46, chapter 12, subchapter 3 of the administrative rules of Montana (ARM).

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 QUALIFIED MEDICARE BENEFICIARIES, CHIROPRACTIC SERVICES (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 or osteopathy.

(2) Reimbursement for chiropractic services is the lowest of:

(a) the provider's submitted charge;

(b) the medicare allowed rate; or

(c) the medicaid fee for the service.

(3) The medicaid fee for this service is the medicare prevailing fee effective on July 1, 1989.

(4) These requirements are in addition to those in Title 46, chapter 12, subchapter 3 of the administrative rules of Montana (ARM).

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 X QUALIFIED MEDICARE BENEFICIARIES, FREE CHOICE OF PROVIDERS (1) Any qualified medicare beneficiary may obtain services from any institution, agency, pharmacy, or practitioner licensed and qualified to perform such services and participating under the medicaid program, unless the department restricts the person's access to services as provided for in ARM 46.12.216.

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 XI QUALIFIED MEDICARE BENEFICIARIES, PROVIDER REQUIREMENTS (1) As a condition of participation in the Montana Medicaid program, including the qualified medicare beneficiary program, all providers of service shall abide by all applicable state and federal statutes and regulations, including but not limited to federal regulations and statutes found in Title 42 of the United States Code and the Code of Federal Regulations governing the medicaid program, and all pertinent Montana statutes and rules governing licensure and certification.

(2) In addition to the requirements provided in these rules, a provider of services to a medicaid qualified medicare beneficiary must comply with the requirements in the following rules:

(a) ARM 46.12.302 concerning provider requirements, participation and service delivery;

(b) ARM 46.12.303(1) concerning billing requirements;
(c) ARM 46.12.303(2) concerning prompt payment of claims and prompt recovery of all payments erroneously or improperly made to a provider;
(d) ARM 46.12.303(3) and (4) concerning reimbursement requirements, payment in full and retroactive payment increases;
(e) ARM 46.12.303(5), (6) and (7) concerning direct provider payments, payment rates for out of state providers and governmental billing of medicaid;
(f) ARM 46.12.304 concerning third party liability;
(g) ARM 46.12.308 concerning record keeping, record disclosure and audits; and
(h) ARM 46.12.401 concerning sanctions.

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 QUALIFIED MEDICARE BENEFICIARIES, PROVIDER RIGHTS (1) A provider may provide services to a person either as a private pay client or as a medicaid client. A person may be medicaid eligible either as a qualified medicare beneficiary or as a qualified medicare beneficiary who is also eligible under another category.
(2) A provider has the rights set forth in ARM 46.12.307, concerning the exercise of professional judgment, management of business affairs and a provider's right to appeal an administrative decision.

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 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 enrolled in the medicaid program.
(2) 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.
(3) Payment in full, except as otherwise provided in (3)(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.

(a) Where a provider does not accept medicare assignment and the person receiving medicaid services is medicaid eligible only as a qualified medicare beneficiary, the provider may bill the person for that portion of the service cost that is the difference between medicare's allowable rate and the provider's charge. A provider who does not accept medicare assignment must inform a person receiving services that this portion may be billed to the person.

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 QUALIFIED MEDICARE BENEFICIARIES, COPAYMENTS

(1) A qualified medicare beneficiary is responsible for the following copayments not to exceed the cost of the service:

(a) inpatient hospital services, $3.00 per day not to exceed $66.00 per admission;

(b) outpatient hospital services, $1.00 per service;

(c) home health services, $1.00 per service;

(d) outpatient physical therapy services, $.50 per service;

(e) outpatient speech therapy services, $.50 per service;

(f) outpatient occupational therapy services, $.50 per service;

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

(h) physician's services, including laboratory and x-ray services, $1.00 per service;

(i) dental services which are oral surgery services, $1.00 per service; and

(j) chiropractor services, $1.00 per service.

(2) The following recipients are exempt from copayments:

(a) persons under the age of 21;

(b) pregnant women; and

(c) inpatients in a hospital, skilled nursing facility, intermediate care facility or other medical institution if the person is required to spend for the cost of care all but a personal needs allowance, as defined in ARM 46.12.4008.

(3) No copayment will be imposed with respect to emergency services or family planning services.

(4) The total of copayments made in any year for each person or couple eligible for medicaid as qualified medicare beneficiaries shall not exceed 5 percent (5%) of the maximum yearly AFDC grant for one adult.

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 QUALIFIED MEDICARE BENEFICIARIES, BILLING (1) The requirements for billing medicaid are as follows:

(a) Claims for qualified medicare beneficiaries must be submitted to medicare first.

(i) Claims for medicare Part A insurance services must be submitted to the medicare Part A insurance intermediary 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.

(ii) Claims for medicare Part B insurance services must be submitted to the medicare Part B insurance carrier for payment with the patient's medicaid eligibility as a qualified medicare beneficiary indicated in that submission. The Part B carrier 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).

RULE XVI QUALIFIED MEDICARE BENEFICIARIES, DETERMINATION OF MEDICAL NECESSITY (1) For services to qualified medicare beneficiaries, medicaid may accept medicare's determination of medical necessity for services which require approval prior to service delivery or review prior to payment. Medicaid may also accept medicare's determination of whether a medical procedure is experimental or not.

(2) The department will only pay for medically necessary, non-experimental services, as established in ARM 46.12.102(2) and ARM 46.12.306.

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 XVII MEDICAL ASSISTANCE MEDICAID PAYMENT (1) Medicaid will pay only for medical expenses:

(a) incurred by a person eligible for the medicaid program;

(b) for services provided for and to the extent provided for under the medicaid program;

(c) for which third party payment is not available;

(d) not used to meet the incurrment requirement at ARM 46.12.3801 and following rules for persons who are medically needy;

(e) which are not the copayment provided for in ARM 46.12.204; and

(f) to the extent allowed by medicaid.

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).

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

46.12.101 MEDICAL ASSISTANCE, PURPOSE (1) The ~~medical assistance~~ Montana medicaid program pays for necessary medical services for eligible low-income persons ~~who are unable to pay for such care for themselves~~. Necessary medical services are those provided for by law and in the rules governing the medicaid program. ~~The covered groups~~ Eligible low-income persons include those categories of persons provided for by law and described in this chapter Title 46, chapter 12 and Rules I through XVI. ~~recipients of AFDC, supplemental security income, and persons considered medically needy. The program is commonly referred to as the "medicaid program".~~

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 and 53-6-141 MCA; Sec. 1, Ch. 310, L. 1989, Eff. 7/1/89 (HB 453).

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

(a) No provider may deny services to any recipient because of the recipient's inability to pay a copayment ~~specified~~ in ARM 46.12.204 or in Rule XIV.

Subsection (4) remains the same.

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, 53-6-111 and 53-6-141 MCA; Sec. 1, Ch. 310, L. 1989, Eff. 7/1/89 (HB 452).

46.12.303 BILLING, REIMBURSEMENT, CLAIMS PROCESSING AND PAYMENT Subsections (1) through (3) remain the same.

(a) A Pproviders may bill a recipients for the copayments specified in ARM 46.12.204 and Rule XIV.

(b) A provider may bill a recipient for services for which the recipient has agreed in writing not to use medicaid coverage.

(c) A provider may bill certain recipients for amounts above the medicare deductibles and coinsurance as allowed in Rule XIII.

Subsections (5) through (7)(b) remain the same.

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, 53-6-111 and 53-6-141 MCA; Sec. 1, Ch. 310, L. 1989, Eff. 7/1/89 (HB 452).

46.12.401 GROUNDS FOR SANCTIONING (1) Sanctions may be imposed by the department against a provider of medical assistance~~,~~ provided under ~~Title 46, Chapters 12~~ this chapter, Title 46, chapter 12, Rules I through XVI, and Title 46, chapter ~~25, of the Administrative Rules of Montana~~, for any one or more of the following reasons:

Subsections (1)(a) through (1)(d) remain the same.

(e) Failure to disclose or make available required records to the department, its authorized agent or other legally authorized persons, ~~or~~ organizations, or governmental entities.

(f) Failure to provide and maintain ~~the quality of~~ services to medicaid recipients ~~that are accepted~~ at a quality that is within accepted medical community standards ~~as acceptable~~ as adjudged by a body of peers.

(g) Engaging in a course of conduct or performing an act which the department's rules~~,~~ or the decision of the applicable professional peer review committee, or ~~applicable~~ licensing board, have determined to be improper or abusive of the Montana ~~medical assistance~~ medicaid program; or continuing such conduct following notification that the conduct should cease.

Subsection (h) remains the same.

(i) Over-utilizing the Montana ~~medical assistance~~ medicaid program by inducing, or otherwise causing a recipient to receive services or goods not medically necessary.

(j) Rebating or accepting a fee or portion of a fee or charge for a medicaid patient referral.

(k) Violating any provision of the ~~State Medical Assistance Act~~ state medicaid law, Title 53, chapter 6, MCA or any rule promulgated pursuant thereto, or violating any provision of Title XIX of the Social Security Act or any regulation promulgated pursuant thereto.

(l) Submission of a false or fraudulent application for provider status.

(m) Violations of any statutes, regulations or code of ethics governing the conduct of occupations or professions or regulated industries.

(n) Conviction of a criminal offense relating to medical assistance programs administered by the department or provided under contract with the state; or conviction for negligent practice resulting in death or injury to patients.

(o) Failure to meet requirements of state or federal law for participation (e.g. licensure).

(p) Exclusion from the medicare program (Title XVIII of the Social Security Act) because of fraudulent or abusive practices.

(q) Charging medicaid recipients for amounts over and above the amounts paid by the department for services rendered, except as specifically allowed under Rules XIII and XIV.

Subsections (1)(r) through (1)(z) remain the same.

AUTH: Sec. 53-2-201, 53-2-803, 53-4-111, 53-6-111 and 53-6-113 MCA; Sec. 9, Ch. 310, L. 1989, Eff. 3/24/89 (HB 453).
IMP: Sec. 53-2-306, 53-2-801, 53-2-803, 53-4-112, 53-6-101 and 53-6-111 MCA; Sec. 1, Ch. 310, L. 1989, Eff. 7/1/89 (HB 453).

46.12.501 SERVICES PROVIDED (1) The following ~~items of~~ medical or remedial care and services shall be available to all persons who are certified eligible for medicaid benefits under this chapter (including deceased persons, categorically related, who would have been eligible ~~but whose fatal condition~~ had death not prevented them from applying)~~,~~ ~~subject to the conditions and limitations contained in the rules on definitions, requirements and reimbursement for each type of service:~~ However, only those medical or remedial care and services also covered by medicare shall be available to a person who is certified eligible for medicaid benefits as a qualified medicare beneficiary under Rules III through IV.

Subsections (1)(a) through (1)(q) remain the same.

(r) durable medical equipment, prosthetic devices and medical supplies;

Subsections (1)(s) through (1)(bb) remain the same.

(2) ~~These services will be furnished in or after the third month before the month in which the application was made if the individual was, or upon application would have been, eligible for assistance at the time the care and services were furnished. Coverage is provided for any full month if the individual met all the eligibility requirements at any time during the month.~~

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, 53-6-103 and 53-6-141 MCA; Sec. 1, Ch. 310, L. 1989, Eff. 7/1/89 (HB 453).

46.12.502 SERVICES NOT PROVIDED BY THE MEDICAID PROGRAM (1) Items or medical services not specifically included within defined benefits of the Montana medicaid program are not reimbursable ~~under the medicaid program~~.

(2) The following medical and nonmedical services are explicitly excluded from the Montana medicaid program except for those services covered under the health care facility licensure rules of the Montana department of health and environmental sciences when provided as part of a prescribed regimen of care to an inpatient of a licensed health care facility; ~~and~~ except for those services specifically available, as listed in ARM 46.12.1404, to persons eligible for home and community-based services; and except for those medicare-covered services, as listed in Rules VIII and IX to qualified medicare beneficiaries for whom the Montana medicaid program pays the medicare premiums, deductible and coinsurance:

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

(j) homemaker services; ~~and~~

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

AUTH: Sec. 53-2-201, 53-6-113 and 53-6-402 MCA; Sec. 5, Ch. 310, L. 1989, Eff. 3/24/89 (HB 453).
IMP: Sec. 53-2-201, 53-6-103, 53-6-141 and 53-6-402 MCA; Sec. 1, Ch.310, L. 1989, Eff. 7/1/89 (HB 453).

46.12.3203 APPLICANT'S CHOICE OF CATEGORY (1) ~~An individual~~ person who ~~would be~~ is eligible ~~in~~ for more than one category of medicaid eligibility will have ~~his~~ eligibility determined for the category ~~he~~ the person selects.

(2) A person who is eligible for medicaid as a qualified medicare beneficiary and under another medicaid eligibility category may have eligibility determined under all categories for which the person may qualify.

(~~2~~3) "Category" as used in this rule means aged, blind, ~~or~~ disabled, ~~or~~ families and children or qualified medicare beneficiary.

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 and 53-6-131 MCA; Sec. 1, Ch. 310, L. 1989, Eff. 7/1/89 (HB 453).

4. These rules implement for Medicaid categorically eligible persons, meeting certain financial and other criteria, coverage by the Montana Medicaid program for the premiums, deductibles and coinsurance necessary for participation in Parts A and B insurance of the Medicare program. This coverage is known as qualified medicare beneficiary coverage. The federal Medicare Catastrophic Coverage Act of 1988 mandates this coverage be assumed by state Medicaid programs.

The purpose of this coverage is to foster the use of the insurance coverages of Medicare by Medicaid recipients. Such utilization will provide appropriate coverage while more efficiently using resources.

5. Interested parties may submit their data, views, or arguments either orally or in writing at the hearing. Written data, views, or arguments may also be submitted to the Office of Legal Affairs, Department of Social and Rehabilitation Services, P.O. Box 4210, Helena, Montana 59604, no later than June 8, 1989.

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

John E. Robinson

Director, Social and Rehabilitation Services

Certified to the Secretary of State May 1, 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 amendment of ARM 46.12.204 and 46.12.501 pertaining to medicaid coverage of hospice services	))))))	NOTICE OF PUBLIC HEARING ON THE PROPOSED ADOPTION OF RULES I THROUGH X AND AMENDMENT OF ARM 46.12.204 and 46.12.501 PERTAINING TO MEDICAID COVERAGE OF HOSPICE SERVICES

TO: All Interested Persons

1. On June 2, 1989, at 9:00 a.m., a public hearing will be held in the auditorium of the Social and Rehabilitation Services Building, 111 Sanders, Helena, Montana to consider the proposed adoption of rules I through X and amendment of ARM 46.12.204 and 46.12.501 pertaining to medicaid coverage of hospice services.

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

RULE I 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.

(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.

(3) "Benefit period" means a period of time that begins on the first day of the month the recipient elects hospice and ends on the last day of the eleventh successive calendar month.

(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.

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

RULE II HOSPICE, CONDITIONS OF PARTICIPATION (1) The hospice program must meet medicare's conditions of participation for hospice programs and have a valid provider agreement with medicare.

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

RULE III HOSPICE, REQUIRED 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:

(a) nursing services provided by or under the supervision of a registered nurse;

(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;

(c) physician's services performed by a physician as defined in ARM 46.12.2001 through 46.12.2003;

(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;

(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.

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

RULE IV 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:

(a) one member of the basic interdisciplinary assessment group must assess the individual's needs;

(b) prior to writing the initial plan that member must discuss his assessment with at least one other group member;

(i) one of these two members must be either a physician or nurse.

(c) the initial plan must be completed on the same day as the assessment if that day is to be a covered day; and

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

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

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

(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.

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

RULE VI HOSPICE, PHYSICIANS (1) 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.

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

RULE VII HOSPICE, ELECTION (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.

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

RULE VIII HOSPICE, REVOCATION OF ELECTION (1) An individual may revoke the election of hospice care at any time.

(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.

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

RULE IX HOSPICE, CHANGE (1) An individual may at any time change their designated hospice during election periods for which he is eligible.

(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.

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

RULE X HOSPICE, REIMBURSEMENT (1) Reimbursement for hospice services is limited to 210 days.

(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.

(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.

(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.

(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 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.

(b) Volunteer physician services are excluded from medicaid reimbursement with the following exceptions:

(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 service 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 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.

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 actually 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 Rule 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.

(f) 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.

(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 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.

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

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

46.12.204 RECIPIENT REQUIREMENTS, CO-PAYMENTS Subsections (1) through (3)(a) remain the same.

(b) family planning services; ~~or~~

(c) hospice services; or

(~~c~~d) eyeglasses provided under a volume purchasing agreement.

Subsection (4) remains the same.

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

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

(cc) hospice services until June 30, 1991, as specified by sunset clause.

Subsection (2) remains the same.

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

4. The Department estimates the financial impact under this rule change for hospice services to be cost neutral. There is a sunset provision in the bill. If the Department finds that this is incorrect, the legislation will be sunset. Estimates of hospice costs are:

	1990	1991
General Fund	$ 43,727	$28,632
Federal Fund	$115,915	71,010
Total	$159,642	$99,642

However, it is believed those costs will be offset by corresponding reductions in primary hospital care.

5. Interested parties may submit their data, views, or arguments either orally or in writing at the hearing. Written data, views, or arguments may also be submitted to the Office of Legal Affairs, Department of Social and Rehabilitation Services, P.O. Box 4210, Helena, Montana 59604, no later than June 8, 1989.

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

7. These rule changes will be effective July 1, 1989.

Julia E. Roberts
Director, Social and Rehabilitation Services

Certified to the Secretary of State May 1, 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 PUBLIC HEARING ON THE PROPOSED AMENDMENT OF RULE 46.12.532 PERTAINING TO REIMBURSEMENT FOR SPEECH THERAPY SERVICES

TO: All Interested Persons

1. On May 31, 1989 at 10:00 a.m., a public hearing will be held in the auditorium of the Social and Rehabilitation Services Building, 111 Sanders, Helena, Montana to consider the proposed amendment of Rule 46.12.532 pertaining to reimbursement for speech therapy services.

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

46.12.532 SPEECH THERAPY SERVICES, REIMBURSEMENT

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

(b) 992507 - treatment (single) ... ~~$26.01~~ $29.50 per hour; and

(c) 992508 - speech group therapy sessions per one and one-half hour ... ~~$15.00~~ $17.01.

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

3. These changes are required by House Bill 100, the General Appropriations bill of the 51st Montana Legislature. It is estimated that in state fiscal year 1990 there would be 9,195 services at an average cost of $29.50 for a total expenditure of $271,252. This is an increase of $64,904 over fiscal year 1989.

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

4. Interested parties may submit their data, views, or arguments either orally or in writing at the hearing. Written data, views, or arguments may also be submitted to the Office of Legal Affairs, Department of Social and Rehabilitation Services, P.O. Box 4210, Helena, Montana 59604, no later than June 8, 1989.

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

Julia E. Robinson
Director, Social and Rehabilitation Services

Certified to the Secretary of State May 1, 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 PUBLIC HEARING ON THE PROPOSED 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 31, 1989, at 11:00 a.m., a public hearing will be held in the auditorium of the Social and Rehabilitation Services Building, 111 Sanders, Helena, Montana to consider the proposed amendment of Rules 46.12.525, 46.12.526 and 46.12.527 pertaining to outpatient physical therapy services.

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

46.12.525 OUTPATIENT PHYSICAL THERAPY SERVICES, DEFINITION Subsection (1) remains the same.

(2) "Outpatient physical therapy" means physical therapy services provided other than by a hospital or home health agency.

Subsections (3) through (5) remain the same.

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

46.12.526 OUTPATIENT PHYSICAL THERAPY SERVICES, REQUIREMENTS Subsections (1) through (6) remain the same.

(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 the same.

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 the same.

(2) Outpatient physical therapy services which are reimbursable under the Montana medicaid program are limited to the following:

EVALUATION AND INSTRUCTION

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

MODALITIES

ONE MODALITY (initial 15 minutes)..... 13.31

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

9-97039	Each additional ~~modality~~ 15 minutes (specify modality)	3.00

PROCEDURES

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

"9-97710 Therapeutic exercises" through "9-97145 Each additional 15 minutes ..... 5.00" remain the same.

OTHER PROCEDURES

9-97139	Postural draining; 15 minute unit	8.65 ~~17.30~~
9-97220	Isolation tub; initial 15 minutes	13.31 ~~26.62~~
	(Use these procedure codes for first 30 minutes only - maximum of 2 units per visit.)	
9-29160	Each additional 15 minutes	5.00
9-97500	Orthotics training (dynamic bracing, splinting); upper extremities; initial ~~30~~ 15 minutes	9.99 ~~19.97~~
	(Use these procedure codes for first 30 minutes only - maximum of 2 units per visit.)	
9-97501	Each additional 15 minutes	5.00
9-97520	Prosthetic training, initial ~~30~~ 15 minutes~~, each visit~~	9.99 ~~19.97~~
	(Use these procedure codes for first 30 minutes only - maximum of 2 units per visit.)	
9-97521	Each additional 15 minutes	5.00
9-97530	Kinetic activities to increase coordination, strength or range of motion, one area (any two extremeties or trunk); initial ~~30~~ 15 min..	9.99 ~~19.97~~

	(Use these procedure codes for first 30 minutes only - maximum of 2 units per visit.)	
9-97531	Each additional 15 minutes	5.00
	ACTIVITIES OF DAILY LIVING (ADL) AND DIVERSIONAL ACTIVITIES	9.99
9-97540	Initial ~~30~~ 15 minutes~~, each visit~~	~~19.97~~
	(Use these procedure codes for first 30 minutes only - maximum of 2 units per visit.)	
9-97541	Each additional 15 minutes	5.00
	POOL THERAPY	7.99
9-97240	Initial ~~30~~ 15 minutes~~, each visit~~.....	~~15.97~~
	(Use these procedure codes for first 30 minutes only - maximum of 2 units per visit.)	
9-97241	Each additional 15 minutes	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~~..... ...	16.64 ~~33.28~~
	(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	
9-97701	Each additional 15 minutes	5.00
9-97720	Extremity testing for strength, dexterity or stamina; initial ~~30~~ 15 minutes~~, each visit~~.....	16.64 ~~33.28~~
	(Use these procedure codes for first 30 minutes only - maximum of 2 units per visit.)	
9-97721	Each additional 15 minutes	5.00
	MUSCLE TESTING	8.32
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)	8.32 ~~33.28~~
	(15 minute units-maximum of 4 units per visit)	

9-95833	Total evaluation of body, excluding hands ..... (15 minute units-maximum of 4 units per visit)	8.32 ~~33.28~~
9-95834	Total evaluation of body, including hands ..... (15 minute units-maximum of 4 units per visit)	8.32 ~~33.28~~
9-95842	Muscle testing, electrical reaction of degeneration, chronaxy, galvanic/ tetanus ratio, one or more extremities, one or more methods .. (15 minute units-maximum of 4 units per visit)	8.32 ~~33.28~~

ELECTROMYOGRAPHY

9-95860	One extremity and related para-spinal areas ..... (15 minute units-maximum of 4 units per visit)	16.64 ~~66.55~~
9-95861	Two extremities and related para-spinal areas ..... (15 minute units-maximum of 4 units per visit)	16.64 ~~66.55~~
9-95862	Three extremities and related para-spinal areas ..... (15 minute units-maximum of 4 units per visit)	16.64 ~~66.55~~
9-95864	Four extremities and related para-spinal areas ..... (15 minute units-maximum of 4 units per visit)	16.64 ~~66.55~~
9-97752	Muscle testing, torque curves during isometric and isokinetic exercise (e.g., by use of cybex machine) ... (15 minute units-maximum of 4 units per visit)	16.64 ~~66.55~~

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

3. This proposal contains three changes. First, the current outpatient physical therapy limitation of 70 visits per state fiscal year, with an additional 30 visits if determined medically necessary by peer review has in the past been applied to physical therapy services provided by home health agencies. It has been determined that the home health services program has adequate program limitations of its own and should not be subject to the outpatient physical therapy service limitation.

Second, it recently has been discovered that the MMIS system has counted each service as a visit. For example, in one 45 minute visit, a therapist may do three modalities and one procedure. This has been counted as 4 visits against the client's limit even though there was only 1 visit of less than an hour. Further, this resulted in higher Medicaid payments than was appropriate.

Third, it was the original intent of both the Department and the Montana Physical Therapy Association that recipients be allowed a maximum of 100 hours per state fiscal year. Therefore, it is necessary to amend ARM 46.12.526(7) to base reimbursement on hours of service rather than visits and to amend ARM 46.12.527 to base reimbursement on time units. Fees have been prorated according to the number of 15 minute units. Many procedures were already weighted at 30 minutes in the Health Care Procedure Coding System (HCPCS). These fees would be prorated over two 15 minute units. Modalities would be weighted at 15 minute units.

Other procedures, such as evaluations, were determined to be one hour services and would be capped at four units per visit allowing one-fourth payment per unit.

It is expected that the financial impact, if any, will be minimal. Each fee has been prorated over the number of units assigned. Where fees did not divide equally, the reimbursement rate was increased by one cent. It is anticipated that the additional cost will be much less than $200 over the year.

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

4. Interested parties may submit their data, views, or arguments either orally or in writing at the hearing. Written data, views, or arguments may also be submitted to the Office of Legal Affairs, Department of Social and Rehabilitation Services, P.O. Box 4210, Helena, Montana 59604, no later than June 8, 1989.

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

6. These changes will be effective July 1, 1989.

Director, Social and Rehabilitation Services

Certified to the Secretary of State May 1, 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 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, 46.27.733, 46.25.742, and 46.25.744 pertaining to General Relief.	)))))))))))	NOTICE OF PUBLIC HEARING ON THE PROPOSED ADOPTION OF RULE I AND THE 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.

TO: All Interested Persons

1. On June 1, 1989, at 1:30 p.m., a public hearing will be held in the auditorium of the Social and Rehabilitation Services Building, 111 Sanders, Helena, Montana to consider the proposed adoption of Rule I and the amendment of Rules 46.25.101, 46.25.711, 46.25.720, 46.25.722, 46.25.725, 46.25.727, 46.25.728, 46.27.732, 46.25.733, 46.25.742, and 46.25.744 pertaining to General Relief.

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

RULE I FORM OF RELIEF (1) The form of relief may be cash, checks, vouchers, lines of credit, in-kind goods and services and food commodities.

AUTH: Sec. 53-3-114 MCA; Sec. 9, Ch. 451, L. 1989, Eff. 7/1/89 (HB 723).
IMP: Sec. 53-3-309 MCA; Sec. 11, Ch. 451, L. 1989, Eff. 7/1/89 (HB 723).

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

46.25.101 DEFINITIONS For purposes of this chapter, the following definitions apply:

~~(1)--"Able-bodied" means the condition of a person who is not infirm.~~

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

(4) "Children" means minor and adult children, who reside in the same household with their parents. The term includes both adoptive and natural children.

Subsections (5) through (11) remain the same.

(12) "General relief" or "general relief assistance" mean the program of public assistance which includes both "general relief for basic necessities" and "general relief medical".

(12~~3~~) "General relief ~~assistance~~ for basic necessities" means a program of public financial assistance to provide basic necessities to those persons determined to be eligible.

Original subsections (13) through (15) remain the same in text but will be recategorized as (14) through (16).

(a) "General relief ~~assistance~~ for basic necessities household" means ~~all~~ a collective body of persons consisting of spouses or parents and their children who reside in the same residence or other persons who, by choice~~,~~ or necessity~~,~~ ~~or legal relationship~~ are mutually dependent upon each other for basic necessities and who reside in the same residence.

Original subsections (15)(b) through (17) remain the same in text but will be recategorized as (16)(b) through (18).

(18~~9~~) "Income" means the value of all property of any nature, earned, unearned, or in-kind, including benefits, that is reasonably certain to be received ~~by or available to a household~~ or is actually received during the month ~~of the receipt of the income. This includes income from supplemental security income and aid to families with dependent children~~ by members of a household.

Original subsections (19) through (20) remain the same in text but will be recategorized as (20) through (21).

(2~~1~~2) "Indigent" or "misfortunate" means a person who is lacking the means, financial or otherwise, by which to prevent destitution for himself and others dependent upon him for basic necessities and who is otherwise eligible~~,~~ for assistance under this chapter.

Original subsections (22) through (26) remain the same in text but will be recategorized as (23) to (27).

(28) "Presumptive income" means the amount of financial assistance that a person would have received under the aid to families with dependent children program, as provided for in title 53, chapter 4, part 2, if the person had not been determined ineligible due to receipt of lump sum income, overpayment, fraud, or failure or refusal to comply with requirements for continued participation in that program.

Original subsections (27) through (29) remain the same in text but will be recategorized as (29) through (31).

(30~~2~~) "Serious medical condition" means a mental or physical condition that causes a serious health risk to a person and for which treatment is medically necessary. Diagnosis and determination of necessary treatment must be made by a licensed medical practitioner, and the department may confirm it through ~~an~~ expert medical review. ~~Serious medical condition~~ Necessary treatment includes ~~pregnancy and~~ prenatal care~~,~~ and such other elective treatments as are determined by department rule to be medically necessary.

Original subsections (31) through (34) remain the same in text but will be recategorized as (33) through (36).

AUTH: Sec. 53-2-201, 53-3-102, 53-2-803 and 53-3-114 MCA; Sec. 3, Ch. 451, L. 1989, Eff. 7/1/89 (HB 723).
IMP: Sec. 53-2-201, 53-2-301, 53-2-802, 53-3-109, 53-3-304 and 53-3-305 MCA; Sec. 11, Ch. 451, L. 1989, Eff. 7/1/89 (HB 723).

46.25.711 CONDITIONS OF ELIGIBILITY ~~(1) General relief assistance for basic necessities will be provided, if otherwise eligible, to the following categories:~~
~~(a) persons with dependent minor children; or~~
~~(b) infirm persons.~~
~~(2) General relief assistance will be provided to able-bodied persons without dependent minor children for two months in any twelve month period, beginning with the month of application.~~
(31) General relief ~~assistance~~ will not be provided to persons ~~in the following categories~~ who are:
~~(a) able bodied persons without dependent minor children who have received general relief assistance for two months within the last twelve months except that assistance received prior to November 1, 1986 will not be counted;~~
(ba) institutionalized persons; or
(eb) incarcerated persons.
(2) General relief applicants or recipients who voluntarily leave employment without good cause or who are discharged due to misconduct shall not be eligible for benefits for three months.
~~(4) General relief medical will not be provided to persons in the following categories:~~
~~(a) institutionalized persons;~~
~~(b) incarcerated persons.~~

AUTH: Sec. 53-2-201, 53-2-803 and 53-3-114 MCA; Sec. 2, Ch. 563, L. 1989, Eff. 4/18/89 (SB 100).
IMP: Sec. 53-3-205, 53-3-206 and 53-3-209 MCA; Sec. 3, Ch. 563, L. 1989, Eff. 4/18/89 (SB 100).

46.25.720 APPLICATION Subsections (1) through (3) remain the same.
(4) Application for general relief medical must be made within 90 days of the initial date of medical service.

AUTH: Sec. 53-2-201, 53-2-803 and 53-3-114 MCA
IMP: Sec. 53-2-201, 53-2-803, 53-3-112, 53-3-301 and 53-3-208 MCA

46.25.722 PROVISION AND VERIFICATION OF ELIGIBILITY INFORMATION (1) A person applying for general relief ~~assistance~~ must make himself available for an interview.
Subsections (2) through (15) remain the same.

AUTH: Sec. 53-2-201, 53-2-803 and 53-3-114 MCA; Sec. 11 Ch. 451, L. 1989, Eff. 7/1/89 (HB 723).
IMP: Sec. 53-3-205 MCA; Sec. 3, Ch. 451, L. 1989, Eff. 7/1/89 (HB 723).

46.25.725 INCOME (1) ~~All income reasonably certain to be received by the household during the month of eligibility~~ During the benefit month all income that is received, reasonably expected to be received, and all presumptive income must be considered when determining eligibility. ~~Countable income and resources must be used to meet basic necessities before general relief assistance will be granted.~~
Subsections (2) through (2)(c) remain the same.

AUTH: Sec. 53-2-201, 53-2-803 and 53-3-114 MCA; Sec. 11, Ch. 451, L. 1989, Eff. 7/1/89 (HB 723).
IMP: Sec. 53-3-205 MCA; Sec. 3, Ch. 451, L. 1989, Eff. 7/1/89 (HB 723).

46.25.727 MONTHLY INCOME AND RESOURCE STANDARD FOR GENERAL RELIEF ASSISTANCE (1) The monthly income standards are:

Monthly Income Standard

Number of Persons in Household	Monthly Income Standard ~~Fiscal 1986~~
1	~~$212~~ $209
2	~~282~~ 281
3	~~354~~ 352
4	~~426~~ 424
5	~~501~~ 495
6	~~570~~ 566
7	~~642~~ 638
8	~~713~~ 709
9	~~785~~ 781
10	~~857~~ 852
11	923
12	995
13	1,066
14	1,138
15	1,209
16 or more	1,280

AUTH: Sec. 53-2-201, 53-2-803 and 53-3-114 MCA; Sec. 4, Ch. 585, L. 1989, Eff. 4/20/89 (HB 742); Sec. 11, Ch. 451, L. 1989, Eff. 7/1/89 (HB 723).
IMP: Sec. 53-3-205 MCA; Sec. 2, Ch. 585, L. 1989, Eff. 7/1/89 (HB 742); Sec. 5, Ch. 451, L. 1989, Eff. 7/1/89 (HB 723).

46.25.728 INCOME AND RESOURCE COMPUTATION (1) Income and resources of all household members, including presumptive income, will be considered when determining eligibility and assistance amount.

~~(a) Countable income and resources of all household members will be deducted from the monthly income standard for a household of the same size to determine the assistance amount. The assistance amount shall not exceed the monthly income standard amount for the number of eligible members.~~

~~(b) Households with countable income and resources in excess of the monthly income standard for a household of the same size are ineligible for general relief assistance.~~

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

(2) A household is eligible for general relief for basic necessities if the household income expected in the benefit month, less the earned income disregard described in (3) if applicable, does not exceed the monthly income standard found in 46.25.725.

(3) After the first month of benefits recipients of general relief shall receive an income disregard from the earned income of each employed household member of $30 plus one-third (1/3) of the remaining income for four consecutive months in which they have earned income. Any person who has received the maximum amount of income disregard will not be eligible for it again until he has not received general relief benefits for twelve (12) consecutive months.

(4) Benefits for general relief for basic necessities shall be determined:

(a) in the first two (2) months of eligibility based upon the income of the household and the nonexempt resources in the benefit month;

(b) in the third and subsequent months of eligibility based upon the income of the household two (2) months prior to the benefit month and the nonexempt resources in the benefit month; and

(c) by disregarding income which terminates in the first or second month when determining benefit amount in the third and/or fourth month unless it was not previously counted. Count income retrospectively that was not counted in the initial two (2) months of eligibility but was actually received.

Subsections (2) through (2)(c) remain the same in test but will be recategorized as (5) through (5)(c).

AUTH: Sec. 53-2-201, 53-2-803 and 53-3-114 MCA; Sec. 11, Ch. 451, L. 1989, Eff. 7/1/89 (HB 723); Sec. 4, Ch. 603, L. 1989, Eff. 4/21/89 (SB 134).

IMP: Sec. 53-3-205, 53-3-209 and 53-3-311 MCA; Sec. 3, Ch. 451, L. 1989, Eff. 7/1/89 (HB 723); Sec. 4, Ch. 603, L. 1989, Eff. 4/21/89 (SB 134).

46.25.732 WORKFARE (1) All recipients of general relief ~~assistance~~ for basic necessities, unless exempted elsewhere in this rule, may be required to participate in workfare for as long as they receive assistance. The work, as experience training assigned by the county office of human services or county department of public welfare or their designee, shall be with a public agency or private nonprofit agency. ~~The household shall be required to work the number of hours equal to the quotient found by dividing their general relief assistance grant amount by the prevailing rate paid in that county by that agency for similar work, but not lower than the federal minimum wage.~~

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

(e) persons residing at a location so remote from the local office of human services or service unit that effective participation in the program is precluded. The individual shall be considered remote if a round trip of more than two (2) hours by reasonably available public or private transportation would be required for a normal work ~~or~~ experience training day;

Subsections (2)(f) through (2)(i) remain the same.

(3) All recipients, unless exempted in subsection (2) of this rule, must, for as long as they receive general relief ~~assistance~~ for basic necessities, register ~~every other month~~ for employment at the local job service office, maintain an active job registration file, and ~~must~~ actively pursue and accept available employment within their capability.

AUTH: Sec. 53-2-803, 53-2-201 and 53-3-114 MCA; Sec. 11, Ch. 451, L. 1989, Eff. 7/1/89 (HB 723).
IMP: Sec. 53-2-822, 53-3-304 and 53-3-305 MCA; Sec. 8, Ch. 451, L. 1989, Eff. 7/1/89 (HB 723).

46.25.733 PENALTY (1) Recipients of general relief ~~assistance~~ who are subject to the provisions found in ARM 46.25.731 and ARM 46.25.732 and who without good cause refuse to participate in any component of the structured job search and training program, ~~participate in~~ including workfare, or register for employment and maintain an active job registration file, or accept available employment shall ~~lose one fourth (1/4) of their next monthly benefit for each refusal.~~ be disqualified for benefits for three (3) months for the first infraction and six (6) months for subsequent infractions.

Subsections (1)(a) through (1)(b) remain the same.

AUTH: Sec. 53-2-201, 53-2-803 and 53-3-114 MCA; Sec. 3, Ch. 579, L. 1989, Eff. 7/1/89 (SB 99).
IMP: Sec. 53-2-822, 53-3-304 and 53-3-305 MCA: Sec. 2, Ch. 579, L. 1989, Eff. 7/1/89 (SB 99).

46.25.742 PERIODS OF ELIGIBILITY FOR GENERAL RELIEF MEDICAL (1) Eligibility for general relief medical ~~begins the date the service is provided and terminates when the serious medical condition has been treated. Conclusion of treatment may be determined based upon a professional medical review.~~ is granted for a period of one (1) month.

(2) A household is ineligible to receive general relief medical if the household is ineligible for medicaid as a result of overpayment, fraud, or failure or refusal to comply with requirements for continued participation in the medicaid program.

(~~2~~3) Eligibility for general relief medical also terminates when the household:

(a) no longer meets eligibility criteria; or

(b) received assistance by means of fraud or mistake.

AUTH: Sec. 53-2-201, 53-2-803 and 53-3-114 MCA; Sec. 11, Ch. 451, L. 1989, Eff. 7/1/89 (HB 723).

IMP: Sec. 53-3-206 and 53-3-209 MCA; Sec. 7, Ch. 451, L. 1989, Eff. 7/1/89 (HB 723).

46.25.744 INCOME FOR GENERAL RELIEF MEDICAL ~~(1) Covered medical services will be provided to an eligible person if their average monthly income is below the monthly income standard for a household of the same size found at ARM 46.25.727.~~

~~(a) Average monthly income is that income reasonably certain to be received by the household in a twelve (12) month period, divided by 12.~~

~~(b) The twelve (12) month period begins with the month medical service is provided.~~

(~~2~~1) Covered medical services will be provided to the eligible person when their household's average monthly income, 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 46.25.728 (1)(c) and dividing by 12.

(b~~i~~) The twelve (12) month period begins the month medical service is provided, ~~and~~.

~~(c) The household incurs covered medical expenses each month of eligibility equal to the difference between their average monthly income and the monthly income standard.~~

(~~3~~2) A household is not eligible for medical services if that income described in subsection (1)(a) ~~and (b)~~ exceeds the monthly income level for the household size.

(3) Covered medical services will be provided to persons during any month in which that person's household was receiving general relief for basic necessities.

(4) Recipients whose general relief for basic necessities is terminated because of increased earned income or loss of the earned income disregard shall remain eligible for general relief medical for one additional month.

(45) The monthly income levels are:

MONTHLY INCOME LEVELS

Family Size	Monthly Income Level
1	~~$ 287~~ 314
2	~~433~~ 422
3	~~526~~ 528
4	~~618~~ 636
5	~~714~~ 743
6	~~804~~ 849
7	~~896~~ 957
8	~~988~~ 1,064
9	~~1,081~~ 1,172
10	~~1,173~~ 1,278
11	~~1,194~~ 1,385
12	~~1,215~~ 1,493
13	~~1,236~~ 1,599
14	~~1,256~~ 1,707
15	~~1,277~~ 1,814
16 or more	~~1,298~~ 1,920

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. These amendments and adoption are necessary to implement legislation passed by the 51st Montana legislature. The legislation affecting the general relief programs which must be implemented by July 1, 1989 include Senate Bill (SB) 99, SB 100, SB 134, House Bill (HB) 100, HB 529 and HB 742. Later amendments will be necessary to implement SB 70, SB 101 and SB 128.

5. Interested parties may submit their data, views, or arguments either orally or in writing at the hearing. Written data, views, or arguments may also be submitted to the Office of Legal Affairs, Department of Social and Rehabilitation Services, P.O. Box 4210, Helena, Montana 59604, no later than June 8, 1989.

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

7. These changes will be effective July 1, 1989.

Julia E. Robinson
Director, Social and Rehabilitation Services

Certified to the Secretary of State May 1, 1989.

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

In the matter of the amendment of ARM 16.20.102 concerning enforcement procedures under the Water Quality Act	NOTICE OF THE AMENDMENT OF ARM 16.20.102 (Water Quality)

To: All Interested Persons

1. On December 22, 1988, at page 2679 of the 1988 Montana Administrative Register, issue number 24, the board published notice of the proposed amendment of rule 16.20.102, concerning enforcement procedures under the Water Quality Act.
2. The board has amended the rule as proposed.
3. No comments were received by the board.

DONALD E. PIZZINI
Director

Certified to the Secretary of State May 1, 1989.

BEFORE THE DEPARTMENT OF LIVESTOCK
OF THE STATE OF MONTANA

In the matter of the rule regulating the state meat and poultry inspection program	NOTICE OF ADOPTION OF AMENDMENT OF RULE 32.6.712 RELATIVE TO FOOD SAFETY AND INSPECTION SERVICE (MEAT, POULTRY)

TO: All Interested Persons

1. On January 26, 1989, the Board of Livestock acting through the Department of Livestock published a notice of proposed amendment of the above-stated rule at pages 186, 187, 1989 Montana Administrative Register issue number 2.
2. The Board amended the rule exactly as proposed.
3. No comments or testimony were received.

Nancy Espy
NANCY ESPY, CHAIRMAN
Board of Livestock

BY: Les Graham
LES GRAHAM, EXECUTIVE SECRETARY
To the Board of Livestock

Certified to the Secretary of State May 1, 1989.

BEFORE THE DEPARTMENT OF REVENUE
OF THE STATE OF MONTANA

IN THE MATTER OF THE AMENDMENT of ARM 42.19.402, 42.21.106, 42.21.107, 42.21.113, 42.21.123, 42.21.124, 42.21.131, 42.21.137, 42.21.138, 42.21.139, 42.21.140, 42.21.151, 42.21.155, 42.21.156, 42.21.301, 42.21.302, 42.21.303, 42.21.304, and 42.21.305, relating to Trending and Depreciating Schedules for Property.	NOTICE OF THE AMENDMENT of ARM 42.19.402, 42.21.106, 42.21.107, 42.21.113, 42.21.123, 42.21.124, 42.21.131, 42.21.137, 42.21.138, 42.21.139, 42.21.140, 42.21.151, 42.21.155, 42.21.156, 42.21.301, 42.21.302, 42.21.303, 42.21.304, and 42.21.305, relating to Trending and Depreciating Schedules for Property.

TO: All Interested Persons:

1. On January 26, 1989, the Department of Revenue published notice of the proposed amendments to the ARM's listed above relating to trending and depreciation schedules for property at page 188 of the 1989 Montana Administrative Register, issue no. 2.

2. A public hearing was held on February 22, 1989 where written and oral comments were solicited but the only person who attended the hearing was from the Property Assessment Division. Mike Noble, Tax Specialist for the Department of Revenue proposed an amendment to the original notice as follows:

42.21.106 TRUCKS (1) through (5) remain the same.

(6) FOR 1988 1 TON VANS AND TRUCKS WHOSE AVERAGE RETAIL PRICE IS NOT LISTED, THE PERCENT GOOD SHALL BE 70%.

~~(6)~~(7) The department of revenue may develop other supplementary schedules for unique equipment and other trucks not listed in the guidebook. These schedules will be used in conjunction with the above schedules in the valuation of trucks. The purpose of the department developed schedules will be to arrive at a value which approximates 80% of the average retail value. Supplemental schedules for other trucks and unique equipment for ~~1988~~ 1989 have been developed and are hereby incorporated by reference. Copies are available to taxpayers at a reasonable cost for copying at Department of Revenue, Helena, Montana 59620.

~~(7)~~(8) This rule is effective for tax years beginning after December 31, ~~1987~~ 1988.

3. This amendment is necessary to rectify a change in the 1989 truck blue book. We are making this change at this late date because we did not receive the book until early January.

The percent good for 1988 one ton vans and trucks is necessary because the 1989 truck blue book does not list retail values for these trucks and vans.

4. Since there were no other comments received the Department has adopted these changes as proposed.

KEN NORDTVEDT, Director
Department of Revenue

Certified to Secretary of State May 1, 1989.

VOLUME NO. 43 OPINION NO. 9

PROPERTY, REAL - Residency requirement for professional land surveyors;
RESIDENCE - Residency requirement for professional land surveyors;
SURVEYORS - Residency requirement for professional land surveyors;
ADMINISTRATIVE RULES OF MONTANA - Section 8.48.1102;
MONTANA CODE ANNOTATED - Sections 37-67-308, 37-67-309, 37-67-319(2).

HELD: A professional land surveyor registered in the state of Montana need not be a resident of Montana when signing off on certificates of survey.

April 19, 1989

Thomas R. Scott
Beaverhead County Attorney
2 South Pacific, CL #2
Dillon MT 59725-2713

Dear Mr. Scott:

You have requested my opinion on the following question:

> Must a professional land surveyor registered in the state of Montana be a resident of Montana when signing off on certificates of survey?

The qualifications of an applicant for registration as a professional land surveyor are set forth in sections 37-67-308 and 37-67-309, MCA. They include satisfactory personal references, a specified combination of education and experience, and satisfactory passage of required examinations. Residency is not a qualification of an applicant for registration as a professional land surveyor in the state of Montana.

On the other hand, as your letter states, there is statutory language which implies that residency is a matter to be considered in land surveying matters, i.e., section 37-67-319(2), MCA. The administrative rules of the Board of Professional Engineers and Land Surveyors (§ 8.48.1102, ARM) also mention residency. However, for the following reasons, I do not find these references dispositive.

Section 37-67-319(2), MCA, provides:

> The practice of land surveying under a temporary permit by a person registered as a professional land surveyor in another state is not considered to be in the best interests of the public and, therefore, may not be granted.

§ 37-67-319(2), MCA. This statute clearly applies to nonresident professional land surveyors who are not registered in Montana. It does not apply to the requirements for registration in Montana. That subject is covered by sections 37-67-308 and 37-67-309, MCA, which make no mention of residency requirements.

With respect to section 8.48.1102, ARM, the statutory requirements for registration in Montana as a professional land surveyor cannot be modified by administrative rule. Michaels v. Department of Social and Rehabilitation Services, 187 Mont. 173, 178, 609 P.2d 271, 273 (1980). The Board of Professional Engineers and Land Surveyors also informs me that the use of "resident" in such rules as section 8.48.1102, ARM, is inadvertent, and that the Board does in fact keep a number of nonresidents who have properly qualified for registration in Montana as professional land surveyors on its roster of licensees.

Finally, I find nothing in the statutes or regulations governing professional land surveyors which requires that a registered surveyor be a Montana resident when he signs a certificate of survey.

THEREFORE, IT IS MY OPINION:

> A professional land surveyor registered in the state of Montana need not be a resident of Montana when signing off on certificates of survey.

Sincerely,

Marc Racicot

MARC RACICOT
Attorney General

VOLUME NO. 43 OPINION NO. 10

COUNTIES - Lack of statutory authority to file lien against real property of general assistance recipient;
LIENS - County's lack of statutory authority to file lien against real property of general assistance recipient;
PROPERTY, REAL - County's lack of statutory authority to file lien against real property of general assistance recipient;
PUBLIC ASSISTANCE - County's lack of statutory authority to file lien against real property of general assistance recipient;
MONTANA CODE ANNOTATED - Sections 25-9-301, 25-13-305, 25-13-402, 45-6-301(4), 53-2-107, 53-2-108, 53-3-112(2);
REVISED CODES OF MONTANA, 1947 - Section 71-243.

HELD: A county welfare department has no statutory authority to file a lien against the real property of a general assistance recipient who received more general assistance funds than those to which the recipient was entitled.

April 20, 1989

Russell R. Andrews
Teton County Attorney
Teton County Courthouse
Choteau MT 59422

Dear Mr. Andrews:

You have requested my opinion concerning the following question:

> May a county welfare department cause a lien to be filed against the real property of a county general assistance recipient who received more general assistance funds than those to which the recipient was entitled?

As a general rule, a lien can be created only by contract, or by statute or other fixed rule of law. 51 Am. Jur. 2d Liens § 6 (1970); 53 C.J.S. Liens § 4 (1987). I understand that there is no contract providing for the creation of a lien in the situation you have described. Thus, the focus of this opinion is whether there is a lien created by statute. There is no statute authorizing the assertion of such a lien in Title 53, MCA, pertaining to general assistance programs. To the contrary, the Legislature in 1973

repealed a statute creating a "lien against the real property of the recipient" of public assistance. § 71-243, R.C.M. 1947, repealed by 1973 Mont. Laws, ch. 299, § 3. By rescinding section 71-243, R.C.M. 1947, the Legislature clearly withdrew statutory authorization to assert a lien against the real property of a general assistance recipient.

I therefore conclude that a county welfare department has no statutory authority to assert a lien against the real property of a general assistance recipient who has received an excess of general assistance funds. However, you have indicated that the overpayment in question may be due to fraud or mistake on the part of the recipient. As a result it is pertinent to discuss whether or not the Teton County Board of Public Welfare may proceed with a civil action pursuant to sections 53-2-108(2) and 53-3-112, MCA.

Overpayments are a debt due the county, regardless of whether the benefits were obtained by fraud or simply by department or recipient error. See §§ 53-2-108, 53-3-112(2), MCA. Thus, whether an overpayment is obtained by fraud or simply by error, the county may file a civil action for recovery of the overpayment. The county can obtain a judgment lien as of the time the judgment is docketed, see § 25-9-301, MCA, and then proceed to recover the overpayment according to the collection remedies generally available under Montana law to judgment creditors, including a writ of execution directing the sheriff to satisfy the judgment by selling real property of the recipient. See §§ 25-13-305, 25-13-402, MCA. Such execution would, of course, be subject to any prior encumbrances of record.

In the alternative, the county may, under section 53-3-112(2), MCA, offset the overpayment from future general relief payments to the recipient, if the recipient remains eligible for general relief assistance.

Finally, if it is determined that the surplus funds were obtained fraudulently, the recipient may also be subject to prosecution for theft pursuant to sections 45-6-301(4) and 53-2-107, MCA.

THEREFORE, IT IS MY OPINION:

A county welfare department has no statutory authority to file a lien against the real property

of a general assistance recipient who received more general assistance funds than those to which the recipient was entitled.

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.

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