RESERVE

MONTANA ADMINISTRATIVE REGISTER

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MONTANA ADMINISTRATIVE REGISTER

ISSUE NO. 6

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 The notice section contains state agencies' proposed new, amended or repealed rules, the rationale for the change, date and address of public hearing and where written comments may be submitted.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

BEFORE THE PUBLIC EMPLOYEES' RETIREMENT BOARD
OF THE STATE OF MONTANA

In the matter of the amendment of ARM 2.43.609 relating to the funding available for post-retirement adjustments.	NOTICE OF PUBLIC HEARING

TO: All Interested Persons.

1. On May 5, 1993 at 9:00 am in the Board Meeting Room of the Public Employees' Retirement Division, 1712 Ninth Avenue, Helena, Montana, a public hearing will be held to consider the amendment of ARM 2.43.609 pertaining to the funding of post-retirement adjustments under the Public Employees' Retirement System, the Game Wardens' Retirement System, and the Sheriffs' Retirement System.

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

2.43.609 POST RETIREMENT ADJUSTMENT (1) Post-retirement adjustments for PERS, game wardens and sheriffs' retirement system retirees will be made in each year ~~that investment earnings are available~~ the amount in the reserve fund is adequate for this purpose as provided in 19-3-1100(3), 19-7-709(3), and 19-8-809(3), MCA.

(2) In accordance with 19-3-1110, 19-7-709, and 19-8-809, MCA, funding available for post-retirement adjustments is determined after the end of each fiscal year by subtracting from the total investment income the actuarial amount necessary to fund the retirement system and multiplying the remainder by the portion of the retirement fund balance representing retired members.

(a) "Total investment income" earned on a pension trust fund in a fiscal year is the net investment yield realized by the pension trust fund during that fiscal year. Unrealized gains or losses, such as unrealized appreciation or depreciation in market value, shall not be considered when calculating total investment income.

(b) The "actuarial amount required to fund the retirement system" is investment income, after payment of administrative and investment expenses, sufficient to attain the actuarially required rate of return for the year(s) since the last post-retirement adjustment. The actuarially required rate is the rate recommended by the consulting actuary and adopted and published by the Board pursuant to ARM 2.43.304.

(c) The "portion of the retirement fund balance representing retired members" is a percentage equal to the present value of accrued benefits for retirees divided by the present value of accrued benefits for all members.

~~(2)~~ is renumbered to become (3).
~~(3)~~ is renumbered to become (4).
~~(4)~~ is renumbered to become (5).

AUTH: 19-3-304, 19-7-201, and 19-8-201, MCA.
IMP: 19-3-1110, 19-7-709, and 19-8-809, MCA.

3. The rules are proposed to be amended in order to clarify the implementation of the statutes governing the funding for post-retirement adjustments in the Public Employees' Retirement System, the Game Wardens' Retirement System and the Sheriffs' Retirement System. Since the adoption of these statutes, the "total investment income" has always exceeded the "actuarially required amount necessary to fund the retirement system." Recent reductions in interest yields may result in the total investment income being less than the actuarially required amount. The current rule is unclear what procedure to follow if this occurs.

The amendments are necessary to provide a procedure for calculating the funding available for post-retirement adjustments in future years to insure that the actuarially required amount is realized before post-retirement adjustments are paid.

4. Interested persons may present their data, views, or arguments, either orally or in writing, at the hearing. Written data, views or arguments may also be submitted no later than May 10, 1993 to:

Mark Cress, Administrator
Public Employees' Retirement Division
1712 Ninth Avenue,
Helena, Montana 59620

5. Kelly Jenkins, legal counsel for the Department of Administration, has been designated to preside over and conduct the hearing.

By: _____
Terry Teichrow, President
Public Employees' Retirement Board

_____
Dal Smilie, Chief Legal Counsel
Rule Reviewer

Certified to the Secretary of State on March 15, 1993.

BEFORE THE DEPARTMENT OF AGRICULTURE
OF THE STATE OF MONTANA

In the matter of the amendment of ARM 4.4.316 and repeal of ARM 4.4.307 and ARM 4.4.314	NOTICE OF AMENDMENT OF ARM 4.4.316 LIABILITY ON ALL CROPS, AND REPEAL OF ARM 4.4.307 PERTAINING TO TIME POLICY BECOMES EFFECTIVE AND, REPEAL OF ARM 4.4.314 CUT OFF DATE

NO PUBLIC HEARING CONTEMPLATED

TO: All Interested Persons:

1. On April 26, 1993 the Department of Agriculture proposes to amend ARM 4.4.316 pertaining to the liability on all crops and repeal of ARM 4.4.307 relating to time policy becoming effective, and repeal of ARM 4.4.314 relating to cut off date.

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

(New matter underlined, deleted matter interlined)

4.4.316 LIABILITY ON ALL CROPS (1) The liability on all crops insured ~~except sugar beets~~, will expire after ~~September 15~~ October 1 at 11:59 P.M. ~~Sugar beets after September 3. The insured may apply for an extension of the risk if his crops, except sugar beets, are not ripe and harvested before September 15, and if he applies for an extension before that date to the State Board of Hail Insurance at Helena, Montana.~~

AUTH: 80-2-201 IMP: 80-2-203

The rules proposed to be repealed, ARM 4.4.307 and ARM 4.4.314 reads as follows:

4.4.307 TIME POLICY BECOMES EFFECTIVE ~~(1) All policies will be in full force and effect from noon of the day following the acceptance by the county assessor. Any policy may be cancelled if fraud or misrepresentation is used in obtaining it.~~

AUTH: 80-2-201 IMP: 80-2-201

4.4.314 CUT OFF DATE ~~(1) Loss claims after October 1 will not be accepted.~~

AUTH: 80-2-201 IMP: 80-2-201

REASON: The reason for the proposed amendment is to make the cut off for liability on all crops the same day.

REASON: The reason for the proposed repeals is that the time the policy becomes effective is provided by statute and the rules are unnecessary.

3. Interested persons may present their data, views, or arguments either orally or in writing to the Montana State Board of Hail Insurance, P.O.Box 200201, Helena, MT 59620, no later than April 23, 1993.

4. If a person who is directly affected by the proposed adoption wishes to express his data, views and arguments orally or in writing at a public hearing, he must make written request for a hearing and submit this request along with any written comments he has to Michael Murphy, Administrator, Department of Agriculture, Ag/Livestock Building, P.O.Box 200201, Helena, MT 59620, no later than April 23, 1993.

5. 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 agency or subdivision or from any 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 and mailed to all interested persons.

Leo A. Giacometto, Director
Department of Agriculture

Timothy J. Meloy, Attorney
Rule Reviewer
Department of Agriculture

Certified to the Secretary of State Office March 16, 1993

BEFORE THE BOARD OF ATHLETICS
DEPARTMENT OF COMMERCE
STATE OF MONTANA

In the matter of the proposed general amendment of rules pertaining to athletics and the proposed adoption of new rules implementing kickboxing	) IN THE MATTER OF THE PROPOSED) AMENDMENT AND ADOPTION OF) RULES PERTAINING TO THE) ATHLETICS INDUSTRY)

NO PUBLIC HEARING CONTEMPLATED

TO: All Interested Persons:

1. On April 24, 1993, the Board of Athletics proposes to amend ARM 8.8.2801, 8.8.2802, 8.8.2803, 8.8.2804, 8.8.2805, 8.8.2806, 8.8.2807, 8.8.2901, 8.8.2903, 8.8.2904, 8.8.3103, 8.8.3105, 8.8.3106, 8.8.3107, 8.8.3201, 8.8.3203, 8.8.3204, 8.8.3301, 8.8.3401, 8.8.3402, 8.8.3403, 8.8.3405, 8.8.3407, 8.8.3701, 8.8.3801, 8.8.3802, 8.8.3803, 8.8.3804, 8.8.3805, 8.8.3806 and 8.8.4001 and adopt new rules pertaining to the athletics industry.

2. The proposed amendments will read as follows: (new matter underlined, deleted matter interlined)

"8.8.2801 GENERAL INFORMATION (1) The mailing address of the board is: Board of Athletics, ~~1424 9th Avenue~~ 111 North Jackson Street, Box 200513, Helena, Montana 59620-~~0407~~0513, (406) 444-5433."

Auth: Sec. 23-3-405, MCA; IMP, Sec. 23-3-405, MCA

"8.8.2802 DEFINITIONS (1) will remain the same.

(2) "Contestant" means any participant in a semiprofessional or professional boxing, kickboxing, ~~sparring~~ or wrestling bout or athletic event ~~contest or exhibition~~ who receives remuneration directly or indirectly as consideration of their performance.

(3) will remain the same.

(4) "Bout or Athletic event" means any semiprofessional or professional boxing, kickboxing or wrestling match, exhibition, contest, show or tournament.

(5) "Professional" ~~for the purpose of engaging in professional boxing event,~~ means a person seeking compensation or reward by ~~boxing~~ participating in an athletic event. A person seeking a license as a "professional" must first truthfully execute a sworn affidavit, which establishes his qualifications~~, and must notify the A.A.U. or golden gloves officials of his "professional" status~~.

(6) will remain the same.

(7) "Kickboxing" or "full contact karate" is the use of hands, feet or other striking techniques which are utilized to disable or cause injury to an opponent in a contest, exhibition or performance."

Auth: Sec. 23-3-405, MCA; IMP, Sec. 23-3-404, MCA

"8.8.2803 PROHIBITIONS (1) The board will not license the following types of ~~professional boxing or wrestling matches, contests or exhibitions~~ athletic events:

(a) Bouts or athletic events in which more than 2 boxing contestants are to appear in the ring at the same time.

(b) ~~Boxing, sparring or wrestling matches~~ Bouts or athletic events between members of the opposite sex.

(c) Any barroom type brawls, "so you think you're tough" type contests, and roughneck type ~~boxing and sparring matches~~ bouts or ~~contests~~ bouts where contestants receive remuneration directly or indirectly, and where they have no prior organized amateur or professional training.

(d) Any exotic form of activity which is advertised as a form of wrestling and which involves recognition, a prize, or a purse, or a purse at which an admission fee is charged, either directly or indirectly, in the form of dues or otherwise ~~will be interpreted by the board of athletics as a form of wrestling subject to regulation by the state and requiring that the participants be licensed~~."

Auth: Sec. 23-3-405, MCA; IMP, Sec. 23-3-405, MCA

"8.8.2804 LICENSING REQUIREMENTS (1) All referees, seconds, managers, ~~boxers, wrestlers,~~ contestants, promoters, judges must be licensed by the board.

(2) will remain the same.

(3) Any club holding an annual license shall obtain a separate permit or sanction from the board before holding any specific ~~boxing or wrestling contests~~ athletic event at least 21 days prior to the event.

(a) The permit shall be posted and prominently displayed in the box office of the premises where the ~~boxing, sparring or wrestling contest~~ athletic event is held.

(4) Every contestant must ~~box or wrestle~~ compete consistently under the same name. Ring names may be used, ~~by and~~ but must appear on the official license as issued by the board.

(5) through (7) will remain the same.

(8) Applications and fees shall be made to the board prior to or on the date of the ~~boxing, sparring or wrestling~~ athletic event.

(8)(a) and (9) will remain the same.

(10) The board must be notified of the names and weights of all contestants involved in an athletic event, at least 10 days before ~~such contest or exhibition~~ the athletic event.

(11) The board reserves the right to question any applicant, ~~and if~~ If, in ~~its~~ the board's judgment, the applicant does not have sufficient knowledge of the sport or is otherwise not deemed responsible to act, such license may be denied.

(12) No applicant, licensee or official shall appear at ringside ~~who is~~ while under the influence of alcohol or drugs.

(13) The board shall be notified in such form and with such detailed information as the board may prescribe, that an athletic event is to be telecast, televised or broadcast in any manner, including but not limited to:

(a) television.

(b) radio,

(c) any transmission via a cable television system,

(d) any transmission via microwave, closed circuit, satellite or fiber optic link, or

(e) any other method of limited distribution.

(14) No person shall charge or receive an admission fee for exhibiting within this state a telecast of any athletic event without a permit issued by the board. Permits are required for simultaneous telecasts, closed circuit telecasts, or any transmission of any kind, including but not limited to, transmission via microwave, closed circuit, satellite or fiber optic link."

Auth: Sec. 23-3-405, MCA; IMP, Sec. 23-3-405, MCA

"8.8.2805 CONTRACTS AND PENALTIES (1) Terms of all contracts between promoters, boxing, kickboxing and wrestling organizations and contestants shall be completed on forms approved by the board. The original or true copy of each contract shall be filed with the board at least 24 hours prior to the date of the event, unless specific, individual delay is approved by the board. Contestants must sign contracts with their legal names.

(2) will remain the same.

(3) No fee shall be paid to a contestant who does not complete the terms of the contract or who is deemed by the board~~, inspector or referee~~ to be putting forth less than maximum effort.

(4) In all cases ~~where contracts have been consummated,~~ in which performance under a contract has begun, if either party to the contract finds it impossible to carry out the terms of the contract, the board must be notified at once. Failure to provide such information may result in ~~the suspension or revocation of a license~~ disciplinary action by the board.

(5) When a ~~boxer~~ contestant is under contract, appears at weigh-in time, and is ready to fulfill his contract, and neither his opponent ~~does not appear,~~ nor ~~is~~ a substitute ~~provided~~ appears, the promoter must pay the ~~boxer~~ contestant his contract guarantee unless a forfeit is provided.

(6) The amount of the forfeit fee must be 25% or the amount of the contract guarantee, whichever is greater.

(7) If a wrestler is booked to wrestle for a ~~licensee~~ promoter and ~~does not~~ fails, without good cause, to appear~~, unless he is sick or injured and can produce a doctor's certificate to that effect, or has a valid excuse, that meets with the approval of the board,~~ he shall be subject to ~~such penalties and forfeitures imposed upon him by~~ disciplinary action by the board."

Auth: Sec. 23-3-405, MCA; IMP, Sec. 23-3-405, MCA

"8.8.2806 FEES

(1) will remain the same.

(2) Boxers/kickboxers	10

(3) through (7) will remain the same.

(8) Timekeeper/knockdown judge	5

(9) Minimum kicking requirement officials 5

Auth: Sec. 23-3-405, 37-1-134, MCA; IMP, Sec. 23-3-405, MCA

"8.8.2807 DISCIPLINARY ACTIONS (1) The board, ~~reserves the discretion to~~ in its discretion will take appropriate disciplinary action provided for in section 37-1-136 and 23-3-603, MCA, against a licensee who has violated any law or rules of the board, ~~and to decide on a case by case basis the type of and extent of~~ The board will impose disciplinary action it deems appropriate, applying the following considerations:

(a) through (2)(d) will remain the same.

(e) limitation or restriction of the license and the licensee's privileges; or

(f) retirement of the licensee from further competition~~; or~~.

~~(g) deferral of disciplinary proceedings or imposition of disciplinary sanctions.~~

(3) Any licensee who verbally or physically abuses a referee, judge, timekeeper, board member or board representative shall be subject to disciplinary action by the board."

Auth: Sec. 23-3-405, MCA; IMP, Sec. 23-3-405, MCA

"8.8.2901 BOXING CONTESTANTS (1) will remain the same.

(2) No contestant under the age of 18 or over the age of 35 will be licensed to ~~box~~ participate in Montana unless ~~permission~~ an exemption is granted by the board.

(3) No contestant under the age of 21 shall be permitted to ~~box~~ participate in more than 6 rounds until he has participated in 10 or more professional bouts involving boxing, unless special permission is granted by the board.

(4) will remain the same.

(5) All contestants to appear in the main event must train in the city ~~wherein said~~ where the bout is to be held, or ~~some~~ another suitable place approved by the board, at least 24 hours prior to the date of their bout.

(6) Any ~~boxing~~ contestant who has participated in ~~the following professional bouts, and lost the bout~~ an athletic event, unless specifically granted an exception by the board, shall be placed under temporary suspension for the health and safety of the contestant as follows:

~~(a) more than 10 rounds 30 days suspension~~
~~(b) 60 to 10 rounds 21 days suspension~~
~~(c) 1 to 6 rounds 14 days suspension~~
(a) physical injury or severe punishment - discretionary upon advice of physician
~~(d)~~(b) knockout - 60 days suspension
~~(e)~~(c) technical knockout (TKO) - 30 days suspension

(7) In any case where the referee decides that the contestants are not honestly competing, that the knockout is a "dive" or the foul a prearranged action, the athletic event shall be stopped and no decision rendered. If the board finds

that the action was a "dive", then the purse reverts to the board and shall be deposited in the board's special revenue account.

~~(7)~~ (8) Any contestant who participates in a sham or fake ~~boxing~~ bout shall be disqualified and shall not thereafter be permitted to contend in any bout in this state for a period of 6 months for the first offense. ~~and f~~For the second offense he shall be ~~totally~~ disqualified from further admission or participation in any ~~boxing contest~~ athletic event held or given in the state of Montana for a period not to exceed one year.

(8) will remain the same but will be renumbered (9).

~~(9)~~ (10) All contestants must be ready to enter the ring immediately upon the finish of the preceding bout or athletic event. The referee may disqualify a ~~boxer~~ contestant breaking this rule. Should an emergency arise requiring a contestant to leave the ring during the minute intermission between rounds, permission must be secured from the referee. Failure to return before the gong sounds announcing the next round will result in disqualification.

~~(10)~~ (11) Whenever a ~~licensed boxer~~ contestant, because of injury or illness, is unable to take part in an ~~contest~~ athletic event for which he is under contract, he or his manager shall immediately report the fact to the board or inspector. He must submit to an examination by a physician designated by the board, which examination must be made prior to the date set for the ~~contest~~ athletic event. The expense of the physician's examination is to be paid by the contestant.

~~(11)~~ (12) Before a license is issued to any ~~boxer~~ contestant, the ~~boxer~~ contestant shall satisfy the board that the ~~boxer~~ contestant has the ability to compete and is fit to participate in an ~~boxing match~~ athletic event. If, ~~at any time~~ in the opinion of the board, a ~~boxer's~~ contestant's ability to perform is questionable, whether from causes of illness, mental condition, or loss of ~~capacity and~~ the ability to compete, ~~or for any other reason,~~ the board may~~,~~ ~~upon being satisfied of the boxer's lack of capacity and ability to compete,~~

(a) refuse to permit the ~~boxer~~ contestant to participate,

(b) retire the ~~boxer~~ contestant from further competition, or

(c) suspend the license.

(13) Applicants ~~for boxers license or renewal,~~ shall furnish verified records of their last six ~~boxing contests~~ athletic events involving boxing.

(14) During the bout, it is prohibited for a contestant to drink anything but water. The use of drugs of any kind, before or during the bout shall be cause for disqualifications and/or other disciplinary action by the board. All contestants may be required to submit to a drug test before and after a bout in which the contestant is involved."

Auth: Sec. 23-3-405, MCA; IMP, Sec. 23-3-404, 23-3-405, 23-3-501, 23-3-603, MCA

"8.8.2902 FEMALE CONTESTANTS (1) through (5) will remain the same.

(6) Hair must be secured ~~in a manner such~~ so that it will not interfere with the vision or safety of either contestant.

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

(11) Physical examinations shall be obtained annually and must include a pelvic examination. Within 24 hours of each contest, an examining physician shall make an abdominal examination ~~noting any masses,~~ and a breast examination, noting any masses.

(12) Only ~~more~~ experienced referees ~~should~~ shall be assigned to control the contests."

Auth: Sec. 23-3-405, MCA; IMP, Sec. 23-3-405, MCA

"8.8.2903 PHYSICAL EXAMINATION (1) Contestants shall be examined by a physician approved by the board, ~~on the day of the bout~~ at the time of weigh-in or at least 5 hours prior to entering the ring. Only the contestant and his manager/trainer are allowed in the examination room during the physical.

(2) through (4)(c) will remain the same.

(5) The weigh-in shall be at least eight hours before the bout. If a contestant appears at weigh-in and his body weight is 5% over his contracted weight, without allowing for dehydration, he will be disqualified from the bout.

(a) will remain the same.

(6) No contestant shall take part in an ~~contest~~ athletic event until pronounced fit to do so by the physician appointed by the commission, ~~and t~~The facts of physical fitness to participate shall be certified by the physician to the board within 24 hours after the contest.

(7) The manager or his authorized agent shall accompany the contestant to the weigh-in at the designated time.

(8) If a contestant is late to weigh-in, his opponent may be weighed in under the direction of the board or inspector. If a contestant is late to weigh-in, the contestant and manager are subject to disciplinary action by the board."

Auth: Sec. 23-3-405, MCA; IMP, Sec. 23-3-405, MCA

"8.8.2904 PHYSICIAN REQUIREMENTS (1) will remain the same.

(2) The ringside physician will perform a post-bout examination. The physician's recommendations, medical disqualifications, injuries to contestants and any other examination results shall be reported to the board within 24 hours after the athletic event."

Auth: Sec. 23-3-405, MCA; IMP, Sec. 23-3-405, MCA

"8.8.2905 MANAGERS (1) through (6) will remain the same.

(7) Contracts to participate in an ~~boxing~~ athletic event must be signed by the boxer's manager, on the boxer's behalf, or personally by the boxer when he has no licensed manager of record."

Auth: Sec. 23-3-405, MCA; IMP, Sec. 23-3-404, 23-3-501, MCA

"8.8.3101 CONTEST REGULATIONS (1) will remain the same.

(2) Smoking will not be permitted at ~~boxing or wrestling~~ athletic events licensed by the board, except outdoor ~~contests and exhibitions~~ athletic events. There must be displayed in conspicuous places throughout the building where the ~~contest~~ athletic event is held, signs reading "NO SMOKING".

(3) Notice of any change in announced or advertised programs for any ~~contest~~ athletic event must be promptly filed with the board and the press at least 24 hours prior to the ~~contest~~ athletic event. Notices announcing such change or substitution must also be conspicuously posted at the box office, and announced from the ring before the opening ~~contest~~ athletic event.

(4) will remain the same.

(5) Ushers are forbidden to seat anyone after the ~~exhibition~~ athletic event has commenced until the round of ~~boxing or wrestling~~ the athletic event going on has been completed.

(6) At all evening ~~exhibitions~~ athletic events, the main or final bout must start ~~not~~ later than 10:00 p.m."

Auth: Sec. 23-3-405, MCA; IMP, Sec. 23-3-405, MCA

"8.8.3102 TICKETS (1) No person shall be admitted to any ~~contest or exhibition~~ athletic event unless he holds a ticket, is a member of the board, holds an identification card issued by the board for official duty, is an official provided for the ~~contest~~ athletic event, or policeman or fireman in uniform and actually on duty.

(2) All tickets issued to the press shall be marked "PRESS", and no one, except the officials designated by the board and the timekeeper, shall be permitted to sit at the press table unless actually engaged in reporting the ~~contest~~ athletic event.

(3) No ~~boxer or wrestler~~ contestant will be allowed to sell tickets for any ~~show or exhibition~~ athletic event in which he is engaged on a commission basis, to serve as a remuneration for his services as a ~~boxer or wrestler~~ contestant.

(4) through (7) will remain the same."

Auth: Sec. 23-3-405, MCA; IMP, Sec. 23-3-405, MCA

"8.8.3103 POINT SYSTEM - SCORING (1) Three judges shall score all athletic events and determine the winner through use of a ten-point must system.

~~(1)~~ (2) At the beginning of each round, the ~~boxer~~ contestant will be given 10 points, from which the judges will deduct points according to his performance in the round. This deduction is based on the following norms:

(a) will remain the same.

(b) 10-9 In favor of the ~~boxer~~ contestant that has won a light margin.

(c) 10-8 In favor of the ~~boxer~~ contestant that has shown more control.

(d) 10-7 If the ~~boxer~~ contestant was severely punished.

(e) 10-8 If the ~~boxer~~ contestant was knocked down and got up right away in good condition for the protection count (mandatory 8 count).

(f) 10-7 If the ~~boxer~~ contestant was knocked down once and received part of the count on the floor and then continued fighting before the count of 10 or 8.

(g) 10-7 If the ~~boxer~~ contestant was knocked down twice and got up for the protection count.

(h) will remain the same.

~~(2)~~ (3) A ~~boxer that~~ contestant who has been knocked down can recover his points if his performance throughout the rest of the round is good. He will be given credit for what he has recovered.

(3) through (6) will remain the same but will be renumbered (4) through (7)."

Auth: Sec. 23-3-405, MCA; IMP, Sec. 23-3-405, MCA

"8.8.3104 NUMBER AND DURATION OF ROUNDS (1) No ~~match~~ athletic event shall be more than ~~15~~ 12 rounds in length and such rounds shall be of not more than 3 minutes' duration, with 1 minute intermission between rounds."

Auth: Sec. 23-3-405, MCA; IMP, Sec. 23-3-405, MCA

"8.8.3105 DOWN (1) through (1)(c) will remain the same.

(2) A ~~boxer~~ contestant hanging over the ropes is not officially "down" until so pronounced by the referee, who can count the ~~boxer~~ contestant out either on the ropes or on the floor.

(3) will remain the same.

(4) Referees in ~~boxing and sparring matches or exhibitions~~ athletic events shall, in rendering their decision, consider and declare a contestant to be "knocked out" when ~~a man~~ the contestant is unable, after being knocked down, to arise unaided inside of 10 seconds.

(5) A ~~boxer~~ contestant who is in distress, but still on his feet and the referee intercedes to save him, or if, while in his corner, his manager and seconds ~~throw up the sponge,~~ notify the referee the contestant is unable to continue, the decision shall be "stopped in so many rounds".

(6) When a contestant's chief second considers the chance of winning hopeless, he may signify his willingness to have the bout stopped by ~~tossing a towel in~~ stepping onto the apron of the ring.

(7) through (9) will remain the same.

(a) This subsection may be waived in "bouts" if agreed to by both contestants, in writing, and the writing is filed with the board prior to the beginning of the athletic event.

(10) Before a fallen contestant resumes competition after having slipped, fallen or been knocked down, the referee shall wipe the contestant's gloves free of any foreign substance.

(11) If a boxer is knocked down after two minutes and 50 seconds of the round, the bell will not sound until he gets up. If he does not get up before the count of 10, he will

lose by KO. The boxer will be saved by the bell only in the last round."

Auth: Sec. 23-3-405, MCA; IMP, Sec. 23-3-405, MCA

"8.8.3106 ACCIDENTAL BUTTS (1) If a ~~boxer~~ contestant is accidentally butted in a bout, but can continue, the referee shall:

(a) will remain the same.

(b) if in ~~later~~ following rounds, as a result of legal blows, the accidental butt injury worsens, and the injured contestant cannot continue, the referee shall stop the bout and declare a technical draw if this occurs before the end of the third round. If this occurs after the start of the fourth round, the referee shall declare a technical decision with the winner being the ~~boxer~~ contestant who is ahead on points.

(2) If a ~~boxer~~ contestant is accidentally butted in a bout so that he cannot continue, the referee shall:

~~(a) call the bout a technical draw if the injured boxer is behind in points on two or more cards, declare the injured boxer the winner on a technical decision if he has a lead in points on two or more cards, otherwise the contest shall be declared a technical draw; and~~

~~(b)~~ (a) call the bout a draw if an accidental butt occurs during the first three rounds of any ~~contest~~ bout.

(b) call the bout a technical decision if the accidental butt occurs after the completion of the third round with the winner being the contestant who is ahead on points. The round in which the bout is stopped shall be scored by the judges."

Auth: Sec. 23-3-405, MCA; IMP, Sec. 23-3-405, MCA

"8.8.3107 FOULS (1) through (1)(o) will remain the same.

(p) roughing on the ropes or pushing the opponent about the ring, ~~or~~ into the ropes or intentionally pushing, shoving or wrestling an opponent out of the ring with any part of the body.

(2) Except as provided otherwise in subsections 9 and 10 of this section, there shall be a deduction of points by the referee after two warnings for the same foul. A point or points shall be taken at the time of the third warning for the same foul or where there is a continued flagrant fouling by a contestant after a deduction of points from the fouling contestant.

~~(2)~~ (3) A ~~boxer~~ contestant who commits a foul, intentional or unintentional, may be fined the total amount of his purse and suspended by the board and/or he may be fined only in such amount as the board may deem warranted by the offense. It will only be by unanimous opinion of the referee, judges and the board inspector that the offender not be held responsible for the foul and the club authorized to pay his purse.

~~(3)~~ (4) Any ~~boxer~~ contestant claiming to be struck by a foul blow must be immediately examined by the board doctor, and if he is not available, by some doctor procured by the referee, or the inspector. If ~~it is the opinion of~~ the examining doctor determines that the ~~boxer~~ contestant is only

temporarily injured, and can proceed after a short rest, ~~he can proceed~~ the ~~boxer~~ contestant shall be ordered to do so by the referee.

~~(4)~~ (5) Any ~~boxer~~ contestant falsely claiming to have been struck by a foul blow will be punished in the same manner as ~~above~~ provided for ~~boxers~~ contestants who commit fouls.

~~(5)~~ (6) Any bout terminated by a foul must be reported to the board immediately by the ~~inspector~~ board representative. Statements from the referee, judges, and examining doctor, and any other person deemed desirable must be submitted with such report.

(6) and (7) will remain the same but will be renumbered (7) and (8).

(9) In the case of a clear and intentional butt when the bout can continue, the contestant who initiated the butt shall have a two point deduction. The referee shall stop the action and inform the judges of the two point deduction.

(10) In the case of a clear and intentional butt when the bout is stopped because of a cut, the contestant who initiated the butt shall lose by disqualification, even if he is the injured contestant.

(11) If a foul occurs in the first round, and the contestant cannot continue, the referee will declare a technical draw."

Auth: Sec. 23-3-405, MCA; IMP, Sec. 23-3-405, MCA

"8.8.3108 APPEAL OF DECISIONS OF OFFICIALS (1) through (1)(e) will remain the same.

(2) On review of an officials' decision, the board shall not substitute its judgment for ~~(second guess)~~ that of the officials as to the weight of the evidence on questions of fact."

Auth: Sec. 23-3-405, MCA; IMP, Sec. 23-3-405, MCA

"8.8.3201 RING - EQUIPMENT (1) through (3) will remain the same.

(4) Only the following ~~S~~substances shall be allowed in the ring:

(a) through (g) will remain the same.

(h) ~~vaseline or surgical lubricant~~ petroleum jelly (unscented) only,

(i) will remain the same.

(5) will remain the same.

~~(6) Excessive use of cocoa butter, petroleum jelly, grease, ointments or strong smelling liniments by a contestant will not be permitted.~~

(6) The ring must be swept, dry mopped, or otherwise adequately cleaned before the athletic event and prior to the first bout.

(7) There shall be a minimum of 12 feet from the outside of the ring apron to the first row of seats."

Auth: Sec. 23-3-405, MCA; IMP, Sec. 23-3-405, MCA

"8.8.3202 HANDWRAPS (1) Handwraps shall not be more than a total of 6 feet of one inch wide surgical tape (tape

cannot be torn into narrow strips). The use of water, or any liquid or other material on the bandage shall be prohibited.

(2) through (4) will remain the same."

Auth: Sec. 23-3-405, MCA; IMP, Sec. 23-3-405, MCA

"8.8.3203 OFFICIAL BOXING GLOVES (1) Gloves in the weight classes of welterweight and below must be no less than 8 ounces, and must have the thumbs attached. Gloves in weight classes of middleweights and above must be of no less than 10 ounces in weight, and must have the thumbs attached. The only exception to this rule is in championship bouts where the ~~commission~~ board may authorize 8 ounce gloves, thumbs attached, for any weight class.

(2) will remain the same.

~~(3) Safety foam gloves in compliance with specifications of the North American Boxing Federation shall be used at all times, unless a waiver is obtained by the board.~~"

Auth: Sec. 23-3-405, MCA; IMP, Sec. 23-3-405, MCA

"8.8.3204 MOUTHPIECE (1) through (3)(b) will remain the same.

(c) Upon the third occurrence, disqualify the participant who deliberately spit out or allowed his mouthpiece to fall out of his mouth. The opponent shall be declared the winner due to disqualification."

Auth: Sec. 23-3-405, MCA; IMP, Sec. 23-3-405, MCA

"8.8.3301 PROMOTER-MATCHMAKER (1) Promoters shall be responsible for permit applications and other requirements. All license fees must be paid prior to the athletic event. Within 24 hours after the conclusion of any ~~boxing or wrestling~~ live or televised athletic event, the promoter shall report on the total number of tickets sold, the total of gross receipts and such other information as prescribed on forms provided by the board.

(2) Promoters are required to provide all materials necessary for the athletic event, such as ring, steps, stools, water buckets, resin, bell, buzzer or whistle, timer, gloves, gauze and tape for handwraps.

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

Auth: Sec. 23-3-405, MCA; IMP, Sec. 23-3-405, MCA

"8.8.3401 OFFICIALS REQUIRED (1) The officials shall consist of a referee, 3 judges, timekeeper, announcer, and a physician. The judges and referee shall be named by the board and paid by the promoter conducting the ~~contest~~ athletic event ~~and approved by the board at least 48 hours prior to any boxing contest or exhibition~~.

(2) The Montana board of athletics shall have the right to appoint at least two officials of their choice for all title bouts licensed by the board."

Auth: Sec. 23-3-405, MCA; IMP, Sec. 23-3-405, MCA

"8.8.3402 REFEREE (1) will remain the same.

(a) must present evidence of 5 years prior experience in judging ~~boxing or wrestling events~~ athletic events involving boxing or wrestling;

(b) through (d) will remain the same.

(2) The referee shall be the chief official of ~~contests~~ athletic events and shall have general supervision over bouts and shall take his position in the ring and shall be properly attired.

(3) The referee~~,~~ shall, before starting an ~~contest~~ athletic event, ascertain from each contestant~~,~~ the name of his chief second and shall hold said chief second responsible for the conduct of his assistant seconds during the progress of the ~~contest~~ athletic event.

(4) through (7)(b) will remain the same.

(8) Whenever a ~~boxer~~ contestant has been injured seriously, knocked out or technically knocked out, the referee shall immediately summon the ringside physician to aid the stricken ~~boxer~~ contestant. Except at the request of the physician, managers and seconds shall not be permitted to attend the ~~boxer~~ contestant.

(a) Any licensee may be disciplined for failure to immediately yield to a ringside physician.

(9) will remain the same.

(10) ~~In the event of serious cuts, the referee shall summon the ringside physician and the physician shall decide if the bout should be stopped.~~ In the case that a cut occurs, the referee shall consult the ringside physician to determine if the bout shall be stopped or can continue. If the ringside physician steps on the ring apron, the referee must have the injured contestant examined by the ringside physician. Final authority for the decision to stop or continue the bout rests with the referee.

(11) When a cut is produced by a legal punch and the bout is stopped, the wounded contestant shall be declared the loser by technical knockout, with the designation of TKOC to indicate the cut as the reason for the technical knockout.

(11) through (13) will remain the same but will be renumbered (12) through (14).

~~(14)~~ (15) Should a contestant leave the ring during the one-minute period between rounds and fails to be in the ring when the gong rings to resume ~~boxing~~ the athletic event, the referee shall count him out, the same as if he were "down".

~~(15)~~ (16) In case of a knockdown, the referee shall require the fallen contestant to take a count of "8". The mandatory "8" count shall not be waived for any ~~contest~~ athletic event under any circumstances as it is a safety measure designed to protect contestants regardless of caliber, ability or rating.

(16) through (18) will remain the same but will be renumbered (17) through (19).

~~(19)~~ (20) Whenever a referee is compelled to disqualify a ~~boxer or boxers~~ contestant for stalling, fouling, or for any other reason, the referee must make a written report of his action, to be given to the inspector in charge, to be submitted to the board along with the inspector's report.

~~(20)~~ (21) Any actions out of the ordinary in any ~~boxing bout~~ athletic event must be so noted on the referee's report.

~~(21)~~ (22) The compensation and traveling expenses of referees for officiating at ~~boxing shows or exhibitions~~ athletic events shall be paid by the person, club, corporation or association conducting such ~~exhibition~~ athletic event.

(22) will remain the same but will be renumbered (23)."

Auth: Sec. 23-3-405, MCA; IMP, Sec. 23-3-304, 23-3-405, MCA

"8.8.3403 JUDGES (1) will remain the same.

(a) must have 3 years prior experience in judging ~~boxing events~~ athletic events involving boxing;

(b) through (2) will remain the same.

(3) It shall be the duty of the judges to watch every phase of the bout and to make a decision, if the ~~contest~~ athletic event lasts the limit of rounds scheduled.

(4) will remain the same.

(5) All 3 votes are of equal value in arriving at the decision as to the outcome of each ~~contest~~ athletic event. In the event of any 2 votes coinciding, the result shall be so determined. In the event of all 3 votes disagreeing, the ~~contest~~ athletic event shall be declared a draw. The decisions of the judges shall be based primarily on effectiveness, taking into account the following points:

(a) through (d) will remain the same.

(e) It is advisable to deduct points when a contestant persistently delays the action of an ~~contest~~ athletic event by clinching and/or lack of aggressiveness.

(f) and (g) will remain the same.

(h) In order to arrive at a true conclusion, every point should be carefully observed and noted as the round progresses. The winner of the round is to be determined by the contestants receiving the largest number of points scored in that round. At the end of the ~~contest~~ athletic event the contestant who has to his credit the greatest number of points is the winner of the bout. Each round is to be accounted for on the score card in figures. The 10-point system will be used.

(6) In the event a judge becomes incapacitated and is unable to finish scoring an athletic event, time out shall be called. The alternate referee shall immediately be assigned to score the event if a fourth judge is not available. The alternate referee shall continue scoring on the score cards used by the incapacitated judge."

Auth: Sec. 23-3-405, MCA; IMP, Sec. 23-3-404, 23-3-405, MCA

"8.8.3404 TIMEKEEPER (1) through (3) will remain the same.

(4) In the event of an ~~contest~~ athletic event terminating before the scheduled limit of rounds, the timekeeper shall inform the announcer of the exact duration of the ~~contest~~ athletic event.

(5) Timekeepers are not to use whistle, buzzer, or other instruments during the progress of a round. The whistle,

buzzer or other instrument must be used only 10 seconds prior to the beginning of the ~~contest~~ athletic event and 10 seconds prior to the beginning of each round."

Auth: Sec. 23-3-405, MCA; IMP, Sec. 23-3-404, 23-3-405, 23-3-501, MCA

"8.8.3405 ANNOUNCER (1) The announcer shall announce the names of contestants, their correct weights, the decisions of the referee and judges, and other matters as directed by the ~~club officials~~ promoter or board representative.

(2) No introductions or announcements, except those pertaining to the ~~contest or exhibition~~ athletic event, shall be made from the ring, unless authorized by a member of the board or inspector."

Auth: Sec. 23-3-405, MCA; IMP, Sec. 23-3-405, MCA

"8.8.3406 SECONDS (1) will remain the same.

(a) must present evidence of assisting at ~~boxing events~~ athletic events involving boxing;

(b) will remain the same.

(c) name of ~~boxer(s)~~ contestant(s) in whose corner he usually assists at ringside.

(2) through (8) will remain the same."

Auth: Sec. 23-3-405, MCA; IMP, Sec. 23-3-404, 23-3-405, 23-3-501, MCA

"8.8.3407 INSPECTORS (1) The board shall appoint official representatives designated as "inspectors" and shall issue to each an authorization which will be his authority to act as a representative of the board. ~~The~~ An inspector shall be present during the physical examinations and weigh-ins. ~~He shall not leave before tickets and receipts have been counted and all tax and license fees due have been collected. The inspector shall see that all rules are strictly enforced. He will also supervise the counting of all receipts.~~

~~(2) The inspector shall provide the official scoring cards. The judges shall score each round of the bout on the score card, total it, name the winner, sign the card and return it to the referee, who shall deliver the cards to the inspector. He will then hand the cards to the announcer who will announce the results and immediately return the cards to the inspector. Score cards must at all times remain in the custody of the inspector who shall deliver the score cards, the rest of his reports and the tax and license fees to the board.~~

(2) The inspector may not have an interest in the management of any contestant, nor act as a referee, judge, timekeeper, or second at any ~~licensed~~ athletic event."

Auth: Sec. 23-3-405, MCA; IMP, Sec. 23-3-402, MCA

"8.8.3701 REFEREE (1) Under no circumstances shall any ~~wrestler~~ contestant lay his hands on the referee. Any violation of this rule shall disqualify the ~~offender~~ contestant.

(2) The referee's instructions given before the bout must be strictly complied with, as he is responsible for the

proper conduct of the ~~match~~ athletic event and the enforcement of the rules of the board. The referee's verdict shall be final and he has the right to stop an ~~match~~ athletic event at any time because of injury or weak physical condition of one or both of the contestants."

Auth: Sec. 23-3-405, MCA; IMP, Sec. 23-3-404, 23-3-405, 23-3-501, 23-3-603, MCA

"8.8.3801 WRESTLING CONTESTANT (1) will remain the same.

(2) Should a ~~wrestler~~ contestant claim injury and refuse to continue an ~~contest~~ athletic event at the referee's command, and if after a physical examination, he is found physically unable to continue the bout, then the referee must decide in favor of his opponent.

(3) ~~Wrestlers~~ Contestants appearing in ~~matches~~ athletic events must be properly clothed in neat and clean athletic apparel. Trunks and tights must be well fitting and held with a high waist band. If short trunks only are used and the limbs bare, the length of the trunks shall not be less than 3 inches below the crotch, and 2 pairs, one over the other, must be worn. Shoes must have soft soles.

(4) will remain the same."

Auth: Sec. 23-3-405, MCA; IMP, Sec. 23-3-404, 23-3-405, MCA

"8.8.3802 TIME LIMITATIONS (1) ~~Matches~~ Athletic events shall be limited to 2 hours of continuous wrestling, except as herein otherwise provided. Should neither contestant have a marked advantage at the end of 2 hours, the referee, in his discretion, following a 5-minute rest period, may order the ~~contest~~ athletic event continued for an added 30 minutes. If, at the end of the extra 30 minutes, the referee is unable to decide the winner, the ~~contest~~ athletic event shall be declared a draw. However, if one of the contestants gets a fall during the extra 30 minute period, that fall shall be the deciding fall and he shall be declared the winner.

(2) Should there only be one fall in the 2 hours of wrestling, the winner of that fall shall be declared the winner of the ~~contest~~ athletic event. If each contestant has gained one fall in the 2 hours of wrestling, then the referee may allow the ~~match~~ athletic event to continue after a 5-minute rest period for an added 30 minutes. If at that time neither of the contestants shall have gained a fall and the referee is unable to declare a winner, he shall then declare the ~~contest~~ athletic event a draw.

(3) In ~~contests~~ athletic events of less than 2 hours duration, when the referee is unable to give a decision in a close match, he shall have the power to declare such ~~contest~~ athletic event a draw, if in his opinion this would be a just decision."

Auth: Sec. 23-3-405, MCA; IMP, Sec. 23-3-405, MCA

"8.8.3803 RING EQUIPMENT (1) Mats shall not be less than 1 1/2 inches thick, and must be stuffed with hair, felt, cotton or other soft material, and shall cover the entire ring

platform. The mat and covering shall be clean and free from disagreeable odors at all times. The ring size ropes shall be the same as those used in ~~boxing~~ athletic events involving boxing."

Auth: Sec. 23-3-405, MCA; IMP, Sec. 23-3-405, MCA

"8.8.3804 HOLDS (1) and (2) will remain the same.

(3) When ~~wrestlers~~ contestants roll off the mat and under the ropes, but not off the ~~ring~~ platform, the referee and timekeeper shall begin a count of 10. In the event that neither ~~wrestler~~ contestant returns before the count of 10 is completed, the ~~exhibition~~ athletic event shall be terminated. In the event one ~~wrestler~~ contestant returns and his opponent fails to return before a count of 10 is completed, then the ~~exhibition~~ athletic event shall terminate with the ~~wrestler~~ contestant in the ring being awarded the ~~contest~~ athletic event.

(4) When one or both ~~wrestlers~~ contestants fall from the ring so that a part of their bodies touch the floor, the referee and timekeeper shall begin a count of 20. In the event that neither ~~wrestler~~ contestant returns before the count of 20, then the ~~exhibition~~ athletic event shall terminate with the ~~wrestler~~ contestant in the ring being awarded the ~~contest~~ athletic event.

(5) ~~Wrestlers~~ Contestants failing to break when instructed to do so by the referee shall be given a count of 4 in which to release the hold, and if the aggressor does not break the hold by the count of 4, the offender shall be disqualified and his opponent shall be awarded the ~~exhibition~~ athletic event."

Auth: Sec. 23-3-405, MCA; IMP, Sec. 23-3-405, MCA

"8.8.3805 FALLS AND DECISIONS (1) will remain the same.

(2) The referee shall slap on the back or the shoulders of a ~~wrestler~~ contestant securing a fall so that the man under him will not be strained by being held too long in a possibly painful position.

(3) will remain the same."

Auth: Sec. 23-3-405, MCA; IMP, Sec. 23-3-405, MCA

"8.8.3806 DELAYS IN CONTEST (1) If for any reason whatsoever it becomes necessary to temporarily stop the ~~contest~~ athletic event during the course of its progress, such time as may be consumed during the delay shall be added to the wrestling period so as to complete the full time allowed for the ~~contest~~ athletic event."

Auth: Sec. 23-3-405, MCA; IMP, Sec. 23-3-405, MCA

"8.8.4001 AUSTRALIAN TAG TEAM WRESTLING (1) A tag team event is an ~~exhibition~~ athletic event between a team of 2 ~~wrestlers~~ contestants against another team of 2 ~~wrestlers~~ contestants.

(2) The ~~exhibition~~ athletic event begins with one ~~man~~ contestant from each team wrestling one ~~man~~ contestant from the opposing team while their respective team ~~partners~~ remain on the apron of the ring outside of the ring ropes. A ~~man~~

contestant cannot enter the ring unless his partner is defeated or he is able to touch his partner and to relieve him. He must have hold of a regulation 3-foot rope with a knot in one end and the other end looped over the ring post of his team's corner. At the time of a tag contact between partners, the ~~man~~ contestant outside of the ropes must have both feet on the apron floor and must reach over the top rope only to make contact. The referee must see to it that the ~~wrestler~~ contestant in the ring after tagging his partner, retires to the outside of the ring before his partner can enter the ring. Not more than 2 referees are permitted to be in the ring at the same time during the ~~exhibition~~ athletic event. During the team ~~exhibition~~ athletic event, team partners may relieve each other as often as they desire as long as neither has lost a fall for his team. When a ~~wrestler~~ contestant loses a fall, he must retire to the ringside at his corner.

(3) If a ~~wrestler~~ contestant is injured so that he cannot continue, his partner must carry on alone. The opposing team must defeat the one ~~wrestler~~ contestant once to win a team fall.

(4) It shall be a foul for a contestant ~~while awaiting his turn on the apron~~ to assist his partner or to interfere with his opponent while awaiting his turn on the apron.

(5) through (7) will remain the same.

(8) Only the referee and ~~wrestlers~~ contestants are permitted in the ring during ~~matches~~ athletic events. In the event anyone other than the performing ~~wrestlers~~ contestants enters the ring, the referee shall stop the ~~match~~ athletic event.

(9) In all other instances, the rules governing ~~wrestling exhibitions~~ athletic events involving wrestling shall prevail."

Auth: Sec. 23-3-405, MCA; IMP, Sec. 23-3-405, MCA

REASON: The rule changes are needed to clean up inconsistent language throughout the rules, through the use of consistent definitional terms. In addition, some of the rule changes have been prepared to bring the rules into accord with the national standards of the Association of State Boxing Commissions.

3. The proposed new rules will read as follows:

"I GENERAL RULES APPLICABLE (1) All general rules, where appropriate, also apply to kickboxing."

Auth: Sec. 23-3-405, MCA; IMP, Sec. 23-3-405, MCA

"II CONDUCT OF ATHLETIC EVENTS (1) All professional, non-title kickboxing athletic events will be a minimum of five up to a maximum of twelve rounds in duration. All title athletic events shall be conducted according to the professional rules and regulations of karate international council of kickboxing.

(2) All offensive kickboxing, punching, and kicking techniques are authorized, with the exception of those

techniques specified as "fouls", and may be executed according to the individual contestant's style or system of kickboxing.

(3) Contestants shall have the option of leg kicks when both contestants have been properly trained for leg kicks and the contract explicitly states that leg kicks will be used.

(4) If leg kicks are allowed, any kicking technique may be used as long as the kicks are not to any foul area, such as a knee joint. Targets include kicks to the inside, outside, and back of the thigh on either leg and kicks to the calf of either leg.

(5) The board may limit, at its discretion, the use of leg kicks or the use of inside kicks.

(6) A contestant intentionally avoiding any physical contact with his opponent will receive a warning from the referee. If the contestant continues to avoid a confrontation with his opponent after receiving a warning during that round, he may be penalized by the referee. If the contestant continues to evade action, either in the same round or in any other round, the referee may, at his discretion, award more penalties."

Auth: Sec. 23-3-405, MCA; IMP, Sec. 23-3-405, MCA

"III SWEEPS (1) Contestants may execute sweeps only by making a sweeping motion to the padded area of an opponent's foot with the padded area of the user's foot, or "boot-to-boot" as it has been called.

(2) Contact to any other part of the leg (thigh, knee, shin and sides of the shin from any angle) while delivering a sweep shall constitute a foul and be treated accordingly.

(3) A sweep is not a kick and shall not be judged as such.

(4) Any techniques thrown following a sweep must land on the opponent prior to any part of his body touching the floor of the ring. If the technique lands after some part of the opponents body, other than the soles of his feet, has touched the floor, the referee may call a foul.

(5) A successful sweep is not considered a knockdown."

Auth: Sec. 23-3-405, MCA; IMP, Sec. 23-3-405, MCA

"IV FOULS (1) All general foul rules of boxing apply to kickboxing in addition to the following fouls:

(a) striking the groin, the spine, headbutts, the throat, collarbone, or that part of the body over the kidneys;

(b) kicking into the knee or striking below the belt in any unauthorized manner;

(c) anti-joint techniques (striking or applying leverage against any joint);

(d) grabbing or holding onto an opponent's leg or foot;

(e) leg checking the opponent's leg or stepping on the opponent's foot to prevent the opponent from moving or kicking;

(f) throwing or taking an opponent to the floor in an unauthorized manner;

(g) failure to throw eight kicks in a given round;

(h) intentional evasion of contact; or

(i) executing any technique which is deemed malicious and beyond the scope of reasonably expected techniques in an athletic event.

(2) All national, continental, intercontinental or world championship kickboxing athletic events shall be required to compete under the regulations set forth by the karate international council of kickboxing.

(3) A contestant who executes a malicious foul may be subject to bearing the medical as well as related recovery and recuperation expenses of the opponent who is injured as a result of a malicious fouling technique.

(4) When the referee determines that a foul has been committed, the judges or scorekeeper shall automatically deduct the appropriate number of points on each judge's scorecard. When both contestants commit fouls, the appropriate points shall be deducted for each contestant. In the event that one contestant commits 2, 3 or 5 point fouls in one round or commits the same fouls two or more times during the course of the athletic event, that contestant may be automatically disqualified by the referee. No contestant will be scored less than zero in a round."

Auth: Sec. 23-3-405, MCA; IMP, Sec. 23-3-405, MCA

"V KICKING REQUIREMENTS (1) All professional kickboxing contestants must execute a minimum of eight hard kicks per round.

(2) In the event a contestant fails to execute the required number of kicks per round, the referee may give one warning to that contestant and his chief second during the one minute rest period following the round.

(3) If the contestant fails to execute the minimum number of kicks in any round following the referee's warning, he shall be penalized one point for each kick short of the minimum requirement.

(4) If a contestant fails to achieve the minimum kicking requirement (hereinafter "MKR") in a majority of the scheduled rounds, the contestant shall be disqualified.

(5) If a contestant executes less than eight kicks in any one round, the MKR official shall immediately notify the referee of the number of kicks thrown. The referee shall, in turn, notify the judges, who shall record the appropriate penalty."

Auth: Sec. 23-3-405, MCA; IMP, Sec. 23-3-405, MCA

"VI CONTESTANT'S EQUIPMENT (1) All promoters must have an extra set of gloves and foot pads to be used in case gloves are broken or in any way damaged beyond use during the course of an athletic event.

(2) Gloves and foot pads for all main events shall be new, furnished by the promoter and made so as to fit the hands and feet of any contestant whose hands and feet may be unusual in size, as well as bandages for all contestants.

(3) In events other than main events, if the gloves and foot pads have been used previously, they must be whole, clean, and subject to inspection by the referee and board

representative as to condition. If found to be imperfect, the gloves shall be changed before the athletic event starts.

(4) No breaking, roughing or twisting of gloves or foot pads shall be permitted.

(5) Shin pads of a soft substance shall be mandatory for all contestants.

(6) No rings, jewelry or items other than those authorized may be worn.

(7) Gloves shall be secured to the hands only after the contestants have entered the ring, unless otherwise directed by a board representative. Each contestant's seconds shall help in securing the gloves. Tape may be used to secure the pads and will be subject to inspection and approval. The referee must also inspect and approve any tape used on the gloves or pads.

(8) Tape shall be supplied by each contestant's corner or seconds.

(9) Bandages shall not exceed one winding of surgeon's adhesive tape, not over 1 1/2 inches wide, placed directly on the hand to protect that part of the hand near the wrist. The tape may cross the back of the hand twice, but shall not cover any part of the knuckles. Contestants shall use soft surgical bandages not over two inches wide, held in place by not more than two yards of surgeon's adhesive tape for hands.

(10) Bandages shall be adjusted in the dressing room in the presence of the board representative, who must sign across the back of the hand before the gloves are secured on each contestant.

(11) For each foot, contestants shall use soft surgical bandages not over two inches wide, held in place by surgeon's adhesive tape not over 1 1/2 inches wide.

(12) Foot wrappings shall not exceed three to four windings of soft surgical bandage around the sole and instep, and no more than four windings around the ankle. Tape shall cross the foot once before being wrapped one more time around the sole and heel.

(13) A karate uniform and belt approved by the board must be worn by all contestants upon entering the ring.

(14) All contestants must appear in long pants, as traditionally worn in the sport of kickboxing or full-contact karate.

(15) No boxer trunks will be allowed.

(16) Prior to the start of an athletic event, all male contestants will remove their uniform jackets and belts."

Auth: Sec. 23-3-405, MCA; IMP, Sec. 23-3-405, MCA

"VII WEIGHT CLASSES (1) The following limitations or weights are placed on all athletic events involving kickboxing:

(a) flyweight..... 112 lbs. or under
(b) super flyweight..... 115 lbs.
(c) bantamweight..... 118 lbs.
(d) super bantamweight..... 122 lbs.
(e) featherweight..... 126 lbs.
(f) super featherweight..... 130 lbs.
(g) lightweight..... 135 lbs.

(h) super lightweight..... 140 lbs.
(i) welterweight..... 146 lbs.
(j) super welterweight..... 152 lbs.
(k) middleweight..... 159 lbs.
(l) super middleweight..... 166 lbs.
(m) light heavyweight..... 174 lbs.
(n) super light heavyweight..... 181 lbs.
(o) cruiserweight..... 189 lbs.
(p) heavyweight..... 205 lbs.
(q) super heavyweight..... over 205 lbs.

(2) No contestant shall engage in an athletic event where the weight difference exceeds the allowance shown in the above schedule. Any greater weight spread requires the approval of the board."

Auth: Sec. 23-3-405, MCA; IMP, Sec. 23-3-405, MCA

"VIII KICKBOXING OFFICIALS (1) In addition to rules for boxing officials as stated in ARM 8.8.3402 through 8.8.3407, the following shall apply to kickboxing:

(a) In the event a referee becomes incapacitated, time out shall be called and the other referee assigned to the event shall assume the duties of the incapacitated referee.

(b) Immediately before an athletic event, the referee will call the contestants to the middle of the ring and conduct a traditional martial arts bow in the following manner:

(i) the contestants, while standing approximately 4 to 6 feet from one another, will face the referee;

(ii) the referee will first bow to the contestants, who will return the bow and then bow to each other in the customary fashion;

(iii) in their position in which the bow takes place, the contestants will prepare to fight as the referee signals that the first round will commence.

(c) There shall be two MKR officials positioned at ringside, who shall count, in order, the number of qualifying kicks executed by their assigned contestant. The MKR officials shall sit opposite their assigned contestant's corner."

Auth: Sec. 23-3-405, MCA; IMP, Sec. 23-3-405, MCA

REASON: These new rules providing for regulation of kickboxing have been prepared in response to the growth of this sport.

3. Interested persons may present their data, views or arguments concerning the proposed adoption in writing to the Board of Athletics, Lower Level, Arcade Building, 111 North Jackson, Helena, Montana 59620-0407, to be submitted no later than 5:00 p.m., April 22, 1993.

4. If a person who is directly affected by the proposed adoption wishes to present his data, views or arguments orally or in writing at a public hearing, he must make written request for a hearing and submit the request along with any comments he has to the Board of Athletics, Lower Level, Arcade

Building, 111 North Jackson, Helena, Montana 59620-0407, to be submitted no later than 5:00 p.m., April 22, 1993.

5. If the Board receives requests for a public hearing on the proposed adoption from either 10 percent or 25, whichever is less, of those persons who are directly affected by the proposed adoption, from the Administrative Code Committee of the legislature, from a governmental agency or subdivision or from an association having no less than 25 members who will be directly affected, a hearing will be held at a later date. Notice of the hearing will be published in the Montana Administrative Register. Ten percent of those persons directly affected has been determined to be 4 based on the 40 licensees in Montana.

BOARD OF ATHLETICS
ANDY VANDOLAH, CHAIRMAN

BY: Annie M. Bartos
ANNIE M. BARTOS, CHIEF COUNSEL
DEPARTMENT OF COMMERCE

Annie M. Bartos
ANNIE M. BARTOS, RULE REVIEWER

Certified to the Secretary of State, March 15, 1993.

BEFORE THE BOARD OF NURSING
DEPARTMENT OF COMMERCE
STATE OF MONTANA

In the matter of the proposed amendment of rules pertaining to foreign nurses and prescribing practices	))))	NOTICE OF PUBLIC HEARING ON THE PROPOSED AMENDMENT OF 8.32.406 LICENSURE FOR FOREIGN NURSES AND 8.32.1505 PRESCRIBING PRACTICES

TO: All Interested Persons:

1. On April 29, 1993, at 9:00 a.m., a public hearing will be held in the conference room of the Professional and Occupational Licensing Bureau, Lower Level, Arcade Building, 111 North Jackson, Helena, Montana, to consider the proposed amendment of the above-stated rules.

2. The proposed amendments will read as follows: (new matter underlined, deleted matter interlined)

"8.32.406 LICENSURE FOR FOREIGN NURSES (1) and (2) will remain the same.

(3) Candidates for licensure as registered nurses will be required to show evidence of having passed the commission on graduates for foreign nursing schools screening examination prior to writing the Montana licensing examination~~.~~, except:

(a) Canadian educated nurses who graduated after 1966 from a school approved by a Canadian province; and who have also passed CNATS in the English language.

(4) will remain the same."

Auth: Sec. 37-8-202, MCA; IMP, Sec. 37-8-407, 37-8-417, MCA

REASON: This amendment is needed to provide for Canadian educated nurses to become licensed by taking the CNATS exam in English, rather than taking the CGFNS international exam. The CNATS exam provides an acceptable substitution for the CGFNS exam with respect to Canadian educated nurses for two reasons. First, the CNATS exam, like the CGFNS exam, tests nursing knowledge and English proficiency. Second, the Board has greater knowledge of Canadian schools of nursing than it does of schools in other countries.

"8.32.1505 PRESCRIBING PRACTICES (1) through (2)(g) will remain the same.

(h) DEB number of the prescriber on all scheduled drugs.

(3) through (8) will remain the same."

Auth: Sec. 37-8-202, MCA; IMP, Sec. 37-8-202, MCA

REASON: This rule change is needed in order to clarify that the DEB number of the prescriber needs to be present on all prescriptions for scheduled drugs, but not for non-scheduled

drugs, per federal requirement and suggestion of the Drug Enforcement Agency.

3. Interested persons may present their data, views or arguments, either orally or in writing, at the hearing. Written data, views or arguments may also be submitted to the Board of Nursing, Lower Level, Arcade Building, 111 North Jackson, P.O. Box 200513, Helena, Montana 59620-0513, to be received no later than 5:00 p.m., April 29, 1993.

4. Lance Melton, Helena, Montana, has been designated to preside over and conduct the hearing.

BOARD OF NURSING
LAURA LENAU, R.N., M.S.,
PRESIDENT

BY: Annie M. Bartos
ANNIE M. BARTOS, CHIEF COUNSEL

Annie M. Bartos
ANNIE M. BARTOS, RULE REVIEWER

Certified to the Secretary of State, March 15, 1993.

BEFORE THE BOARD OF PUBLIC EDUCATION
OF THE STATE OF MONTANA

In the matter of the amendment of Teacher Certification	)))	NOTICE OF PROPOSED AMENDMENT OF ARM 10.57.404 CLASS 4 VOCATIONAL EDUCATION NO PUBLIC HEARING CONTEMPLATED

To: All Interested Persons

1. On April 24, 1993, the Board of Public Education proposes to amend ARM 10.57.404, Class 4 Vocational Education.

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

10.57.404 CLASS 4 VOCATIONAL CERTIFICATION (1) will remain the same.

(2) The three types of class 4 certificates are as follows:

(a) through (c)(iii) will remain the same.

(vi) Issuance of the class 4C (temporary) certificate is issued for five years, ~~and~~ is not renewable, except that it may be reinstated one time upon application to the office of public instruction, without additional requirement, for a period of five years.

AUTH: Sec. 20-4-102 IMP: Sec. 20-4-106, 20-4-108

3. The board proposes to amend this rule so that those who apply and receive class 4C certification, possibly due to a requirement for application for a vocational teaching position, may not complete the original plan of professional intent.

4. Interested parties may submit their date, views or arguments in writing to John Kinna, Acting Chairman of the Board of Public Education, 2500 Broadway, Helena, MT 59620, no later than April 24, 1993.

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 John Kinna, Acting Chairman of the Board of Public Education, 2500 Broadway, Helena MT 59620, no later than April 24, 1993.

6. If the Board receives requests for a public hearing on the proposed amendment from either 10% or 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 of those persons directly affected has been determined to be 10 as there are 100 school districts presently in Montana.

Wayne Buchanan

Wayne Buchanan, Executive Secretary
Board of Public Education

Certified to the Secretary of State, March 15, 1993.

BEFORE THE DEPARTMENT OF FISH, WILDLIFE & PARKS
OF THE STATE OF MONTANA

IN THE MATTER OF THE PROPOSED AMENDMENT OF ARM 12.5.301 PERTAINING TO YELLOW PERCH AS NONGAME SPECIES IN NEED OF MANAGEMENT	) NOTICE OF PROPOSED AMENDMENT OF ARM 12.5.301)) No Public Hearing Contemplated

TO: All interested persons

1. On May 14, 1993, the Montana Department of Fish, Wildlife & Parks proposes to amend ARM 12.5.301 to read as follows:

12.5.301 NONGAME WILDLIFE IN NEED OF MANAGEMENT (1) The following nongame wildlife species are determined by the department to be nongame wildlife in need of management within the meaning of the Nongame and Endangered Species Conservation Act, 87-5-101, MCA et seq. Management regulations for these species will be issued annually by the department.

(a) through (b) remain the same

(c) Yellow Perch - Perca flavescens

AUTH: Sec. 87-5-105 MCA IMP: Sec. 87-5-105 MCA

2. Rationale for proposed amendment: The Montana Department of Fish, Wildlife and Parks and the Confederated Salish and Kootenai Tribes regulate waters of the Flathead Reservation by joint regulations which have been adopted by each entity.

The 1993 Fishing Regulations proposed by the Flathead Reservation Fish and Wildlife Board require a 50 fish daily limit for yellow perch. This is a new requirement intended to limit the harvest of yellow perch in Flathead Lake and other reservation waters. The Montana Fish, Wildlife and Parks Commission has adopted the 1993 Fishing Regulations.

The yellow perch is not listed as a game fish under Montana statutes. The yellow perch must be designated as a "nongame species" in need of management to allow the department authority to develop and enforce harvest limits on this species.

3. Interested parties may submit their data, views or arguments, either orally or in writing, to Howard Johnson, Department of Fish, Wildlife and Parks, 1420 East Sixth, Helena, Montana 59620, no later than April 22, 1993.

4. 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 to Howard Johnson, Department of Fish, Wildlife and Parks, 1420 East Sixth, Helena, Montana 59620, no later than April 22, 1993.

5. 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 agency or subdivision or from any 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 and ~~mailed to~~ all interested persons.

Robert N. Lane
Rule Reviewer

Patrick J. Graham, Director
Montana Department of Fish,
Wildlife and Parks

Certified to the Secretary of State March 8, 1993.

BEFORE THE DEPARTMENT OF LABOR AND INDUSTRY
OF THE STATE OF MONTANA

In the matter of the amendment of Montana's prevailing wage rates, pursuant to Rule 24.16.9007	))))	NOTICE OF PUBLIC HEARING ON PROPOSED AMENDMENTS OF PREVAILING WAGE RATES-SERVICE OCCUPATIONS

TO ALL INTERESTED PERSONS:

1. On Monday, April 19, 1993, at 1:30 p.m., a public hearing will be held in room 104, Department of Labor and Industry, 1327 Lockey, Helena, Montana, to consider proposed amendments to the prevailing wage rates.

The Department of Labor and Industry will make reasonable accommodations for persons with disabilities who wish to participate in this public hearing. If you request an accommodation, contact the Department by not later than 5:00 p.m., April 13, 1993, to advise us of the nature of the accommodation that you need. Please contact the Research, Safety and Training Division, Attn: Mr. Dave Folsom, P.O. Box 1728, Helena, MT 59624-1728; telephone (406) 444-3239; TDD (406) 444-5549; fax (406) 444-2638.

2. The Department of Labor and Industry hereby proposes to adopt and incorporate by reference the "State of Montana Prevailing Wage Rates-Service Occupations" which sets forth the service occupations prevailing wage rates. These rates are to be effective July 1, 1993. A copy of the prevailing wage rates may be obtained from Dave Folsom, Research and Analysis Bureau, Research, Safety and Training Division, Department of Labor and Industry, P.O. Box 1728, Helena, Montana 59624.

The prevailing wage rates to be amended are for service occupations, which relate to the repair, maintenance and upkeep of public buildings. Office, clerical, and supervisory services are not included in these rates. The building construction and heavy highway rates are not being amended at this time.

3. Interested parties may submit their data, views, or comments, either orally or in writing, at the hearing. Written data, views, or comments may also be submitted by April 26, 1993, to Dave Folsom, Research and Analysis Bureau, Research, Safety and Training Division, Department of Labor and Industry, P.O. Box 1728, Helena, Montana 59624.

4. The Hearings Unit of the Legal Services Division, Department of Labor and Industry, P.O. Box 1728, Helena, Montana 59624, has been designated to preside over and conduct the hearing.

5. AUTH: 18-2-431 AND 2-4-307 MCA;

IMP: 18-2-401 through 18-2-432 MCA.

6. Reason: Pursuant to 18-2-402 and 18-2-411(b)(5), MCA, the Department is updating the standard prevailing wages for service occupations. Prevailing wage rates are established for each wage rate district in the state. The Department updates the prevailing wages for service occupations every two years. Prevailing wages for building construction occupations and heavy highway occupations are updated biennially in the intervening year. Prevailing wages for service occupations were last updated in 1991. Use of prevailing wage rates is required in public contracts by 18-2-422, MCA.

David A. Scott
Rule Reviewer

Laurie Ekanger, Commissioner
DEPARTMENT OF LABOR & INDUSTRY

Certified to the Secretary of State: March 15, 1993

BEFORE THE BOARD OF DENTISTRY
DEPARTMENT OF COMMERCE
STATE OF MONTANA

In the matter of the amendment of rules pertaining to introduction, exams, licensure by credentials, unprofessional conduct, qualifying standards and the adoption of a new rule pertaining to denturist interns	))))))	NOTICE OF AMENDMENT AND ADOPTION OF RULES PERTAINING TO DENTISTS, DENTAL HYGIENISTS AND DENTURISTS

TO: All Interested Persons:

1. On October 15, 1992, the Board of Dentistry published a notice of public hearing on the proposed amendment and adoption of rules pertaining to dentists, dental hygienists and denturists, at page 2229, 1992 Montana Administrative Register, issue number 19. The hearing was held on November 6, 1992, at 9:00 a.m. in the Elkhorn A Room of the Park Plaza in Helena.

2. The Board has amended ARM 8.16.601, 8.16.605, 8.16.722, 8.16.902 and 8.16.903 and adopted new rule II (8.17.405) exactly as proposed. The Board has vacated the proposed amendment of 8.16.602 and the proposed adoption of new rule I until a later date.

3. The Board has thoroughly considered the comments and testimony received. Those comments and the Board's responses are as follows:

COMMENT: The Montana Dental Hygiene Association (MDHA) proposed that the amendment to 8.16.605 be revised to allow the Board the option to grant a local anesthetic permit to applicants for licensure by credentials.

RESPONSE: The Board adopted the rule as proposed without the amendment offered by MDHA. The Board believes that the current testing by the Western Regional Examining Board (WREB) adequately demonstrates the individual's competency to administer local anesthetic agents. Further, the Board is familiar with WREB; board members participate in the structuring and administration of WREB examinations and are satisfied that the WREB examinations are complete and adequate. Because the Board does not participate in other examinations that are contemplated by MDHA's proposal, it has no ability to monitor those examinations on a regular basis.

4. No other comments or testimony were received with regard to the rules amended and adopted by the Board in this adoption notice.

BOARD OF DENTISTRY
ROBERT W. RECTOR, D.M.D.
PRESIDENT

BY: Annie M. Bartos
ANNIE M. BARTOS, CHIEF COUNSEL
DEPARTMENT OF COMMERCE

Annie M. Bartos
ANNIE M. BARTOS, RULE REVIEWER

Certified to the Secretary of State, March 15, 1993.

BEFORE THE BOARD OF MEDICAL EXAMINERS
DEPARTMENT OF COMMERCE
STATE OF MONTANA

In the matter of the amendment of a rule pertaining to utilization plans) CORRECTED NOTICE OF 8.28.1506 UTILIZATION PLAN

TO: All Interested Persons:

1. On December 24, 1992, the Board of Medical Examiners published a notice of proposed amendment of the above-stated rule at page 2677, 1992 Montana Administrative Register, issue number 24. The Board published a notice of adoption at page 341, 1993 Montana Administrative Register, issue number 5, adopting the rule as proposed but with changes to subsection (2).

2. Staff inadvertently stated that subsection (1) through (1)(a)(i) would remain the same. The statement should have read, "(1) through (1)(b)(i) will remain the same." The amendment should have appeared as shown below. The amendments are in the numbering of subsections and are not substantive.

"8.28.1506 UTILIZATION PLAN (1) through (1)(b)(i) will remain the same.

(ii) the location of the supervising physician's office or hospital assignment in relationship to the location where the physician~~'s~~ assistant-certified ~~intends to work,~~ proposes to practice;

(c) the physician assistant-certified's proposed scope of practice;

~~(c) intended protocols;~~

(d) plans for supervision when the supervising physician is not available~~, such as in emergencies~~;

(e) any other information which will assist the board in determining that the physician~~'s~~ assistant-certified will be adequately supervised.

..."

BOARD OF MEDICAL EXAMINERS
PETER BURLEIGH, M.D.
CHAIRMAN

BY: Annie M. Bartos
ANNIE M. BARTOS, CHIEF COUNSEL
DEPARTMENT OF COMMERCE

Annie M. Bartos
ANNIE M. BARTOS, RULE REVIEWER

Certified to the Secretary of State, March 15, 1993.

BEFORE THE BOARD OF NURSING HOME ADMINISTRATORS
DEPARTMENT OF COMMERCE
STATE OF MONTANA

In the matter of the amendment of a rule pertaining to examinations and reciprocity licenses) CORRECTED NOTICE OF 8.34.414 EXAMINATIONS AND 8.34.417 RECIPROCITY LICENSES

TO: All Interested Persons:

1. On December 24, 1992, the Board of Nursing Home Administrators published a notice of proposed amendment of the above-stated rule at page 2686, 1992 Montana Administrative Register, issue number 24. The Board published a notice of adoption at page 264, 1993 Montana Administrative Register, issue number 3, adopting the rules exactly as proposed.

2. Staff inadvertently used a copy of ARM 8.34.414, which rule had been amended at page 2640, 1992 Montana Administrative Register, issue number 23. ARM 8.34.414 should have been proposed as follows in the original notice published in issue number 24. The amendments shown below are in the numbering of subsections and are not substantive.

"8.34.414 EXAMINATIONS (1) will remain the same. ~~(2) A passing core in examinations prepared by the professional examination service, or the national association of boards and passing score in an open book examination relating to the provisions of the Montana long term care facility licensing law and regulations will be required of each applicant.~~

~~(3)~~ (2) Each applicant shall be required to attain a ~~final~~ passing scaled score, as determined by the national association of boards of examiners for nursing home administrators, on an ~~of at least 113 raw score in~~ examinations prepared by the professional examination service, or the national association of boards~~, and~~. In addition, each applicant must attain a final score of at least 90% in the open book examination relating to the provisions of the Montana long-term care facility licensing law and regulations.

(4) will remain the same but will be renumbered (3)."

Auth: Sec. 37-1-131, 37-1-134, 37-9-201, 37-9-203, 37-9-304, MCA; IMP, Sec. 37-1-134, 37-9-201, 37-9-203, 37-9-301, 37-9-303, 37-9-304, MCA

3. The Board also amended section (1) by adding subsections (a) and (b). Subsection (a) should have shown the language "of 113" as being deleted. The amendment should have appeared as follows:

"8.34.417 RECIPROCITY LICENSES (1) will remain the same.

(a) that the applicant attained a ~~miniraw~~ passing scaled score ~~of 113~~, as determined by the national association of boards of examiners for nursing home administrators on an examination ~~administered~~ prepared by the professional

examination service or the national association of boards; and ~~setting forth~~

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

BOARD OF NURSING HOME
ADMINISTRATORS
MOLLY MUNRO, CHAIRMAN

ANNIE M. BARTOS
Rule Reviewer

BY: ANNIE M. BARTOS, CHIEF COUNSEL
DEPARTMENT OF COMMERCE

Certified to the Secretary of State, March 15, 1993.

BEFORE THE BOARD OF OPTOMETRISTS
DEPARTMENT OF COMMERCE
STATE OF MONTANA

In the matter of the adoption of new rules pertaining to surgery	)))	NOTICE OF ADOPTION OF NEW RULES PERTAINING TO SURGERY

TO: All Interested Persons:

1. On December 10, 1992, the Board of Optometrists published a notice of public hearing on the proposed adoption of rules pertaining to surgery, at page 2625, 1992 Montana Administrative Register, issue number 23. The public hearing was held on January 4, 1993, at 9:00 a.m., in the conference room of the Professional and Occupational Licensing Bureau, Helena, Montana.

2. The Board is continuing to review new rule I and will address whether or not to adopt it at a later date. The Board has adopted new rule II (8.36.415) exactly as proposed and has adopted new rule III (8.36.416) as proposed but with the following change:

"8.36.416 OPTOMETRIST'S ROLE IN POST-OPERATIVE CARE

(1) A licensed optometrist may provide post-operative and/or follow-up care for any patient who has undergone any ocular surgical procedure. The optometrist ~~shall~~ may deliver post-operative and/or follow-up care after consultation with the surgeon and the patient."

Auth: Sec. 37-10-202, MCA; IMP, Sec. 37-10-101, MCA

3. The Board has thoroughly considered all comments and testimony received. Those comments and the Board's responses are as follows:

COMMENT: Steve Brown, attorney for the Montana Academy of Ophthalmology, suggested the second sentence of Proposed New Rule III be amended to read: "The optometrist may deliver post-operative and/or follow-up care under the direct supervision of a physician." Mr. Brown said this proposed amendment was designed to strike language that seemed to make post-operative care by an optometrist mandatory, and to recognize that existing protocol permits an optometrist to provide post-operative care under the direction of a physician.

RESPONSE: The Board voted to adopt the discretionary language by amending the rule to provide the optometrist may deliver post-operative care and striking the mandatory term "shall" deliver. The Board voted to adopt its proposed language that such care may be delivered after consultation with the surgeon and the patient. The Board rejected the Montana Academy of Ophthalmology's suggestion that the language be changed to "under the direct supervision of a physician." The Board stated that to accept the further amendment that such post-operative care be under the care of a physician, rather than in consultation with the surgeon and the patient, would

require the physician to assume liability for optometric procedures that Medicare already allows optometrists to receive payment for.

4. No other comments or testimony were received with regard to new rules II and II.

BOARD OF OPTOMETRISTS
LARRY BONDERUD, O.D., CHAIRMAN

BY: Annie M. Bartos
ANNIE M. BARTOS, CHIEF COUNSEL
DEPARTMENT OF COMMERCE

Annie M. Bartos
ANNIE M. BARTOS, RULE REVIEWER

Certified to the Secretary of State, March 15, 1993.

BEFORE THE MILK CONTROL BUREAU
OF THE STATE OF MONTANA

In the matter of the amendment of Rule 8.79.301 regarding licensee assessments	)	**NOTICE OF AMENDMENT**
	)	**LICENSEE ASSESSMENTS**
	)	**DOCKET #15-93**

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

1. On January 28, 1993, the milk control bureau of the Department of Commerce published notice of a proposed amendment to rule 8.79.301 concerning assessments to be levied upon licensees, effective July 1, 1993, at page 95 of the 1993 Montana Administrative Register, issue No. 2, as MAR Notice No. 8-79-29.

2. The bureau has amended the rule 8.79.301(1) as proposed.

AUTH: 81-23-104, MCA
IMP: 81-23-202, MCA

3. No comments or testimony were received.

DEPARTMENT OF COMMERCE

By: _____
Andy J. Poole, Deputy director
Montana Department of Commerce

By: _____
Annie Bartos, Rule Reviewer
Commerce Chief Legal Counsel 2-4-110

Certified to the Secretary of State March 15, 1993.

BEFORE THE MONTANA STATE LOTTERY
DEPARTMENT OF COMMERCE
STATE OF MONTANA

In the matter of the amendment of rules pertaining to the organizational rule and retailer commissions and the adoption of a new rule pertaining to sales staff incentive plan	) NOTICE OF AMENDMENT OF) 8.127.101 ORGANIZATIONAL) RULE AND 8.127.407 RETAILER) COMMISSION AND THE ADOPTION) OF NEW RULE I (8.127.1007)) SALES STAFF INCENTIVE PLAN

TO: All Interested Persons:

1. On November 25, 1992, the Montana State Lottery published a notice of proposed amendment and adoption of the above-stated rules at page 2486, 1992 Montana Administrative Register, issue number 22.

2. The Montana Lottery has amended ARM 8.127.407 and adopted new rule I (8.127.1007) exactly as proposed. The Montana Lottery has amended ARM 8.127.101 as proposed but with the following changes of appointed Commission members:

"8.127.101 ORGANIZATIONAL RULE (1) and (2) will remain the same as proposed.

(3) The commission consists of five members appointed by the governor. The commission is allocated to the department of commerce for administrative purposes as prescribed by 2-15-121, MCA. The names and addresses of the members of the commission are as follows:

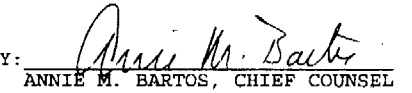
~~Ward Shanahan, P.O. Box 1715, Helena, Montana 59601~~
Becky Erickson, 114 Lomond, Glasgow, Montana 59230
Cliff Brophy, Stillwater County Sheriff's Office, Columbus, Montana 59019
Dwaine Inverson, 301 1st Street South, Shelby, Montana 59474
David Kasten, SR 277, Box A-14, Brockway, Montana 59214
Larry O'Toole, 209 North Main, Plentywood, Montana 59254
~~William J. Ware, 221 Breckenridge, Helena, Montana 59601~~

(4) The director of the Montana Lottery is appointed by the governor. The director is ~~Sandra Gueder~~ Charmaine Murphy, 2525 North Montana, Helena, Montana 59601. The assistant director for security is appointed by the lottery director. All other employees are hired by the lottery director. A chart of the organization of the lottery is attached as the following page and by this reference is herein incorporated."

Auth: Sec. 23-7-202, MCA; IMP, Sec. 23-7-202, MCA

3. No comments or testimony were received.

MONTANA STATE LOTTERY
CHARMAINE MURPHY, DIRECTOR

BY: 
ANNIE M. BARTOS, CHIEF COUNSEL
DEPARTMENT OF COMMERCE


ANNIE M. BARTOS, RULE REVIEWER

Certified to the Secretary of state, March 15, 1993.

BEFORE THE DEPARTMENT OF
FAMILY SERVICES OF THE
STATE OF MONTANA

In the matter of the amendment of Rules 11.12.101, 11.12.204, 11.12.205 and 11.12.215 pertaining to maternity homes licensed as youth care facilities.	NOTICE OF AMENDMENT OF RULES 11.12.101, 11.12.204, 11.12.205 and 11.12.215 PERTAINING TO MATERNITY HOMES LICENSED AS YOUTH CARE FACILITIES

TO: All Interested Persons

1. On January 28, 1993 the Department of Family Services published notice of public hearing on the proposed amendment of Rules 11.12.101, 11.12.204, 11.12.205 and 11.12.215 pertaining to maternity homes licensed as youth care facilities, at page 102 of the 1993 Montana Administrative Register, issue number 2.

2. On February 19, 1993, a public hearing was held in the second-floor conference room of the Department of Family Services, 48 North Last Chance Gulch, Helena, Montana, to consider the proposed amendment of Rules 11.12.101, 11.12.204, 11.12.205 and 11.12.215 pertaining to maternity homes licensed as youth care facilities.

3. The department has amended the rules as proposed.

4. No written comments were received. Karen Northey, representing the Florence Crittenton Home, 846 Fifth Avenue, Helena, Montana attended the hearing and testified informally in favor of the amendments. The department has thoroughly considered her comments:

COMMENT: Homes soliciting residence of pregnant youth and young women provide no services while charging a fee. Quite often all the residents do is sit. Services such as pre-natal counseling and care are not offered and these types of facilities are often un-licensed. The department should adopt the amendments and make sure that homes are licensed and that they follow the rules.

RESPONSE: The department agrees and efforts will be made to bring these facilities into compliance.

Hank Hudson, Director

John Melcher, Rule Reviewer

Certified to the Secretary of State, March 15, 1993.

BEFORE THE DEPARTMENT OF LABOR AND INDUSTRY
OF THE STATE OF MONTANA

In the matter of the adoption of proposed rules I through XVII, relating to medical services for workers' compensation, and the repeal of Rules 24.29.1403, Selection of Physician; 24.29.1405, Physicians' Reports; 24.29.1420, Relative Value Fee Schedule; and 24.29.2001, Treatment and Reporting)	NOTICE OF ADOPTION AND REPEAL

1. On January 28, 1993, the Department published MAR Notice No. 24-29-38 at pages 107 to 130 of the Montana Administrative Register, Issue No. 2, in the matter of the proposed adoption of new rules I through XVII and the repeal of certain existing rules, all concerning medical services for workers' compensation.

2. On February 18, 1993, a public hearing was held in Helena concerning the proposed rules at which oral and written comments were received. Additional written comments were received prior to the closing date of February 26, 1993.

3. The Department has thoroughly considered the comments and testimony received on the proposed new rules. The following is a summary of the comments received, along with the Department's response to those comments:

Forty six parties submitted written comments to the Department during the comment period. Comments were received from medical providers, insurers, insurer representatives, an attorney, and associations representing providers. Twenty three persons made oral comments at the public hearing on these rules. Following the close of the comment period the Department met again with its advisory committee and discussed the comments received and the various concerns raised. In preparing the summary of the comments, the Department has attempted (where possible) to organize the various comments by the rule to which the comments pertain.

MATTERS OF GENERAL APPLICABILITY:

Comments: There were comments that were generally favorable to the rules proposed, as well as comments suggesting that the Department's entire approach to preparing these rules was fatally flawed and basically unfair.

Response: The Department thanks each party that took the time and effort to comment on these rules. The Department realizes that no set of regulations will be totally acceptable to all those affected by the rules. However, the Department, by use of an advisory committee composed of insurers and providers from different specialties, has tried to find a consensus

position among providers, insurers, and Department staff for these rules.

Comments: Several persons raised comments that indicate they are confused about the difference in the functions of the Department and the State Compensation Mutual Insurance Fund (the "State Fund").

Response: The Department of Labor and Industry, through its Employment Relations Division ("ERD"), is the regulatory agency for many workers' compensation matters. It regulates self-insured employers (Plan 1), private workers' compensation insurers (Plan 2), and the State Fund (Plan 3). The State Fund is, in effect, an insurance company that is owned and operated by the State of Montana. The State Fund is not a part of the Department of Labor and Industry and it does not perform any regulatory functions.

Comments: Several commenters raised concerns about the State Fund and how it (and perhaps other insurers) conduct business operations. Specific comments related to the training and qualifications of claims examiners, and the inability of providers to reach examiners by telephone.

Response: While the Department has certain regulatory authority in workers' compensation matters, it does not have general regulatory power over all claims management practices of insurers and adjusters. The Department does not believe it presently has the authority to require insurers (including the State Fund) to have specific education or training standards in place for their claims staff. Likewise, the Department does not have the authority to require that claims staff answer their telephones.

If an insurer (through its staff) acts unreasonably in its handling of a claim, recourse is available under the Workers' Compensation Act. Disputes between claimants and insurers will generally go to the Workers' Compensation Court (via mediation if a post July 1, 1987 claim). Disputes between providers and insurers will generally go to contested case proceedings held by the Department.

Comment: An organization of providers suggested that insurers should be able to decide which part of these rules they want to have applicable to them.

Response: The Department does not believe that insurers should be able to "pick and choose" which rules will apply to them. It is outside the Department's regulatory power to permit parties to "opt out" of rules they don't like.

Comment: A person suggested that because the Legislature is in session and considering bills that may substantially change the law, the Department should postpone further action.

Response: With all due respect for the Legislature and the commenter, the Department feels that it should not wait until the next round of bills become law. There is no assurance that bills addressing the subject matter of these rules will become law. Likewise, there is no indication that there would not be some period of time before those new laws (which have not yet been finalized) go into effect. The Department has been

developing these rules over the last 18 months, and feels that further delays are not in the best interests of the public.

Comments: Several persons indicated that they felt that the advisory committee had not agreed to some of the concepts or specifics proposed in these rules.

Response: The Department is deeply indebted to the volunteer members of the advisory committee for their many hours of work on these rules. However, the purpose of the advisory committee was to provide the Department with advice, comments, suggestions and input from providers and insurers. The Department is the regulatory body that has the non-delegable duty of deciding what these rules should say. While the Department values the input from all of the committee members and commenters, it has the ultimate responsibility for deciding what the rules will contain. In addition, there were some subjects on which the committee did not reach agreement.

Comment: Numerous providers objected that it was unfair to apply these rules to private practice therapists when they do not apply to hospital based providers.

Response: The Department feels that utilization RULES I through VI, VIII and IX apply equally to all providers, whether in a hospital setting or not. The fee schedule rules, RULES X through XVII, however, are for non-hospital services.

Comment: Several providers objected to the fact that hospital based providers may be reimbursed a different amount than non-hospital providers.

Response: The Department is aware of the fact that hospitals are reimbursed on a different basis than private practice providers. The Department intends to update the hospital fee rules in the near future. However, the Department feels that given the language of 39-71-704, MCA, which acknowledges that hospital services are different from those rendered by a physician, some differences in reimbursement methods are both inevitable and justified.

Comment: One provider questions why there might be different reimbursement for the same service (such as ultrasound) depending on whether the provider is a chiropractor, M.D., or a physical therapist.

Response: The Department feels that under current law, it is justified in setting different fees for services rendered by a physician and similar services rendered by a therapist.

Comment: A physical therapist commented that injured workers should have direct access to physical therapists.

Response: The treating physician is responsible for the overall medical management of the claimant. The Department feels that this suggestion goes beyond the scope of the Department's rulemaking authority and would require a statutory change to be implemented.

Comment: Several providers expressed frustration that different insurers wanted different kinds or items of information, thus making it difficult for office staff to handle the paperwork demands of various insurers.

Response: The Department sympathizes with the frustration expressed. These rules on documentation are intended to

minimize those frustrations. The rules are designed to spell out what information insurers may demand from providers. However, if an insurer does not want all the information, it is free to ask that a provider not send it. In that circumstance, a provider can then determine whether it is easier to send less information to that specific insurer, or to send out all of the information called for by rule. The Department does not intend to make "spot checks" to see that all of the information is being transmitted. The intent is to make sure that appropriate and adequate information is available to insurers.

Comment: Several comments were made that these rules don't provide for a remedy or a forum for resolving disputes.

Response: The forum for disputes depend on the vintage of the claim (law at the time of the injury) and who is involved in the dispute. The forums are specified in the Workers' Compensation Act and in ARM 24.29.207. Disputes between claimants and insurers will generally go to the Workers' Compensation Court (via mediation if a post July 1, 1987 claim). Disputes between providers and insurers will generally go to contested case proceedings held by the Department.

Due to the complexity of workers' compensation law and the variety of statutory provisions which are tied to the date of the claim, parties to disputes are urged to consider seeking the advice of their own legal counsel before deciding which forum is most appropriate for any given dispute.

RULE I PURPOSE

Comment: Many of the comments on these rules express general support for the efforts of the Department to make rules to help control medical costs in the workers' compensation system.

Response: The Department appreciates the time, interest, and support of all those persons who made an effort to provide the Department with input on these rules.

Comment: Several persons suggested that the purpose of these rules ought to include statements to the effect that quality care for injured workers is a requirement of "the system".

Response: The Department agrees with the comment and has amended the rule accordingly to remedy the oversight.

RULE II DEFINITIONS

Comment: Several persons noted that the rules did not define the term "provider", and suggested that it be defined.

Response: The Department agrees with the comment, and has added a definition of the term "provider".

Comment: One person suggested that the term "objective evidence" needed a definition.

Response: The Department agrees that a definition might be helpful. The Department has replaced the term "objective evidence" with the term "objective medical findings" and created a definition for it.

Section (2) comment: A person suggested that the definition of "improvement status" should make it explicit that

the status was to be with respect to the goals of the treatment plan.

Response: The Department agrees with the suggestion and has modified the definition.

Section (4) comment: Many comments were received concerning the definition of "prior authorization". The vast majority of these same commenters also commented on RULE III, section (3), too. The concern was whether prior authorization must be obtained for each procedure in a series of related procedures.

Response: The Department has clarified the definition by stating that a provider may seek prior authorization for a series of related procedures as well as for a specific procedure. The Department has also clarified the definition by stating that "prior authorization" is necessary only for the limited number of items specified by RULE VI.

Section (5) comment: A Family Nurse Practitioner comments that the use of the term "physician" is inappropriate as being too restrictive and excluding nurse practitioners. The same comments applied also to other places where the term "physician" or "treating physician" is used.

Response: The Department feels that the use of the term "physician", as defined, is consistent with the Workers' Compensation Act, but that expansion of the term would not be consistent with the Act and § 33-22-111, MCA. If a nurse practitioner is providing services pursuant to the direction of a "physician", that would be appropriate and acceptable under these rules.

Section (7) comments: Several physical therapists comment that the treating physician should not be required to spell out in detail the treatment plan that a physical therapist is to follow.

Response: The comments overlook the fact that the treating physician may defer to the professional judgment of a provider in a different field in the selection of particular methods of treatment. The Department directs the commenters attention to the last sentence of the definition.

Comment: A physical therapist suggests that the definition be made more specific as to who has responsibility for formulating the details required in a treatment plan.

Response: The Department feels that the definition is as specific as it can be, given the wide range of conditions that are treated under the Workers' Compensation and Occupational Disease Acts.

RULE III SELECTION OF PHYSICIAN

Comment: An insurer noted that there is pending litigation concerning the validity of existing ARM 24.29.1403, and questions whether this rule will meet judicial scrutiny.

Response: The Department is aware that there is pending litigation concerning ARM 24.29.1403, the existing rule, and that this rule may be held to be contrary to § 33-22-111, MCA. However, the Department feels that this rule should be adopted as part of the overall framework of utilization rules. In the

event this rule or ARM 24.29.1403 is found by the courts to be invalid, it will be amended or replaced by a rule that will satisfy the objections noted by the courts.

Section (3) comments: A physical therapist comments that he receives a prescription from a doctor before beginning treatment. That prescription is updated every 30 days. He feels that the prescription should be adequate authorization. He wonders what happens if the insurer does not authorize the referral to the physical therapist? Isn't that letting the insurer overrule the medical judgment of the treating physician?

Numerous providers also commented that requiring prior authorization for all referrals interferes with the sound medical judgment of the treating physician. Most of these comments also expressed dismay that prior authorization would cause delays in providing acute care services to injured workers.

Response: The Department agrees that the language as proposed was too broad. The Department has removed the language that requires prior authorization for all referrals. Matters for which prior authorization is required are described in RULE VI. However, the Department has repeated the requirement that prior authorization is required for a change of treating physician in this rule (as well as stating it in RULE VI) so that a person looking at the rule on selection of physician is put on notice of that requirement.

Comment: Several physical therapists comment that the requirement for prior authorization for all referrals (see previous comment) does not apply to referrals by a hospital based providers and thus is unfair to private practice therapists.

Response: The Department feels that the utilization rules apply to providers regardless of whether they are in a hospital or non-hospital setting.

Comments: One commenter suggested that the prior authorization requirement should be in section (2), and that a process for changing treating physician should be provided.

Response: The Department has provided a process for changing treating physician in RULE VI, prior authorization. The Department will add language to section (2) to clarify that a worker who wishes a change of treating physician must obtain prior authorization.

Comment: One commenter felt that it was unfair that after a worker selected a treating physician, that physician could transfer "treating" status to another physician.

Response: The Department can not force a physician to see or treat a worker. If a physician is no longer willing or able to accept the responsibilities of being the "treating physician", then the physician should discuss that fact with the worker. Typically that will occur when there is a specialist who is better suited to managing the worker's care, rather than when a physician wants to discontinue the doctor-patient relationship.

Comment: At least one provider questioned whether a consulting specialist could make referrals.

Response: Only the treating physician can make referrals. If the referral is truly for a consultation, then the treating physician remains responsible for the management of the worker's medical care. (That is not to say that the treating physician may not follow the advice and recommendations of the consultant.) However, if the intent is to transfer the responsibility for care and management to the consultant, then it is really a change in treating physicians. There is no prohibition against changing to a specialist for some period of time when the specialist is best suited to manage the case, and then changing back to the original physician when the specialist's services are no longer needed to manage the care. The only requirement is that prior authorization be obtained. The Department can not imagine many instances when such a request could be reasonably denied by an insurer.

RULE IV DOCUMENTATION REQUIREMENTS

General comment: Providers objected to having to fill out additional forms without being paid for their time in doing so. They objected to having to send out all notes and bills within two days of providing services to a claimant.

Response: The documentation requirements do not require use of additional forms. A provider's office notes, together with the billing, typically already contains all the information required by this rule. Once the claimant becomes an established patient, office notes and bills are to be sent to the insurer every thirty days, as required by existing rule ARM 24.29.1405. Office notes must accompany (or precede) the bill, so the insurer knows what happened at the visit it is being billed for. There is no requirement that notes and/or bills be sent out daily or weekly. The requirement of being sent "promptly" is intended merely to require that the notes be sent to the insurer in the normal course of business and without any undue delay.

Comment: A provider suggests that each provider be required to furnish their license number on their bill, to prevent unlicensed persons from billing for services.

Response: The Department feels that such a requirement is not appropriate. There is no single license system in Montana for all providers, and license numbers do not indicate which specialty they are from. The Department believes that this issue would be better addressed to the Legislature.

Comment: An association of providers suggests that electronic claim filing be exempted from this rule.

Response: The Department thanks the association for the comment, but declines to adopt the suggestion at this time.

Section (1) comments: Many providers object to the requirement that the initial bill be sent to the insurer within two business days of the first visit as being overly burdensome. Other comments indicated that providers felt that anything other than their regular billing cycle was burdensome, and some objected to the use of additional forms.

Response: The Department will change the time to seven business days. The Department will specify that the form to be used is the "report of initial treatment" appropriate to the

provider's specialty, rather than using the "appropriate ERD form" language.

Comment: Several providers expressed confusion over which providers fell within the scope of section (1).

Response: The Department has reworded the section to clarify that this section only applies to treating physicians and emergency room-type care providers.

Comment: An association of providers suggests that emergency rooms be exempted from this section.

Response: In many cases, the only treatment that a worker obtains or needs is that which is received from an emergency room or similar facility. A reasonably prompt report and bill is needed so that the insurer can begin the claims process.

Section (2) comments: Some providers objected to having to send in the treatment plan within two business days. Other providers objected that they can't decide what treatment is appropriate until they have a diagnosis.

Response: There is no "two day" requirement for treatment plans. The requirement of being sent "promptly" is intended merely to require that the treatment plan be sent to the insurer in the normal course of business and without any undue delay. Although a treatment plan may consist of a plan to first obtain a diagnosis (see definition in RULE II), the Department has clarified the intent of the rule.

Comment: Several physical therapists stated that it is not reasonable to require every change in the treatment plan be noted, since their treatment plan may change on a daily basis in response to the condition of the worker.

Response: The Department has clarified the rule to state that overall changes must be noted. The same concern is also addressed in a change in RULE V, section 1.

Section (3) comment: A chiropractor questioned whether supplemental reports will have to be furnished in addition to the documentation required by this rule.

Response: The existing rule which required supplemental chiropractic reports, ARM 24.29.2001, is being repealed as part of this rulemaking process.

Comment: A provider asked whether this rule meant that a worker must see the treating physician every 30 days.

Response: The rule is not intended to require the worker to see any provider at any set frequency, regardless of the medical need for a visit. The rule is intended to require that if a worker is seen by a provider, then the office notes and bill, plus the other items, must be sent to the insurer within a maximum of 30 days.

Section (4) comments: A physical therapist commented that the "special treatment" for health clubs and home health care services is unfair and inappropriate. He stated that there should be supervision of health club activities. He also suggested that home health care services be subject to Medicare criteria.

Response: The treating physician has the obligation to monitor these services, and remains responsible for providing the information showing that there is a medical need for them.

Montana law sets the parameters for when such services are appropriate; there is no statutory authority for the Department to make a rule imposing Medicare criteria.

Section (5) comments: A provider suggested that the rules should provide a way to compensate providers for the time spent in fulfilling the documentation requirements.

Response: The Department does not believe that providers should bill out their time spent in billing insurers. Presumably the provider keeps office or chart notes which contain the information concerning how the worker is progressing toward the treatment goals, and showing when the visit was made. Likewise, the Department presumes that sending out a bill for services is part of the customary office functions of the providers' business. No special charge is justified for these customary functions.

RULE V IMPROVEMENT STATUS

Comment: A physical therapist commented that her association supports the Department's rule which recognizes that sometimes there is no improvement, or negative improvement, despite ongoing treatment.

Response: The Department appreciates the comment.

Comment: A provider comments that it is unreasonable to require improvement on every visit.

Response: The rule does not require improvement; it requires information as how the worker is responding to the treatment.

RULE VI PRIOR AUTHORIZATION

General comments: Most providers felt that the proposed rule is burdensome and the process of obtaining prior authorization is too slow, causing hardship on claimants. Many of these comments were made in conjunction with comments concerning the need for prior authorization for all referrals (RULE III comments).

Some providers felt that "verbal authorizations" simply don't work. Other providers felt that requiring all authorizations to be in writing was unworkable, too.

Response: The Department has clarified the scope of when prior authorization is needed (see RULE III comments and responses).

Providers have a choice of requesting prior authorization either in writing or orally, as they do under existing practice. The Department recognizes that some providers will always seek authorization in writing, while others will typically seek verbal authorization.

Comment: Several physical therapists comment that not only must the treating physician get prior approval before referring a worker to the therapist, but the therapist must also get prior authorization before treating the worker.

Response: The Department's amendments to this rule and RULE III clarify that routine referrals for reasonable and appropriate physical therapy do not require prior authorization.

Comments: Several providers stated that allowing the insurer the right to require prior authorization amounts to letting the insurer practice medicine. Several providers questioned the competence of claims staff to make those decisions.

Response: As noted above, the rule as proposed was too broad, and has been substantially amended to limit the number of situations where prior authorization is required. However, the concerns expressed may still remain. The Department notes that the insurer can not be unreasonable in withholding authorization. If an insurer does not have legitimate reasons for withholding authorization, both the provider and the worker can challenge the insurers' decision. One of the comments and the response in the Matters of General Applicability addresses the issue of the forum for resolving the dispute.

Comment: A comment was received that additional rules should be developed that would clarify that the insurer may be liable for the medical consequences of denial of services.

Response: The worker has recourse against the insurer under the terms of the Workers' Compensation Act, and perhaps other law. The Department does not have regulatory authority to expand the remedies available to the worker. The rule states that: "The insurer may not unreasonably withhold its authorization." If the provider feels that the insurer has unreasonably withheld its authorization, it may resolve the dispute through a contested case hearing before the Department.

Comment: A physical therapist requested that guidelines be developed for what is "unreasonable withholding" of authorization.

Response: The rule states that reasonableness will be judged in light of the circumstances surrounding the medical procedure and the claim. Reasonableness must be judged on a case-by-case basis. The Department does not feel that any specific guidelines can be developed in this area. If the provider feels that authorization has been unreasonably withheld it may request a contested case hearing.

Comment: One physical therapist asked for clarification as to what specific information is required to get prior authorization.

Response: The request must contain enough information to allow the insurer to make an informed decision regarding authorization. Information that would be required will vary on a case-by-case basis depending on the nature of the claim and the circumstances of the request. The Department does not feel that it can detail what specific information might be required in any given case.

Comment: One physical therapist questioned how long prior authorization was good for.

Response: The provider and insurer should discuss if there are any limitations as to the length of time in which the service(s) are to be performed. How long the authorization is good for will vary on a case-by-case basis.

Comment: One person questioned who was responsible for notifying the referral physician that prior authorization had been granted.

Response: The Department expects that the treating physician would be in contact with the physician to whom the referral was made and would pass on the authorization.

Comment: A physical therapist comments that physicians will be unwilling to obtain prior authorization, and this will place the burden on the injured worker or his attorney.

Response: Only a limited number of activities require prior authorization. The Department does not feel that this rule will create a significant amount of additional work for the physicians and their office staff. The Department does not believe that physicians will decline to request authorization.

Comment: A question was received whether prior authorization guarantees payment for the procedures performed.

Response: While prior authorization will generally provide assurance that the services will be paid for by the insurer, there is no "guaranty" of payment. However, an insurer would have to have a compelling reason to deny payment for a service which it had authorized. The Department can imagine that an insurer might authorize a procedure, based on information that the service was related to the covered condition, only to later discover that the need for the service was due to a non-occupational condition. Recourse for the provider is available through contested case hearing if the provider believes that the insurer is unreasonably withholding payment for the services authorized.

Comment: A provider commented that the injured workers should be responsible for obtaining the prior authorization required in this rule.

Response: The Department believes that providers are in a better position than injured workers to be knowledgeable of prior authorization requirements. The Department believes that the public is better served by having the requirement remain with the provider.

Section (1) comments: A "reasonable period of time" is not defined.

Response: There is no arbitrary period of time that is, or is not, "reasonable". Reasonableness must be judged in light of the circumstances. However, there is a presumption in Section 2 that 14 days advance written request for authorization is a reasonable period of time. Nothing in the rule implies that a period of less than 14 days is unreasonable per se.

Comment: A physical therapist would like to see guidelines established for what is "unreasonable withholding" of authorization.

Response: The reasonableness of an insurer's actions can only be judged in the context of the facts surrounding the particular claim. Given the need for particularized consideration of those facts, the Department does not feel that such guidelines can be established by rule.

Comment: A comment was received expressing a concern that in the last sentence of Section (1), the "procedure" used should

not be a factor in deciding the reasonableness of the request, and that a claimant should not be thwarted by procedural hurdles.

Response: The Department will clarify its meaning by using the phrase "medical procedure" in the last sentence. The Department foresees that some medical procedures might, by their nature, necessarily have a shorter or longer "lead time" than others.

Comment: A physical therapist suggested that the rule should be changed to state the insurer "must" state the reason for denying prior authorization.

Response: The Department agrees with the suggestion and has amended the rule accordingly.

Section (2) comments: Several persons noted that the rule as proposed could let the insurer wait until the day of a procedure to deny authorization, even though more than 14 days have elapsed.

Response: The Department will change the rule so that if written authorization is sought, the insurer must respond within 14 days or else the authorization is automatically granted. Denials made during the last three days of the 14 day period must also be made by telephone or fax. The Department hopes that insurers will make every effort to respond to written requests sooner than in 14 days, but feels that two weeks is a reasonable time in which to respond. Providers will continue to have the option of seeking verbal authorization, which will be a speedier way of getting authorization for procedures.

Comment: Several providers complained that the rule will allow a "pocket authorization" whereby insurers will just let the 14 days expire, rather than giving the authorization in a more timely manner.

Response: The Department feels that the rule strikes a reasonable compromise between no rule, a rule that doesn't provide for a default authorization, and a rule that imposes a more stringent response time. The Department feels that with the clarification of this rule and RULE III, a workable system is being adopted. The Department also notes that insurers have a self-interest in seeing that workers receive treatment as promptly as possible, with the goal of the worker returning to the workplace (and getting off wage loss benefits) as soon as possible.

Section (3) comment: A medical provider suggested that the insurer should be responsible for confirming that prior authorization was granted verbally, instead of the medical provider.

Response: The Department notes that the provider is not required to send a confirmation to the insurer. The Department believes that it is in the provider's own interest to confirm the verbal authorization. In the event of a dispute, many providers would hesitate to have to rely upon an insurer having protected the provider's interests by writing a confirming letter. This rule is intended to establish an evidentiary burden of proof in the event of a dispute going to contested case proceedings.

Section (4)(a) comment: A provider notes that this section is confusing and unclear as to its intent and meaning.

Response: The Department agrees with the observation and has amended the section to clarify the meaning.

Sections (4)(b) and (c) comments: A provider questions whether they would be forced to turn a patient away once they found out that the patient has not been treated for a workers' compensation injury within the last six months, or has reached maximum medical healing.

Response: The provider may need to review their medical records for the worker and obtain authorization if needed prior to the appointment. The provider may wish to inquire whether the condition is work-related and a new or old injury, if the worker is a new patient. If the worker is already there for the appointment, the provider may call the insurer and get authorization.

Section (4)(e)(iv) comment: One physical therapist commented that a time limit should be placed on memberships in health clubs.

Response: The treating physician remains responsible for the overall medical management of the patient and can place limitations on health club memberships as they feel appropriate. The Department does not feel revision of the rule is necessary to clarify this issue.

Section (4)(e)(vi) comment: A physician feels it will be burdensome for physicians to document the length of time a patient has been on pain medication.

Response: The treating physician is responsible for the overall medical management of the patient. Therefore, their medical file should contain sufficient documentation regarding prescriptions to determine if the patient has been on pain medication for a period of six months. The Department does not feel that this will cause the provider to be unduly inconvenienced.

Section (4)(e)(viii) comment: Several physical therapists comment that this would indicate that prior authorization is required before one physical therapist could "cover" for a sick or vacationing colleague, even if in the same office or clinic.

Response: The rule is intended to require prior authorization for a permanent change from one provider's specialty practice to the specialty practice of a different provider. The Department will clarify the rule by stating that an occasional and temporary change in provider due to illness, vacation or emergency does not require prior authorization.

Rule VII SECOND OPINIONS

Comment: A provider association suggested the rule be amended to allow the injured worker to also obtain a second opinion.

Response: The Department feels the current workers' compensation law allows an injured worker to request a second opinion or undergo any medical procedure at the worker's own expense. To the extent the commenter suggests that a worker should be permitted a right to a second opinion at the expense

of the insurer, the Department believes that it does not have the authority to make such a rule. Nothing in the rule prohibits an insurer from paying for a worker-requested second opinion.

RULE VIII MEDICAL EQUIPMENT AND SUPPLIES

Comment: Two comments were received stating that the 30% - $30.00 provision was unreasonable and arbitrary. One provider stated that $30.00 is not sufficient to cover the cost of assembling or fitting a $2,500.00 wheel chair.

Response: The Department's intent was to limit the mark-up on goods where there is no "value added" by the provider. The Department has amended the rule to exclude hospitals, pharmacies and supply houses. If a provider adds value to an item (such as complex assembly, modifications or special fabrication) then that is service for which a reasonable fee can be charged. Merely unpacking an item is not a "value added" service. While extensive fitting of devices may be billed for, simple fitting (such as adjusting the height of crutches) is not billable. Based upon discussions with the advisory committee, the Department believes that the limitation in the rule is reasonable.

Comment: Insurers and providers should be allowed some flexibility as to whether invoices must be sent with every bill for goods.

Response: The Department has amended the rule to allow insurers to decide if they want an invoice on any given item.

RULE IX DISALLOWED PROCEDURES

Comments: A chiropractor suggested the Department look to the licensing boards for guidance in making determinations regarding disallowed procedures.

Response: The Department agrees licensing boards are an excellent source for guidance in this area. However, the Department feels the language of the rule as proposed does not preclude the department from utilizing licensing boards as well as other knowledgeable sources in the medical community to determine if procedures should be disallowed because the procedure is not generally accepted.

Comment: A medical doctor testified in support of the proposed rule to specifically disallow thermography as a payable procedure. The doctor also submitted written material from medical publications in support of his comments.

Response: The Department appreciates the support from the doctor in regards to this rule.

RULE X USE OF FEE SCHEDULES

Comment: An association of providers suggested the Department adopt the Health Care Procedure Coding System (HCPCS) in order that unique coding systems are not fostered for workers' compensation.

Response: The Department is aware that hospital and non-hospital medical providers will be reimbursed on a different basis. The Department intends to update the hospital rules in

the near future based on legislation which may be passed by the 1993 legislature. However, the language in 39-71-704, MCA, specifically recognizes services provided by hospitals are different from services provided by non-hospital medical providers. Therefore, differences in reimbursement will naturally and justifiably occur.

Comment: The association also commented that coding disputes should not serve as a reason to delay payments. It suggested the rule require payment to be made, disputes resolved by the Department retrospectively, and adjustments to payments be made retroactively.

Response: The Department thanks the association for bringing this concern to light. However, this subject did not surface during the discussions with the advisory committee in the development of these rules. Adding a rule relating to this issue would represent a significant change to the rules as proposed and would require rewriting and renoticing the rules. This suggestion will be taken under advisement by the Department and may be noticed in new rules at some time in the future.

Comment: An association of private insurers also suggested that medical fee schedules are better tied to the relative value schedules for the federal Medicare programs which provides a more efficient and adaptable method of regulating fees.

Response: Various methodologies were discussed by the advisory committee formed by the Department to obtain advice in regards to the rule. The consensus was to adopt the Relative Values for Physicians (RVP) system. The primary reasons for this decision were the relative values are updated on a quarterly basis which will keep the system current and the system utilizes the Current Procedural Terminology (CPT) codes which are generally in use by non-hospital medical providers in Montana. In addition, Medicare cost increases are not limited to increases in the state average weekly wage.

Comment: Several physical therapists who commented suggested the rules be revised to add a provision which would preclude an insurer from recoding bills for services submitted by medical providers.

Response: The Department agrees the insurer should not recode procedures billed unless it is evident that the bill has been miscoded. If insurers are improperly recoding bills, the provider has the option to request a contested case hearing before the Department. The Department feels, similar to the response to a comment relating to the potential for delay of payments resulting from coding disputes, that adding a rule relating to this issue would represent a significant change to the rule as proposed which would require renoticing the rule. The comment will also be taken under advisement and considered for future revisions of this rule.

Comment: A chiropractor commented that, for the same service, all medical providers who are authorized to perform the service should receive the same fee.

Response: The Department feels that under current law, it is justified in setting different fees for services rendered by

a physician and similar services rendered by a another type of medical service provider.

Comments: A commenter suggested that physical therapists should not be allowed to use the relative value for physicians fee schedule.

Response: The Department has developed a separate fee schedule for physical therapists and occupational therapists, RULE XVII. Those providers are not allowed to use the Relative Value for Physicians established in this rule.

Comment: A physician questioned how physician assistants and nurse practitioners are paid under the fee schedule.

Response: Section (1)(c) addresses this question. The appropriate CPT procedure code (but not the unit value) should be used for the service and the fee charged must be "reasonable". Section (9) states that when a procedure is not covered by these rules, a reasonable fee may not exceed the usual and customary fee charged to non-workers' compensation patients.

RULE XI CONVERSION FACTORS - METHODOLOGY

Comment: An association of private insurers stated they did not support tying fee schedules to the state's average weekly wage because there is no factual basis to link the average weekly wage and medical costs as a control on escalating medical costs. The association suggested it would be more appropriate to use the Medicare fee schedule.

Response: The Department appreciates the concern expressed by the association, however 39-71-704 (4), MCA, clearly restricts the increase in medical costs payable to the annual percentage increase in the state's average weekly wage.

RULE XII ACUPUNCTURE FEES

No specific comments were received on this rule.

RULE XIII DENTAL SPECIALTY AREA FEES

No specific comments were received on this rule.

RULE XIV PHYSICIAN FEES -- MEDICINE

General comments: A physician objected to having to fill out additional forms without being paid for his time in doing so. He particularly found paperwork submitted by rehabilitation providers to be burdensome.

Response: Physicians may charge for time spent reviewing rehabilitation reports and commenting on job descriptions, using the appropriate procedure code and unit value.

Comment: An insurer commented that it felt that it was improper to include chiropractors in the same rule as medical doctors. The insurer continued by suggesting that because the Current Procedural Terminology ("CPT") was developed by a physician group, it should not be used by chiropractors.

Response: The Department believes that, given the current state of workers' compensation law, which allows chiropractors treating physician status and grants them equal status with medical doctors, it would not be proper to restrict the scope of

their practice beyond what is permitted under their licensing laws. To the extent that the CPT describes the services that chiropractors perform, it seems that it would be inefficient for insurers to have to use a different set of codes for chiropractic service billing.

Comment: The insurer also commented that it was concerned that allowing chiropractors to bill for a full range of services would cause medical costs to rise by more than the amount allowed by law.

Response: The Department believes that its rules are consistent with the 1991 amendments to 39-71-704(4), MCA [Chapter 574, L. 1991]. The Department contends that overall medical costs under these rules will be within the statutory limits. The new fee schedule in these rules contains many procedures which were not included in the "old" fee schedule, and thus the Department believes that costs will be reduced as many more services become subject to the fee schedule. Likewise, the utilization rules will help reduce the overall growth of medical costs.

The Department has been advised that chiropractic fees account for only 4% of the State Fund's medical costs, with fees for medical doctors and hospitals accounting for 92% of costs. The remaining 4% of costs come from physical therapy and occupational therapy costs. Assuming that the State Fund's experience with medical costs is reasonably representative of all insurer's costs, the Department believes that even a significant percentage growth of current chiropractic costs will not outweigh the savings obtained by adoption of these rules.

RULE XV PHYSICIAN FEES -- ANESTHESIA SPECIALTY AREA

No specific comments were received on this rule.

RULE XVI PHYSICIAN FEES -- CHIROPRACTIC EVALUATIONS

No specific comments were received on this rule.

RULE XVII PROVIDER FEES -- OCCUPATIONAL AND PHYSICAL THERAPY SPECIALTY AREA

General comments: Several providers suggested that the Department use fees and codes that had been previously agreed to by the State Fund.

Response: The Department has an independent regulatory function and obligation which it can not delegate to private individuals or other organizations. The Department believes that its overall approach to implementing these fee schedule rules is in the best interests of the workers' compensation system and the people of Montana.

Comment: A physical therapist suggested that chiropractors, physicians, and occupational therapists not be allowed to practice physical therapy.

Response: Many of the physical therapy procedures are within the scope of the licensure of chiropractors, physicians, and occupational therapists. The fact that there may be an overlap of certain procedures does not, in the Department's opinion, mean that other providers are "allowed to practice

physical therapy". To prohibit those providers to perform procedures would be outside of the scope of the Department's rulemaking authority and would require legislative change. The Department believes that the concern expressed is better addressed by the appropriate professional licensing bodies that regulate the various medical specialties.

Comments: Numerous comments were received recommending that occupational therapists be removed from this rule. Several physical therapists stated that they were "insulted" by the inclusion of occupational therapists in the rule. Still other comments advised that the specific codes which occupational therapists can perform should be identified within the fee schedule in some manner. Other comments received recommended that the occupational therapists remain part of this rule.

Response: The Department recognizes that many providers have strongly held beliefs on this topic. The Department recognizes that while some of the codes in the fee schedule may be used by occupational therapists, there are others that are outside the scope of occupational therapy practice.

The rule prohibits a provider from billing for a procedure that is outside of the provider's scope of licensed practice. Performing or billing for a procedure outside of a provider's scope of practice is unethical and could result in action taken by the provider's licensure board. It is the opinion of the Department that the professional licensing boards, rather than the Department, are better equipped to decide what constitutes the scope of a field of practice, as well as providing a more appropriate forum for those disputes.

The Department believes that the rule as proposed also appropriately accommodates any pending legislative and statutory changes to the occupational therapy laws. The Department respectfully declines to change the scope of this rule.

Comment: A suggestion was made that physical therapy evaluations should be required at the onset of treatment of every injury.

Response: The Department notes that the treating physician is responsible for the overall medical management of the injured worker. The physician determines the medical needs of the worker and can refer the injured worker to a physical therapist. The Department does not presently have the regulatory authority to enact the suggested requirement.

Comments: Comments were also received that the physical and occupational therapy fee schedule did not reflect the increase of 4.02% for 1992 required by 39-71-704(4), MCA (1991).

Response: The Department disagrees with the implication that any specific increase in fees is mandated by law. Section 39-71-704 (4), MCA, states in part: "After December 31, 1991, the percentage increase in medical costs payable under this chapter may not exceed the annual percentage increase in the state's average weekly wage . . . ." The Department believes that there is no requirement that specific, individual fees go up.

These rules adopt a new coding system, based on the RVP. There is no direct, code-to-code comparison of procedures

allowed under the "old" versus the "new" system. The Department believes that given the inherent change involved in conversion from one coding system to another, there will naturally be certain procedures which, when viewed by themselves, are inequitable when the fees under one system are compared to the fees under the other system. However, the Department believes, based upon the advice of the members of the advisory committee and the recommendations of its own staff, that the overall fee schedule is appropriate and fair.

Section (4) comments: As noted above, many providers objected to the requirement that prior authorization was required for referral to physical or occupational therapy.

Response: The Department has amended the rule to eliminate the requirement that the initial referral have prior authorization.

Section (6) comment: A comment was received that, while the time element allowed within procedures was eliminated, section (6) was still referencing time.

Response: Certain procedure codes still contain a time element. The Department believes that section (6) should remain in the rule.

Section (7) comments: Comments were received that the definitions contained within some procedure codes were redundant or would lead to confusion over which codes should be used when billing. The commenters suggested that more clear and concise definitions were needed.

Response: The Department agrees that certain codes in the proposed fee schedule are redundant and has removed 98950 and 97772 from the rule. Definitions for many of the procedures that are contained in the fee schedule were drafted with the assistance of the Montana Chapter of the American Physical Therapy Association, and the Department has in many instances relied on their expertise in this matter. The Department thanks the Chapter for its many hours of advice and assistance.

Comment: Several physical therapists urged the Department remove the combination codes from the occupational and physical therapy fee schedule.

Response: The Department feels that when the provider is performing multiple procedures in the same visit, economies of scale can be realized because of time savings of performing multiple procedures. The Department has carefully considered these suggestions. Department staff met with the advisory committee on March 4, 1993. Committee members received a copy of all the oral and written testimony presented concerning the hearing as well as all of the written comments received by the Department. At the meeting the physical therapy provider member(s) representing the Montana Chapter of the American Physical Therapy Association felt that the reimbursement schedule, as modified in the March 4 meeting, provided for adequate compensation. Based on their expert input, and the recommendation of staff, the Department declines to make further changes to the rule in these areas.

Comments: A comment was received that insurers should not be able to recode procedures that providers have included on

their bills. An insurer representative opposes letting physical therapists "unbundle" combined procedures.

Response: The Department agrees the insurer should not recode procedures billed unless it is evident that the bill has been miscoded. If an insurer improperly recodes a bill, the provider has the option of requesting a contested case hearing before the Department.

Comment: Several people commented that their billing procedures are computerized and they would have difficulty programming procedure codes 97200 and 97301 due to their complexity. Consequently, they might have to resort to manually adjusting bills for these procedures. New definitions were also suggested for procedure codes 97200 and 97301.

Response: The Department recognizes the complexity of codes 97200 and 97301. These codes were developed in conjunction with the input of physical and occupational therapists. Based on these comments, the Department has, in conjunction with the advice from the Montana Chapter of the American Physical Therapy Association, adopted new definitions for these procedure codes. The Department hopes these changes to the definitions of these procedures will make these codes easier for providers to include in their computerized billing programs.

Comment: One provider commented that the Department should add procedure codes for telephone consultations.

Response: While the Department recognizes that additional procedures may be performed that are not listed in the fee schedule, it feels that the most commonly used procedures are included. Procedures not otherwise covered may be billed using 97799.

Comment: A question was received regarding how a provider would bill for the time required to fit and instruct a patient in the use of equipment or supplies under code 97880.

Response: In response to this and other similar concerns the Department has amended Rule VIII to allow providers to be reimbursed for adding value to the medical equipment or supplies being furnished. Services provided that are not covered by a specific procedure code can be billed under 97799.

Comment: A question was raised regarding whether procedure codes 97544 and 97546 require that the therapist actually supervise the worker the entire time the procedure is performed.

Response: The Department feels that the therapist is in the best position to exercise the professional judgment as to what supervision is appropriate. The provider remains obligated to follow, at a minimum, the standard of care required by that provider's profession.

Comments: Comments were received from physical therapists that when comparing the unit values of various procedures, the relative unit values do not reflect the complexity or time required to perform the procedure. Some physical therapists suggested the Department consider raising the unit values to reflect adequate reimbursement for overhead and equipment costs. Other suggestions were that more complex or time consuming procedures should be reimbursed at a higher rate. As an example

the provider contends that the hubbard tank should be reimbursed at a higher rate than pool therapy while 97241 includes group pool therapy or hubbard tank at the same relative unit value. A provider suggests "hands on" procedures performed by a licensed physical therapist should be compensated at a higher rate than treatment performed by an aide or non-professional.

Several providers suggested the Department should consider raising or lowering the relative unit values associated with various procedures. The procedure codes identified and the comments made were: Additional time codes associated with 97200 and 97301 need to be added to allow for adequate reimbursement; unit values should be increased to 9 or 10 for 97200 and 12 to 13 for 97301; additional time codes were also suggested for 97110, 97112, 97114, and 97116; 97050, 97200, and 97301 do not allow for adequate reimbursement for comprehensive treatment to multiple areas; 97134 is valued too high; 97010 through 97050, 97241, 97544, 97546, 98950, 98951, and 99085 are valued too low; 8.5 units was suggested for 97544 and 97546; 3.5 units was suggested for 98950, 98951, and 99085; and the maximum hours allowed under 97770 should be raised to 8.

Response: The Department has carefully considered these suggestions. Department staff met with the advisory committee on March 4, 1993. Committee members received a copy of all the oral and written testimony presented concerning the hearing as well as all of the written comments received by the Department. At the meeting the physical therapy provider member(s) representing the Montana Chapter of the American Physical Therapy Association felt that the reimbursement schedule, as modified in the March 4 meeting, provided for adequate compensation. The Department has adjusted codes 97200, 97301, 97544, 97546, 97752, and 97762. Based on their expert input, and the recommendation of staff, the Department declines to make further changes to the rule in these areas.

"RULE XVIII" (NO RULE PROPOSED)

Comment: Several physical therapists commented on this "rule".

Response: It appears that these commenters were responding to an earlier draft of these rules, and not the text as officially noticed.

MISCELLANEOUS COMMENTS:

Comment: One physician noted that the rules do not make provision for an anonymous hotline to report abuses by claimants, providers and lawyers. The comment suggests that the rules include the hotline and that it be highly publicized.

Response: The Department has such a toll-free hotline already, 1-800-WC ABUSE [1-800-922-2873]. This "fraud hotline" does not need to have an administrative rule to be in existence. The Department will endeavor to further publicize the existence of the hotline and encourage its use to the greatest extent possible, within the budgetary constraints of the Department.

Comments: The responsibilities of the injured worker should be more clearly spelled out. Workers who don't show up for appointments should have their benefits stopped.

Response: Most of the workers' obligations are detailed in the statutes. The Department does not have regulatory authority over benefit termination.

Comment: The Department's rules do nothing to educate illiterate workers about their duties under the law.

Response: The Department strongly encourages all employers, insurers, and providers to provide information to illiterate workers. One role of the Department is to provide information to the general public on workers' compensation matters. However, that function is outside the scope of these rules.

Comment: A provider notes that sometimes workers don't specify that the injury is work related. Othertimes, the worker fails to file a claim after receiving treatment. Sometimes injured parties insist that non-work related injuries be billed to workers' compensation insurers.

Response: The Department sympathizes with providers, but it can not force a worker to file a claim. A provider should not send in bills that are clearly not related to on the job conditions. The Department encourages providers, employers and insurers to report suspected cases of fraud and abuse to the Department and the affected insurer.

Comment: Several persons commented on differences between the "matrix" and these rules.

Response: The "matrix" is not a part of these rules. The Department and its advisory group developed the matrix as a tool to help draft the utilization rules. It appears that the same persons who commented on the matrix also based their other comments on draft versions of these rules rather than on the officially noticed text.

Comments: One person suggested that the Department make rules to allow insurers or rehabilitation providers to refer workers for Functional Capacity Evaluations. Another suggested that employers should be allowed to authorize medical procedures.

Response: The Department thanks these commenters for these suggestions. The Department feels, however, that these suggestions are outside of its rulemaking authority, given the statutes in existence.

4. After consideration of the comments received on the proposed rules, the Department has adopted, the new rules either as proposed, or with the following changes as noted (new material is underlined, deleted material is interlined):

RULE I [24.29.1501] PURPOSE (1) The purpose in developing utilization rules is to ~~address the rising cost of medical services in workers' compensation~~ assure that appropriate quality and cost effective medical services are available to individuals injured on the job. Health care programs outside the workers' compensation arena such as the

federal Medicare and Medicaid programs, as well as private health insurers, have had medical cost containment measures in place for some time. While reimbursement for medical services will continue to be based on fee ~~service~~ schedules, the need for cost containment measures similar to those implemented in the non-workers' compensation area has been recognized.

(AUTH: Sec. 39-71-203, MCA; IMP: Sec. 39-71-704, MCA.)

RULE II [24.29.1504] DEFINITIONS As used in this subchapter, the following definitions apply:

(1) Same as proposed.

(2) "Improvement status" means written information that is complete, clear, and legible, which identifies objective ~~evidence~~ medical findings of the claimant's medical status with respect to the treatment plan.

(3) Same as proposed.

(4) "Objective Medical Findings" means medical evidence that is substantiated by clinical findings. Clinical findings include, but are not limited to, range of motion, atrophy, muscle strength, muscle spasm, and diagnostic evidence. Complaints of pain in the absence of clinical findings are not considered objective medical findings.

~~(4)~~(5) "Prior authorization" means that for those matters identified by Rule VI the provider receives (either verbally or in writing) authorization from the insurer to perform a specific procedure or series of related procedures, prior to performing that ~~specific~~ procedure.

~~(5)~~(6) "Physician" means those persons identified by section 33-22-111, MCA, practicing within the scope of the providers' license.

(7) "Provider" means any health care provider, unless the context in another rule clearly indicates otherwise. "Provider" does not include pharmacists nor does it include a supplier of medical equipment who is not a health care provider.

~~(6)~~(8) "Treating physician" means the physician selected in accordance with RULE III.

~~(7)~~(9) "Treatment plan" means a written outline of how the provider intends to treat a specific condition or complaint. The treatment plan must include a diagnosis of the condition, the specific type(s) of treatment, procedure, or modalities that will be employed, a timetable for the implementation and duration of the treatment, and the goal(s) or expected outcome of the treatment. Treatment, as used in this definition, may consist of diagnostic procedures that are reasonably necessary to refine or confirm a diagnosis. The treating physician may indicate that treatment is to be performed by a provider in a different field or specialty, and defer to the professional judgment of that provider in the selection of the most appropriate method of treatment; however, the treating physician must identify the scope of the referral in the treatment plan and provide guidance to the provider concerning the nature of the injury or occupational disease.

(AUTH: Sec. 39-71-203, MCA; IMP: Sec. 39-71-704, MCA.)

RULE III [24.29.1511] SELECTION OF PHYSICIAN

(1) Same as proposed.

(2) The worker has a duty to select a treating physician. Initial treatment in an emergency room or urgent care facility is not selection of a treating physician. The selection of a treating physician must be made as soon as practicable. A worker may not avoid selection of a treating physician by repeatedly seeking care in an emergency room or urgent care facility. The worker should select a treating physician with due consideration for the type of injury or occupational disease suffered, as well as practical considerations such as the proximity and the availability of the physician to the worker. A worker must obtain prior authorization before changing treating physician.

(3) Only the treating physician may refer an injured worker to another ~~health care~~ provider. ~~Except in an emergency, the treating physician must obtain prior authorization before making a referral.~~ The treating physician remains responsible for the overall medical management of the injured worker, despite the referral. If the treating physician transfers that responsibility to another physician, the physician loses the status of being the worker's "treating physician" and will not be able to make referrals. Prior authorization is required for change of treating physician.

(AUTH: Sec. 39-71-203, MCA; IMP: Sec. 39-71-704, MCA.)

RULE IV [24.29.1513] DOCUMENTATION REQUIREMENTS (1) ~~If the provider is seeing~~ When a treating physician, emergency room or similar urgent care facility sees the claimant for the first time (related to the claim) ~~other than on referral~~, the provider must furnish to the insurer the initial report and ~~initial~~ treatment bill ~~for their specialty area~~ on the appropriate ~~ERD~~ first report of treatment form within ~~2~~ 7 business days of the visit.

(2) ~~By not later than the second visit~~ As soon as possible, upon completion of the initial diagnostic process, the provider must prepare a treatment plan and promptly furnish a copy to the insurer. Changes in the overall treatment plan must be noted and a copy of the amended treatment plan must be promptly furnished to the insurer.

(3) To be eligible for payment for ~~the second and any~~ subsequent visits, the provider must furnish to the insurer:

(a) Same as proposed.

(b) improvement status with respect to the treatment plan; and

(c) Same as proposed.

(4) (a) Certain treatment plans may require services be obtained from a vendor that is outside the tradition of being a professional health care provider. Under that circumstance, the treating physician has the obligation to include the need for the service in the treatment plan and furnish improvement status as appropriate. The vendor, however, is responsible for furnishing documentation.

(b) Same as proposed.

(5) Same as proposed.
(6) Same as proposed.
(AUTH: Sec. 39-71-203, MCA; IMP: Sec. 39-71-704, MCA.)

RULE V [24.29.1515] IMPROVEMENT STATUS (1) Improvement status must identify objective ~~evidence~~ medical findings of the claimant's medical status, and note the effect of the medical services (positive, neutral, or negative), with respect to the goals of the treatment plan.

(2) If there are any significant changes in the treatment plan, that fact must be noted and described.
(AUTH: Sec. 39-71-203, MCA; IMP: Sec. 39-71-704, MCA.)

RULE VI [24.29.1517] PRIOR AUTHORIZATION (1) When prior authorization is required, the provider must request the authorization a reasonable amount of time in advance of the time the procedure is scheduled to be performed. The request must contain enough information to allow the insurer to make an informed decision regarding authorization. The insurer may not unreasonably withhold its authorization. An insurers' denial ~~should~~ must contain an explanation of the reasons for its denial. Reasonableness will be judged in light of the circumstances surrounding the medical procedure and the claim.

(2) If a provider makes a written request for prior authorization at least 14 days prior to the date the service is scheduled to be performed, authorization is presumed to be given by the insurer if there is no written denial sent by the insurer to the provider ~~before~~ within 14 days of the date the ~~procedure is to be done~~ written request was mailed. If the written denial is made within three days of the ~~date the procedure is to be performed~~ expiration of the 14 day response period, the insurer must also notify the provider of the denial by telephone or facsimile ("fax").

(3) Same as proposed.
(4) Prior authorization is required when:
(a) the provider to whom the referral is made is ~~not the treating physician~~ a consulting specialist; or
(b) Same as proposed.
(c) Same as proposed.
(d) Same as proposed.
(e) any of the following is proposed:
(i) Same as proposed.
(ii) Same as proposed.
(iii) Same as proposed.
(iv) Same as proposed.
(v) Same as proposed.
(vi) pain medication is being prescribed for a period of six months or longer;
(vii) Same as proposed.
(viii) a permanent change ~~of therapist~~ from one provider's specialty practice to the specialty practice of a different provider, for treatment of the same injury. The occasional and temporary change of provider due to illness, vacation, or emergency, does not require prior authorization;

(ix) any physical rehabilitation program involving work hardening, physical restoration, or similar programs; or

(x) Same as proposed.

(5) Same as proposed.

(6) Same as proposed.

(AUTH: Sec. 39-71-203, MCA; IMP: Sec. 39-71-704, MCA.)

RULE VII [24.29.1519] SECOND OPINIONS

(1) Same as proposed.

(2) Same as proposed.

(3) For the purpose of this rule, a qualified provider is one who is board-certified or board-eligible in a specialty that is reasonably related to the service or procedure for which the second opinion is sought.

(AUTH: Sec. 39-71-203, MCA; IMP: Sec. 39-71-704, MCA.)

RULE VIII [24.29.1521] MEDICAL EQUIPMENT AND SUPPLIES

(1) Reimbursement for ~~physician~~ provider supplied ~~items~~ medical equipment and supplies is limited to the lesser of $30.00 or thirty percent (30%) above the cost of the item including freight, except prescription medicines are limited to charges allowed under section 39-71-727, MCA. An invoice documenting the cost of the equipment or supply must ~~accompany the billing~~ be sent to the insurer upon the insurer's request.

(2) If a provider adds value to medical equipment or supplies (such as by complex assembly, modification, or special fabrication) then the provider may charge a reasonable fee for those services. Merely unpacking an item is not a "value-added" service. While extensive fitting of devices may be billed for, simple fitting (such as adjusting the height of crutches) is not billable.

(3) This rule does not apply to equipment supply houses that are not also health care providers, hospitals, or pharmacies.

(AUTH: Sec. 39-71-203, MCA; IMP: Sec. 39-71-704, MCA.)

RULE IX [24.29.1526] DISALLOWED PROCEDURES

Same as proposed.

RULE X [24.29.1531] USE OF FEE SCHEDULES

Same as proposed.

RULE XI [24.29.1536] CONVERSION FACTORS - METHODOLOGY

Same as proposed.

RULE XII [24.29.1541] ACUPUNCTURE FEES

Same as proposed.

RULE XIII [24.29.1551] DENTAL SPECIALTY AREA FEES

Same as proposed.

RULE XIV [24.29.1561] PHYSICIAN FEES -- MEDICINE

Same as proposed.

RULE XV [24.29.1566] PHYSICIAN FEES -- ANESTHESIA SPECIALTY AREA Same as proposed.

RULE XVI [24.29.1571] PHYSICIAN FEES -- CHIROPRACTIC EVALUATIONS Same as proposed.

RULE XVII [24.29.1581] PROVIDER FEES -- OCCUPATIONAL AND PHYSICAL THERAPY SPECIALTY AREA (1) Same as proposed.

(2) Same as proposed.

(3) Same as proposed.

(4) ~~In addition to needing prior authorization for the initial referral for occupational and physical therapy,~~ eOccupational and physical therapists must obtain prior authorization for any of the following procedures:

(a) 97544, work hardening;

(b) 97546, work conditioning;

(c) 97750, off-site therapy;

(d) 97751, off-site equipment;

(e) 97764, job site visit; or

(f) 97770, physical capacity evaluation.

(5) Same as proposed.

(6) Same as proposed.

(7) The following special procedure codes, with the associated description and unit values, are recognized for physical medicine services:

	Procedure Code	Description	Unit Value
(a)	Same as proposed.		
(b)	Same as proposed.		
(c)	Same as proposed.		
(d)	Same as proposed.		
(e)	Same as proposed.		
(f)	Same as proposed.		
(g)	Same as proposed.		
(h)	97200	treatment involving ~~two~~ one or more procedures from group A below, and ~~including~~ at least one procedure also in group B Group A: 97010-97039; 97118-97139; 97260 (minutes n/a); 97261 (minutes n/a) Group B: 97118-97139; 97260 (minutes n/a); 97261 (minutes n/a)	6.8
(i)	Same as proposed.		
(j)	Same as proposed.		
(k)	Same as proposed.		
(l)	97301	treatment involving ~~two~~ one or more procedures from group A below, and ~~including~~ at least one procedure also in group B	9.5

		Group A	Group B	
		97110	97118-97139	
		97112	97260 (minutes n/a)	
		97114	97261 (minutes n/a)	
		97116		
(m)	Same as proposed.			
(n)	Same as proposed.			
(o)	Same as proposed.			
(p)	97540	training in activities of daily living (self care skills and/or daily life management skills); each visit		6.6
	97544	work hardening; each 1 hour [an individualized, therapist-supervised, work-oriented treatment process involving the worker in simulated or actual work tasks which are structured and graded to progressively increase physical tolerances, adaptability, pacing, knowledge of task performance, body-mechanics, efficiency, endurance, and productivity to return-to-work goals. To be conducted only when a job has been identified for the worker to return to and specific job demands have been identified through a job analysis.] Other services are billable separately from work hardening.	~~5.5~~	8.5
	97546	work conditioning; each 1 hour [an individualized, therapist-established and -supervised therapeutic exercise program which may include aerobic conditioning, education, limited work tasks and simulation, and progressive resistive functional exercises.]	~~5.5~~	8.5
(q)	Same as proposed.			
(r)	Same as proposed.			
(s)	Same as proposed.			
(t)	97750	physical or occupational therapy provided outside usual location of practice		12.0
	97751	physical or occupational therapy equipment and personnel provided outside usual location of practice		12.0
	97752	muscle testing with torque curves during isometric and isokinetic exercise, mechanized or	~~7.4~~	9.0

		computerized evaluations with printout (includes representation in graph form of muscle-joint **measurements** of velocity, acceleration, power, range of motion, endurance, and work)	
(u)	97762	computerized movement analysis testing--kinematic and/or kinetic (includes computerized measurement and analysis of functional human movement and the forces [velocity, acceleration, displacement, and muscle and joint reaction] involved in movement; can include interfacing or individual measurement of electromyogram muscle activity and/or force plate analysis [three-dimensional analysis of ground reaction forces during weight-bearing activities and movements])	~~7.4~~ 9.0
	97764	job site visit, each 60 minutes (includes report)	12.0
(v)	97770	physical capacity evaluation, each 60 minutes, up to 6 hours (includes report) [Objective, directly observed measurement of a worker's ability to perform a variety of physical tasks combined with statements of abilities by worker and evaluator. Includes 97772 if requested along with physical capacity evaluation by insurer. Also called "physical tolerance screening", "functional capacity evaluation", "functional capacity assessment", or "work tolerance screening".]	14.0
	~~97772~~	~~completion of job descriptions or analysis forms requested by insurer or insurer's agent~~	~~5.6~~
(w)	Same as proposed.		
(x)	Same as proposed.		
(y)	Same as proposed.		
(z)	Same as proposed.		
(aa)	~~98950~~	~~Non-physician conference with payor representatives to update status of patient~~	~~2.2/ 15 min.~~
	98951	Report associated with non-physician conference, required by payor	3.4
(ab)	99085	Completion of job description or	4.2

	job analysis forms; initial 30 minutes	
99086	each additional 15 minutes	2.1

(AUTH: Sec. 39-71-203, MCA; IMP: Sec. 39-71-704, MCA.)

5. The Department has repealed rule 24.29.1403, found at page 24-2153 of the Administrative Rules of Montana ("ARM"). The Department has repealed rule 24.29.1405, found at page 24-2154 of the ARM. The Department has repealed rule 24.29.1420, found at pages 24-2157 through 59 of the ARM. The Department has repealed rule 24.29.2001, found at page 24-2201 of the ARM.

AUTH: 39-71-203, MCA
IMP: 39-71-203, 39-71-704, MCA

6. The effective date of the repeal of rules, and the effective date of the adoption of the new rules, is April 1, 1993.

David A. Scott
Rule Reviewer

Laurie A. Ekanger, Commissioner
DEPARTMENT OF LABOR & INDUSTRY

Certified to the Secretary of State: March 15, 1993.

BEFORE THE DEPARTMENT OF REVENUE
OF THE STATE OF MONTANA

IN THE MATTER OF THE AMENDMENT of ARM 42.11.211, 42.11.212, 42.12.102, 42.12.103, 42.12.104, 42.12.131, 42.12.141, 42.12.207, 42.12.313, 42.13.401; and NEW RULES I (42.13.109) and II (42.13.110) relating to Liquor Division	CORRECTED NOTICE OF ARM 42.12.103 Supporting Documentation -- Corporate Applicants

TO: All Interested Persons:

1. On November 25, 1992, the Department published notice of the proposed amendments and adoptions of the above-referenced liquor rules at page 2492 of the 1992 Montana Administrative Register, issue no. 22. The Department subsequently adopted the proposed amendments and new rules with changes at page 158 of the 1993 Montana Administrative Register, issue no. 2.

2. ARM 42.12.103 (2) which was to be renumbered (5) was inadvertently omitted from the Notice of Public Hearing and Notice of Adoption.

42.12.103 SUPPORTING DOCUMENTATION -- CORPORATE APPLICANTS

(1) through (4) remains as adopted.

~~(2)~~ (5) In the case of a corporation whose stock is listed on a national exchange, supporting documentation shall include a sworn statement identifying all directors and officers of the corporation.

AUTH: Sec. 16-1-303, MCA; IMP. Sec. 16-4-203, MCA.

CLEO ANDERSON
Rule Reviewer

MICK ROBINSON
Director of Revenue

Certified to Secretary of State March 15, 1993.

BEFORE THE DEPARTMENT OF REVENUE
OF THE STATE OF MONTANA

IN THE MATTER OF THE AMENDMENT of ARM 42.22.101, 42.22.105, 42.22.106, 42.22.121, 42.22.122 relating to Centrally Assessed Companies	NOTICE OF THE AMENDMENT of ARM 42.22.101, 42.22.105, 42.22.106 42.22.121, 42.22.122 relating to Centrally Assessed Companies

TO: All Interested Persons:

1. On January 28, 1993, the department published notice of the proposed amendment of ARM 42.22.101, 42.22.105, 42.22.106, 42.22.121, 42.22.122 and the adoption of new rule I relating to Centrally Assessed Companies at page 131 of the 1993 Montana Administrative Register, issue no. 2.

2. A public hearing was held on February 23, 1993, where written and oral comments were received. Representatives of the following companies appeared to testify: Dave Wood, Itel Rail; John Ethen, Detroit Edison; Mark Grego, GE Railcar; Jack Etzkorn, TTX; Carl Eckhoff, ACF; Doug Thornley, GATX; Bob Zwartz, UTC; Mike Greeley, GE Railcar/Itel Rail.

3. Oral and written comments received during and subsequent to the hearing are summarized as follows along with the response of the department:

COMMENT: The only fair and equitable method for allocating cars to the state would be to use solely an equivalent car count formula or an actual car count. The miles to miles method is used by many states because it is easy. The miles to miles method tends to allocate property fairly in "terminal" states. If a bridge state uses the same allocation method as a terminal state the railcar presence would be overstated. All leases are based on time, not miles traveled. Allocation based on mileage is incorrect, totally irrelevant and intellectually bankrupt.

RESPONSE: The Legislature directed the department to utilize miles-to-miles as the method of allocation to the state unless another method was adopted by administrative rule. The department has been analyzing methods of allocation and accepting input from industry in attempting to derive an equitable method of allocation.

A precise and theoretically correct formula of allocation is difficult to achieve when attempting to allocate interstate activity. In recognition of this, the courts have allowed the states wide latitude in adopting allocation methodologies.

> Judicial approval has been given to a number of formulas designed to approximate average presence, of which probably the most important is line mileage: the

> taxing state takes as the basis of assessment such proportion of the total value of the equipment as the number of miles of line used within the state bears to the total line miles used in all states. Also approved have been formulas based on car mileage, percentage of time the equipment is physically present during a relatively brief representative period, and combinations of many such factors . . .

"Developments in the Law - Federal Limitations on State Taxation of Interstate Business" Harvard Law Review 953, 991 (1962).

The equivalent car count methodology (and the direct inventory method) allocate car value strictly on the basis of estimated time. Unless equivalent car count statistics are very carefully constructed, it is unlikely that allocation will total 100%. The miles-to-miles methodology, used in isolation, does not make any allowance for time spent loading and unloading, or for different times of travel from state to state. However, the courts have many times upheld the use of the miles-to-miles methodology for the allocation of mobile property value.

An allocation method based on the average of the equivalent car count factor and the miles-to-miles factor results in a fair allocation of value by utilizing a multiple method. The comment is not accepted.

COMMENT: It was recommended that the department change the language in ARM 42.22.121(4)(b) from "365" to "number of days in the year" to account for leap year.

RESPONSE: The department agrees with this suggestion and the rule will be amended accordingly.

COMMENT: The equivalent-car-count in the state should be the total annual Montana car miles divided by the product of a minimum of 500 miles per day. One company strongly recommends a higher speed amount of 674 miles per day. Two other companies indicated new speed studies indicate miles at 327-387 miles per day and at 316-327 miles per day.

Assume 500 miles/day in the calculation of the equivalent car count for all flat cars, rather than just coal and intermodal cars in unit trains. Mileage in Montana is primarily from covered hopper cars carrying grain from the mid-west to the western seaports for export. These cars travel in unit trains of approximately 100 to 120 cars in length.

RESPONSE: Upon examination of the companies' supporting documentation that accompanied their studies, it was determined that some studies did not include all layover/switching/load/unload times. A conclusion of an average rate of speed for cars

traveling through the state requires that all time be included.

Utilizing information provided by the railroads, the department conducted an independent speed study. The population from which the cars were selected were railroad car line companies cars which operated over MRL tracks during CY 1991. Car types represented in the study included hopper cars, vehicular flat cars, intermodal flat cars, coal gondolas, and tank cars. The department's analysis indicated an uppermost average rate of speed to be 500 miles/day with all layover/switching/load/unload times.

Based upon the department's study, analysis of the companies' submitted studies and comparison to other states using speed factors, the department had proposed using 500 miles per day for cars in unit train activity and 350 miles per day for all other cars. However, in order to qualify for the 500 miles per day, the companies would be required to provide documentation indicating which portion of their fleets were in unit train contractual agreements versus single car contractual agreements. The department is concerned that the record maintenance and reporting requirements to be eligible for the higher speed would be burdensome for the companies. Therefore, the rules will be amended to use 500 miles per day for all cars.

COMMENT: For purposes of allocation, afford to the taxpayer the option to choose which method to use based on either: 1) standard car count on the lien date; 2) at a speed factor actual miles per day based on a speed factor study performed by the taxpayer every 3 years; 3) the average number of cars necessary to generate the mileage in the state for the prior calendar year based on time/speed studies of cars within the state divided by the cars in the system.

RESPONSE: The allocation methodology was specifically included in HB 24 to ensure the department utilized the same method for similar companies. Since some companies cannot provide an actual car count, the department, in keeping with this clear statement of legislative intent, will use one method for all similar companies.

A one-day inventory would not be sufficiently accurate to measure the presence of the companies in the state throughout an entire year. The department has historically relied on factors that measure activity throughout the year for other migratory property such as railroads and airlines. The comment is not accepted.

COMMENT: The valuation model should be adjusted to account for economic and functional obsolescence. This can be done by shortening the depreciable life used in the model or by introducing the concept of remaining economic life into the

model. Change the model to use a 15 to 20 year life.

RESPONSE: Valuation is not addressed in the proposed amendments to the administrative rules. Valuation of centrally assessed companies is already addressed in ARM 42.22.111 through 42.22.114.

The department analyzed valuation methods used by other states and methods proposed by the companies, and researched independent sources. Most of the companies suggested the use of historical costs depreciated as a basis for the value.

The ICC assumes a 30-year depreciation life when determining the rates for private car line-owned railroad cars. The ICC prescribes the service life and annual depreciation rates that are to be used in calculating car hire rates for railroad-owned cars. The prescribed depreciation rates range from 3.56% to 2.03%, which imply depreciation lives ranging from 28 to 49 years. The prescribed service lives range from 23 to 38 years.

The department has indicated that a 25 year life with a half-year convention and a $2,000 residual value would be a reasonable basis for the valuation of carline companies. The department will consider presentations of proposed valuations from individual companies on a case-by-case basis.

COMMENT: Some companies stated that they have no employees, offices, regular/systematic solicitations or other facilities within the State of Montana. Railcars are leased to customers, ergo, no title (sale) of tangible property passes in Montana, therefore use no state services. Their only connection with the state is the railcars traveling in interstate commerce through the state on lease to others.

RESPONSE: The Courts have concluded that:

> The basis of the jurisdiction is the habitual employment of the property within the state.

Braniff Airways, Inc. v. Nebraska State Board of Equal, 347 U.S. 590, 98 L. Ed. 967, 74 S. Ct. 757 (1954), reh den 348 U.S. 852, 99 L. Ed. 671, 75 S. Ct. 18.

> The state, having the right, for the purposes of taxation, to tax any personal property found within its jurisdiction, without regard to the place of the owner's domicile, could tax the specific cars which at a given moment were within its borders.

Pullman's Palace Car Co. v. Pennsylvania, 141 U.S. 18, 35 L. Ed. 613, 11 S. Ct. 876 (1891).

> So far as due process is concerned the only question is whether the tax in practical operation has relation to opportunities, benefits, or protection conferred or afforded by the taxing State.

Ott v. Mississippi Valley Barge Line Co., 336 U.S. 169, 93 L. Ed. 585, 69 S. Ct. 432 (1949), reh den 336 U.S. 928, 93 L. Ed. 1089, 69 S. Ct. 653).

The department has the responsibility to assess for ad valorem tax purposes certain properties or portions of properties that cross county and state lines. The department employs generally accepted practices and strives to achieve uniformity between states. The comment is not accepted.

COMMENT: It was expressed at the special session of the legislature that the intent of HB 24 was to be revenue neutral.

RESPONSE: The minutes of all hearings regarding HB 24 during the special session were reviewed. The department did not characterize the bill as being revenue neutral. The only reference related to revenue neutrality is one Senator's comment stating that language should be added to the bill to state that the tax should be no greater than what was paid in the previous years. That language was never added through amendment.

Fiscal Note for HB 24, as introduced states: "Revenues: Preliminary figures regarding the appraisal of the largest railroad car company indicate a property tax liability for tax year 1991 of approximately $760,000. Given that there are at least 169 other railroad car companies the department believes the 1991 property tax on all companies will at least match the $1.2 million dollars collected from the repealed freight license tax." The comment is not accepted.

4. As a result of the comments received, and in the interest of simplicity of reporting and cooperation, the department amends ARM 42.22.121 as follows:

42.22.121 ALLOCATION PROCEDURE (1) through (4)(a) remain as proposed.

(b) equivalent car count FOR ALL PRIVATE RAILROAD CARS IS THE TOTAL ANNUAL MONTANA CAR MILES DIVIDED BY THE PRODUCT OF 500 MILES/DAY MULTIPLIED BY THE NUMBER OF DAYS IN THE YEAR. ~~in Montana to total cars in system. Equivalent car count is computed as follows:~~

~~(i) for railroad cars used exclusively for unit coal and intermodal trains, the equivalent car count is the total annual Montana car miles divided by the product of 500 miles/day x 365 days/year;~~

~~(ii) for all other railroad cars, the equivalent car count is the total annual Montana car miles divided by the product of~~

~~350 miles/day x 365 days/year.~~

(5) remains as proposed.

AUTH: 15-23-108 MCA; IMP: Title 15, chapter 23, part 2, and 15-23-213 MCA.

5. As the result of the comments received the department is withdrawing proposed new rule I. The department believes that existing law clearly defines the mill levy to be used. Pending legislation would amend § 15-23-211, MCA, changing the definition of the average levy for the taxation of railroad car companies to be the average statewide rate of commercial and industrial property instead of the average applicable to fleet motor carriers.

6. Therefore, the department adopts ARM 42.22.121 with the amendments listed above, withdraws proposed new rule I, and amends ARM 42.22.101, 42.22.102, 42.22.105, 42.22.106 and 42.22.122 as proposed.

CLEO ANDERSON
Rule Reviewer

MICK ROBINSON
Director of Revenue

Certified to Secretary of State March 15, 1993.

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

In the matter of the adoption of Rule I pertaining to statistical sampling audits	))))	NOTICE OF THE ADOPTION OF RULE I PERTAINING TO STATISTICAL SAMPLING AUDITS

TO: All Interested Persons

1. On October 15, 1992, the Department of Social and Rehabilitation Services published notice of the proposed adoption of Rule I pertaining to statistical sampling audits at page 2272 of the 1992 Montana Administrative Register, issue number 19.

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

46.12.310 [RULE I] STATISTICAL SAMPLING AUDITS (1) At the option of the department, the amount of money erroneously paid to a provider for any given period of time may be determined by the use of statistical sampling and extrapolation, rather than by an audit of 100% of the claims submitted by the provider during the period of time under review. STATISTICAL SAMPLING AND EXTRAPOLATION SHALL NOT BE USED TO DETERMINE OVERPAYMENTS FOR INPATIENT HOSPITAL SERVICES, OUTPATIENT HOSPITAL SERVICES, OR HOSPITAL INPATIENT PSYCHIATRIC SERVICES, OR IN CASES WHERE THE NUMBER OF LINE ITEMS IN THE REVIEW PERIOD DOES NOT EQUAL 500 OR MORE.

(a) A LINE ITEM CONSISTS OF A SINGLE SERVICE, PROCEDURE OR ITEM ON A MEDICAID CLAIM FORM FOR WHICH A PROVIDER HAS RECEIVED PAYMENT.

(2) If the department chooses to use statistical sampling and extrapolation to determine an overpayment, it will ~~not audit every claim for which the provider has been paid during the review period. Instead the department will~~ use a statistical method to draw a random sample of claims for the review period ~~time~~ and will audit these claims. ~~From the dollar amount overpaid to the provider in this sample, t~~The department will calculate the provider's error rate BASED ON THE NET DOLLAR AMOUNT OVERPAID TO THE PROVIDER AFTER ANY UNDERPAYMENTS OCCURRING IN THE SAMPLE HAVE BEEN OFFSET AGAINST THE OVERPAYMENTS OCCURRING IN THE SAMPLE. The department will then calculate the total overpayment for the review period using ~~a computer program which incorporates a statistical formula~~ AN APPROPRIATE STATISTICAL METHODOLOGY.

Subsection (3) remains the same.

(4) It is presumed that the overpayment amount determined by the use of statistical sampling and extrapolation is correct. However, the provider may rebut this presumption by presenting evidence that the sampling and extrapolation process used by the

department was invalid. BY PRESENTING EVIDENCE THAT CLAIMS IN THE SAMPLE DETERMINED BY THE DEPARTMENT TO BE ERRONEOUS OR OVERPAID WERE CORRECTLY PAID, OR BY REQUESTING AN AUDIT OF 100% OF THE CLAIMS PAID IN THE REVIEW PERIOD, AS PROVIDED IN SUBSECTION (5).

(5) A PROVIDER WHO DOES NOT AGREE WITH THE OVERPAYMENT AMOUNT DETERMINED BY STATISTICAL SAMPLING MAY REQUEST THAT THE DEPARTMENT CONDUCT A 100% AUDIT OF THE CLAIMS PAID IN THE REVIEW PERIOD. THE REQUEST FOR A 100% AUDIT MUST BE MADE WITHIN 30 DAYS OF THE DATE OF THE NOTICE INFORMING THE PROVIDER OF THE RESULTS OF THE STATISTICAL SAMPLING. THE DEPARTMENT MUST THEN CONDUCT SUCH A REVIEW.

(a) IF THE AUDIT SHOWS AN OVERPAYMENT AMOUNT WHICH IS DIFFERENT FROM THE OVERPAYMENT AMOUNT DETERMINED BY SAMPLING AND EXTRAPOLATION, THE AMOUNT DETERMINED BY THE AUDIT SHALL BE USED BY THE DEPARTMENT IN ASSESSING AN OVERPAYMENT AGAINST THE PROVIDER. A PROVIDER WHO DISAGREES WITH THE RESULTS OF THE AUDIT MAY APPEAL BY MEANS OF THE FAIR HEARING PROCEDURES SET FORTH IN ARM 46.2.202.

(b) THE PROVIDER MUST PAY THE DEPARTMENT'S COSTS FOR SUCH AN AUDIT, UNLESS THE OVERPAYMENT AMOUNT DETERMINED BY THE 100% AUDIT IS AT LEAST 10% LESS THAN THE OVERPAYMENT AMOUNT DETERMINED BY THE STATISTICAL SAMPLE.

(~~5~~6) A provider who disagrees with an overpayment determined by statistical sampling and extrapolation may appeal by means of the fair hearing procedures set forth in ARM ~~46.12.409~~ 46.2.202.

AUTH: Sec. 53-6-113 MCA
IMP: Sec. 53-6-101 and 53-6-111 MCA

3. The Department has thoroughly considered all commentary received:

COMMENT: The department does not have authority to adopt a rule providing for the use of statistical sampling to determine medicaid overpayments and creating a presumption that the overpayment amount determined by the sampling method is correct. Neither 53-6-101, 53-6-111, 53-6-113, MCA, nor any other Montana statute authorizes the department to use sampling or to create a presumption of correctness of the amount established by the statistical sample.

RESPONSE: The commentor is correct in stating that no Montana statute specifically authorizes the department to use statistical sampling to determine the amount of medicaid overpayments. However, section 53-6-113(1), MCA, requires the department to adopt appropriate rules necessary for the administration of the Montana medicaid program as required by Montana and federal law. Section 53-6-111(2), MCA, requires the department to adopt rules establishing a system of penalties and sanctions applicable to medicaid providers who engage in fraudulent, abusive, or improper activities.

The Montana Administrative Procedure Act (MAPA) indicates that statutory authority to adopt rules implementing a statute may be express or implied. 2-4-305(6), MCA. Therefore, the lack of express mention of statistical sampling in the medicaid statutes does not indicate that the department lacks statutory authority to adopt it by rule.

MAPA also states that to be valid a rule must be consistent with the statute and be reasonably necessary to effectuate the purpose of the statute. 2-4-305(6)(a) and (b), MCA. The ability to use sampling to determine the amount of an overpayment is consistent with the requirement of 53-6-111(2) that the department establish penalties against medicaid providers who engage in fraudulent activities and with the requirement of 53-6-113(1) that the department adopt rules necessary to administer the program in compliance with state and federal law, since federal law requires the recovery of overpayments made to medicaid providers.

The rule is reasonably necessary to recover overpayments as required by federal law and to penalize providers who are billing improperly, because the department does not have sufficient staff to do 100% audits of all providers where a potential overpayment exists if there is a large number of claims in the period to be reviewed. The rule has been changed to provide that statistical sampling will only be used in cases involving at least 500 claims. In such cases the ability to use sampling is necessary to allow the department to identify and recover overpayments in a timely manner, because an individual case-by-case audit of large numbers of claims would not be economically feasible nor could it be accomplished in a timely manner.

With regard to the creation of a presumption of the correctness of the amount of overpayment determined by a statistical sample, the rule does not create an irrebuttable presumption. The rule as originally proposed provided that the provider can rebut the presumption by proving that the sampling and extrapolation process used by the department was invalid. The rule has now been modified to provide that the presumption can be rebutted by conducting an audit of 100% of the claims paid in the review period or by showing that claims disallowed in the sample were not erroneous. In Illinois Physicians Union v. Miller, 675 F.2d 151 (1982), the U.S. Court of Appeals, Seventh Circuit, upheld the Illinois Department of Public Aid's practice of presuming a provider overpayment based on statistical sampling was correct. The Court noted that the presumption was rebuttable and that the presumption was proper because a rational connection exists between overpayments in the audited sample and the overpayments in the total number of cases.

The department contends that the presumption is proper because there is a rationale connection between overpayments for the

audited sample and overpayments in the total universe of claims as long as a valid sampling methodology is used.

COMMENT: The proposed statistical sampling methodology violates evidentiary principles and specifically Rule 404(b) of the Montana Rules of Evidence, which states that evidence of other crimes, wrongs, or acts is not admissible to prove action in conformity therewith. Evidence of erroneous claims in the sample is irrelevant and inadmissible to prove that the provider was overpaid for non-audited claims in the review period.

RESPONSE: Rule 404(b) does not allow evidence of other wrongs or acts committed by a person to be admitted for the purpose of showing that the person committed a particular wrong or act of which he is allegedly guilty. The department is not attempting to use statistical sampling to prove that a provider filed an erroneous claim in any particular case. Instead, the rule will allow the use of accepted statistical principles to project the nature of a large population by reviewing a relatively small number of its components.

Statistical methods have been recognized by a number of courts as reliable evidence to establish adjudicative facts. *See* Jones v. Georgia, 389 U.S. 24, 88 S.Ct. 4, 19 L.Ed2d 25 (1967)(finding of discrimination based entirely on jury selection statistics and absence of explanation); Hernandez v. Texas, 347 U.S. 475, 74 S.Ct.667, 98 L.Ed2d 866 (1954) (same); Zippo Mfg. Co. v. Rogers Imports, Inc., 216 F. Supp. 670 (S.D.N.Y. 1963) (unfair competition--sample of consumers). Similarly, the overpayment amount in a statistical sample is reliable evidence of the amount a provider has been overpaid in the total population of claims paid, although it would not prove that a provider had erred on any particular claim. Therefore the department contends that the rule is not violative of Rule 404(b).

COMMENT: After the adoption of the proposed rule, the department will attempt to apply statistical sampling retroactively to claims submitted by providers prior to the effective date of the rule. This contravenes the requirement of 2-4-306(4), MCA, that an administrative rule shall be effective after publication. The department should limit the rule to prospective application for claims submitted after the effective date of the rule.

RESPONSE: Section 2-4-306(4), MCA, merely states that a rule is effective after publication and does not address the issue of retroactive application of a rule. Although retroactive laws may be disfavored, statutes relating to remedies or modes of procedure which do not create new rights or take away vested rights do not come within the general rule against the retroactive operation of statutes. 73 Am Jur 2d, Statutes, §354. Several Montana cases have held that laws which affect procedural matters only and do not relate to substantive rights of the parties do not constitute retroactive legislation and may be applied retrospectively. State Comp. Ins. Fund v. Sky

Country, Inc., 239 M 376, 780 P.2d 1135 (1989); Castles v. State ex rel. Mt. Dept. of Highways, 187 M.356, 609 P.2d 1223 (1980).

This rule only affects the procedure by which the amount of a medicaid overpayment may be determined and does not affect substantive rights of medicaid providers. No change is being made in the services that providers can bill for or the documentation required for payment of a claim although the procedure for determining the overpayment is being modified. Therefore it is proper for the department to use statistical sampling to determine overpayments in claims submitted prior to the effective date of the sampling rule.

COMMENT: Under the proposed rule, a provider whose overpayment is determined by statistical sampling is denied due process and equal protection when compared to the class of providers who get the benefit of a 100% audit of their claims. Under the rule as written, the provider can only attack the presumption of correctness of the extrapolated overpayment amount on the grounds that the sample and extrapolation process was invalid. It does not provide for challenging the disallowance of claims in the sample or for rebutting the extrapolated overpayment amount by conducting an audit of 100% of the claims in the review period.

RESPONSE: Changes have been made in the rule to address these concerns. A provider's right to due process is enhanced by allowing the provider to rebut the presumption of correctness of the extrapolated overpayment on grounds other than the invalidity of the methodology used. The rule now provides that a provider who disagrees with the overpayment amount determined by statistical sampling may request an audit of 100% of the claims in the review period. It also specifically states that the provider may dispute the overpayment amount by challenging the disallowance of any claim in the sampled cases, as has always been the department's intention.

The creation of a presumption in itself is not violative of due process, given the fact that it is rebuttable and that there is a rational connection between the overpayment in the audited sample and the overpayment for all the claims in the review period, as long as valid statistical methods are used.

The use of statistical sampling for some providers but not others as permitted in the revised rule does not deny equal protection to the providers to whom it is applied. Since the classification of providers into those who will have 100% audits and those whose overpayments will be determined by sampling does not involve a suspect class or a fundamental right, the standard of review is the rational basis test. The rational basis standard merely requires that a classification be reasonably related to a permissible government objective.

The proposed rule has been modified to specify that statistical sampling will only be used when the number of line items in the review periods is at least 500. The use of statistical sampling in cases involving large numbers of claims is reasonably related to the department's goal of determining overpayments as required by federal law in a timely and cost-effective manner. Thus the classification created by the rule passes the rational basis of review and complies with the requirements of equal protection.

COMMENT: The proposed rule is too vague and leaves too much to the unfettered discretion of the department. It appears that the department intends to apply it to physician providers who submit thousands of claims per year, yet the rule does not limit use to cases involving high volumes of claims nor define what constitutes a high volume of claims. Also, the rule does not state the period of time for which statistical sampling could be used. Finally, the rule does not state what would constitute a valid sample size or the methodology to be used for the sampling process. Without guidance in the rule on these issues, the rule is arbitrary, capricious, and vague.

RESPONSE: The rule has been changed to specify that statistical sampling may only be used in cases where there are at least 500 line items in the period under review. It is not the department's intention to limit the use of statistical sampling only to physician providers. The rule as revised allows sampling to be used for any provider type, with certain limited exceptions which are now stated in subsection (1).

With regard to the period of time for which sampling can be used, the use of statistical sampling will not result in any change in the department's policy as to how far back claims should be reviewed. Federal regulations governing the medicaid program require state agencies to recover all overpayments to providers with no limit on how far back they must go. Thus, when the department has identified a possible error in billing which may have caused an overpayment, the department will review claims back to the earliest point at which the error occurred.

The department will do the same in cases where sampling is used. For most billing errors the department can determine at what point in time the error began by reviewing the department's paid claims records, without actually reviewing the provider's medical records as is done in an audit. The statute of limitation which would apply, if any, to the department's administrative activities to recover overpayments is the eight year statute of limitation for a written contract.

The rule does not specify what will constitute a valid sample size because sample size may vary depending on the total number of claims to be reviewed. There are also various sampling methodologies which the department can use which are equally valid, and the department therefore does not wish to limit itself by rule to a specific method. In some cases the

methodology may be chosen by the U.S. Office of the Inspector General which may assist the department in conducting the sampling and extrapolation.

When the sampling and extrapolation process is complete, the department will notify the provider of the overpayment amount, if any, and will also provide the provider with information regarding the sample size, sample selection method, and the formulas and calculations used in the extrapolation as provided in subsection (3). The provider may use this information to challenge the validity of the sample size or the methodology used for the sample selection process. If the department were to use invalid methods for determining an overpayment by statistical sampling they would be subject to exposure in the fair hearing process or when a 100% audit was done at the provider's request.

COMMENT: Several commentors expressed concern that statistical sampling and extrapolation methodology can not account for or compensate for all variables which contribute to an overpayment. One commentor referred to variables such as changes in billing personnel or in the types of medical services provided which occur over time.

RESPONSE: Valid statistical methods allow accurate projection from a relatively small sample to a large universe despite certain variable factors. However, with regard to variables which change over time, the results of a sample taken from one period of time cannot validly be projected to a different period of time, and the department will not attempt to do so. The period of time from which the sample is drawn will be the same as the period for which the overpayment is being determined by extrapolation.

When attempting to determine whether an overpayment has occurred, the department generally will try to identify the cause of the error or errors leading to the potential overpayment. If there is reason to believe that certain types of erroneous claims are limited to a certain period of time, the department will take that into consideration in choosing the period of time to be sampled.

In any event, if a provider feels that the overpayment amount determined by sampling and extrapolation is invalid because of variables which the department has failed to take into consideration, the provider can rebut the presumption of correctness by presenting evidence as to why sampling and extrapolation is not valid in this situation.

COMMENT: Several commentors expressed concern that department staff might not have sufficient knowledge and skill to understand the issues associated with statistical sampling and to conduct a valid statistical sample. One asked for specific information about the credentials of SRS personnel.

RESPONSE: The department currently has personnel with expertise in the area of statistical sampling. If necessary the department may contract with qualified non-SRS employees to provide assistance in this area. The U.S. Office of the Inspector General is also available to assist the department in conducting statistical sampling.

The persons involved in the sampling and extrapolation process will thus vary from time to time. The credentials of the person conducting the sampling and extrapolation in a particular case will be available to the provider upon request.

COMMENT: Several commentors felt that the department should be limited as to how far back it can review claims. One suggested that statistical sampling audits be used only on claims less than one year old.

RESPONSE: As discussed in a previous response, federal regulations do not limit how far back the department must go in recovering overpayments to medicaid providers. For this reason the rule does not place any limit on how far back an overpayment can be determined using statistical sampling.

COMMENT: The rule doesn't give the provider the option of showing that the department is wrong. The provider should be permitted to have a 100% audit at its own expense if it does not agree with the results of the department's statistical sampling.

RESPONSE: The rule as originally proposed allowed a provider who disagreed with the department's results to present evidence that the sampling and extrapolation was invalid. A provision has now been allowed which permits a provider to request a 100% audit. The provider must bear the costs of the audit unless the overpayment determined by the 100% audit is at least 10% less than the overpayment determined by the statistical sample.

COMMENT: Providers should be allowed to determine underpayments by statistical sampling without submitting all claims for correction.

RESPONSE: It is necessary for the department to use sampling in cases with a high volume of claims in order to comply with the federal requirement that all overpayments be recovered. Providers are not under these same constraints. The rule therefore authorizes the department but not providers to use statistical sampling.

COMMENT: The rule as proposed only provides for the determination of overpayments using statistical sampling and extrapolation. As a matter of fairness, the rule should also allow for the identification of provider underpayments using the same process.

RESPONSE: It has always been the department's policy to offset any underpayments found against overpayments in calculating the total overpayment to a provider. Subsection (2) of the rule has been revised to provide specifically that underpayments identified in the sample will be offset against the overpayments. The error rate used to determine the total overpayment for the review period will therefore be based on the net overpayment amount in the sampled claims.

COMMENT: Statistical sampling should be used only with the consent of both the department and the provider. The rule could provide that once consent was given, it could not be revoked.

RESPONSE: As discussed in a previous response, the ability to use statistical sampling in cases with a high volume of claims is necessary in order for the department to determine and recover overpayments in a timely and cost-effective manner. Since all providers may not wish to consent, the department must have the authority to use sampling without the provider's consent. The rule does now permit a provider to have a 100% audit if the provider is dissatisfied with the results of the sampling and extrapolation.

COMMENT: The rule should state that if the department finds another error and intends to do another statistical sample, it will use the same records that were used for the first statistical sample.

RESPONSE: Generally the department looks for all errors when it audits provider claims, not only the particular error which caused the department to suspect an overpayment might have occurred. Thus all errors should be caught the first time a sample is taken and it should not be necessary to go back and take a second sample.

However, if the department were to discover another error which occurred during the same period of time from which the first sample was drawn, the department probably would use the same sample. If the newly discovered error occurred during a different time period, a new sample would have to be used.

COMMENT: Several commentors representing providers of hospital services expressed concerns about the use of statistical sampling in regard to such services.

RESPONSE: The department has determined that statistical sampling will not be used to determine overpayments for inpatient hospital services, outpatient hospital services, or hospital inpatient psychiatric services. Claims for such services are audited and cost-settled at regular intervals and there is thus no need to determine overpayments by sampling.

Similarly, since most claims submitted by nursing home providers are cost-based and are audited and cost-settled at regular

intervals, statistical sampling is not appropriate and will not be used to determine overpayments for most nursing home claims. However, the rule does not exclude the possibility of using statistical sampling for some nursing home claims, since in some instances it may be appropriate.

COMMENT: The rule refers nursing home and hospital providers to a different appeal process than that cited in other department rules.

RESPONSE: The rule as proposed provided that a provider who was dissatisfied with the overpayment amount determined by statistical sampling could appeal under ARM 46.12.409. As the commentor notes, there is a specific appeal process for nursing home providers at ARM 46.12.1268 which was not referenced in the proposed rule. The rule has now been changed to state that providers may appeal overpayments determined under this rule by the procedures set forth in ARM 46.12.202, which is the general fair hearing rule and cross-references 46.12.409 and 46.12.1268.

Rule Reviewer

Director, Social and Rehabilitation Services

Certified to the Secretary of State March 15, 1993.

VOLUME NO. 45 OPINION NO. 1

CITIES AND TOWNS - Commission-manager form of government: power to appoint city department heads;
LOCAL GOVERNMENT - Commission-manager form of government: power to appoint city department heads;
MUNICIPAL GOVERNMENT - Commission-manager form of government: power to appoint city department heads;
MONTANA CODE ANNOTATED - Title 7, chapter 3; sections 7-3-102, 7-3-114, 7-3-304, 7-3-304(13), 7-3-305, 7-3-305(2), 7-3-4362, 7-3-4363, 7-3-4402, 7-3-4403, 7-3-4441, 7-3-4463 to 7-3-4466;
MONTANA CONSTITUTION - Article XI, sections 3(1), 9(1);
OPINIONS OF THE ATTORNEY GENERAL - 41 Op. Att'y Gen. No. 48 (1986), 41 Op. Att'y Gen. No. 37 (1985).

HELD: A city council in a council-manager form of government may adopt an ordinance authorizing the council rather than the city manager to appoint heads of city departments.

March 8, 1993

Mr. Robert L. Jovick
Livingston City Attorney
P.O. Box 1245
Livingston, MT 59047-1245

Dear Mr. Jovick:

You have requested my opinion concerning the following question:

> May a city council in a city with the council-manager form of government adopt an ordinance whereby the city council rather than the city manager appoints heads of city departments?

I conclude that the city council in a council-manager form of government may adopt an ordinance pursuant to MCA § 7-3-304 authorizing the council rather than the city manager to appoint the heads of city departments.

The Montana Constitution requires the Legislature to provide for the adoption of statutory alternative forms of local government and for a local government review process. 41 Op. Att'y Gen. No. 37 (1985). Specifically, Article XI of the Constitution provides in pertinent part:

> Section 3. Forms of Government. (1) The legislature shall provide methods for governing local government units and procedures for incorporating, classifying, merging, consolidating, and dissolving such units, and altering their boundaries. The legislature shall

> provide such optional or alternative forms of government that each unit or combination of units may adopt, amend, or abandon an optional or alternative form by a majority of those voting on the question.
>
> ....
>
> Section 9. Voter review of local government. (1) The legislature shall, within four years of the ratification of this constitution, provide procedures requiring each local government unit or combination of units to review its structure and submit one alternative form of government to the qualified electors at the next general or special election.

In 1975, the Legislature implemented the above constitutional mandate and enacted a statutory scheme which allowed the electorate to choose alternative forms of local government. See MCA Tit. 7, ch. 3, pts. 1 to 7. MCA § 7-3-102 offers the electorate five basic alternative forms of local government, plus a charter form. One of the options under MCA § 7-3-102 is a commission-manager or council-manager form of government. In 1977, the city of Livingston chose to adopt a council-manager form of government. Prior to 1977, Livingston operated under a council-mayor form of government.

You have asked whether the Livingston city council may adopt an ordinance in which the council rather than the city manager appoints the heads of city departments. There are two sets of statutes that define the power of the city manager to appoint department heads. Those statutes can be found in MCA Title 7, chapter 3, parts 3, 43 and 44. To answer your question it is necessary to examine the statutory powers of the city manager under both part 3 and parts 43 and 44.

Under MCA Title 7, chapter 3, part 3, the duties of the city manager, including the power to appoint department heads, is controlled by MCA § 7-3-304, which provides:

> Duties of manager. The manager shall:
>
> (1) enforce laws, ordinances, and resolutions;
>
> (2) perform the duties required of him by law, ordinance, or resolution;
>
> (3) administer the affairs of the local government;
>
> (4) direct, supervise, and administer all departments, agencies, and offices of the local government unit except as otherwise provided by law or ordinances;
>
> (5) carry out policies established by the commission;

(6) prepare the commission agenda;

(7) recommend measures to the commission;

(8) report to the commission on the affairs and financial condition of the local government;

(9) execute bonds, notes, contracts, and written obligations of the commission, subject to the approval of the commission;

(10) report to the commission as the commission may require;

(11) attend commission meetings and may take part in the discussion, but he may not vote;

(12) prepare and present the budget to the commission for its approval and execute the budget adopted by the commission;

(13) appoint, suspend, and remove all employees of the local government except as otherwise provided by law or ordinance;

(14) appoint members of temporary advisory committees established by the manager. [Emphasis added.]

MCA § 7-3-304(13) by its clear language contemplates that the city manager has the power to appoint and remove all city employees "except as otherwise provided by law or ordinance." Accordingly, I conclude that under MCA § 7-3-304(13) the city council could enact an ordinance which would curtail the city manager's power to appoint department heads and instead give the council the authority to appoint them.

In addition, MCA § 7-3-305 also supports my conclusion that the city council through an ordinance may eliminate the city manager's authority to appoint department heads. MCA § 7-3-305 states in pertinent part:

(1) Employees appointed by the manager and his subordinates shall be administratively responsible to the manager.

(2) Neither the commission nor any of its members may dictate the appointment or removal of any employee whom the manager or any of his subordinates are empowered to appoint. [Emphasis added.]

Under MCA § 7-3-305(2), the city council cannot dictate the appointment of any employees whom the city manager is "empowered to appoint." The clear implication of this language is that the

city manager's power to appoint and remove is not exclusive, and that some employees must, under some circumstances, be subject to appointment and removal by someone other than the city manager. The provisions of MCA § 7-3-305(2) emphasized above have meaning only if MCA § 7-3-304(13) is interpreted to allow the city council to make other provisions for the appointment and removal of city employees.

MCA §§ 7-3-304 and 7-3-305 are in pari materia, and they must be construed together in a manner which gives effect to all parts of both statutes, if such a construction is possible. Crist v. Segna, 191 Mont. 210, 212, 622 P.2d 1028, 1029 (1981). In my opinion, MCA §§ 7-3-304(13) and 7-3-305(2) can only be harmonized by holding that MCA § 7-3-304(13) authorizes the city council by ordinance to restrict the city manager's powers with respect to the hiring and retention of employees. Thus, if the Livingston city council passed an ordinance limiting the city manager's power to make appointments, there would be no restrictions under MCA § 7-3-305(2) on the council's authority to dictate the appointment of employees.

Prior to the enactment of the statutes defining the commission-manager form of government under MCA Title 7, chapter 3, part 7, there existed a statutory scheme for "Municipal Commission-Manager Government" under MCA Title 7, chapter 3, parts 43 and 44. A number of statutes under parts 43 and 44 place the authority of appointing city employees solely with the city manager and, unlike MCA §§ 7-3-304 and 7-3-305, these statutes do not provide the city council with the power to limit the city manager's authority to appoint employees. See MCA §§ 7-3-4362, 7-3-4363, 7-3-4402, 7-3-4403, 7-3-4441, 7-3-4463 to 4466. These statutes vest the city manager with the apparently unrestricted authority to appoint, remove and manage city employees and do not provide for the city council to limit that authority. Raynes v. City of Great Falls, 215 Mont. 114, 118-19, 696 P.2d 423, 426 (1985).

In Raynes, the Court held that the city manager in the commission-manager form of government had the sole power to affirm, modify, or veto the police commission's decision to discharge a police officer. Raynes, 215 Mont. at 119. The Court explained that a city manager's authority under the municipal commission-manager form of government was "broad and pervasive." Specifically, the Court stated:

> [A]n elected commission is required to appoint a city manager, section 7-3-4361, MCA, who shall be the administrative head of the municipal government and be responsible for the efficient administration of all departments. Specifically, he/she is empowered to appoint and remove all subordinate officers and employees of the departments in both the classified and unclassified service.

Raynes, 215 Mont. at 118-19.

The report of the Raynes decision does not indicate that the City of Great Falls had adopted an ordinance restricting the power of the city manager with respect to the hiring and retention of city employees. The court in Raynes, therefore, did not consider the restrictive language on the city manager's power to appoint city employees under MCA §§ 7-3-304 and 7-3-305. Specifically, the court in Raynes did not explore the clause "except as otherwise provided by law or ordinance" under MCA § 7-3-304(13), and the possibility that the city council could pass an ordinance enabling it to limit the city manager's authority to appoint heads of departments. Furthermore, the court was not presented with the issue of whether the city council could enact such an ordinance.

There is a clear conflict between the statutes under MCA Title 7, chapter 3, part 3 and MCA Title 7, chapter 3, parts 43 and 44 concerning the scope of the city manager's appointment power, which the court in Raynes did not address. The enactment of parts 43 and 44, however, preceded the enactment of part 3. Earlier statutes, to the extent of any repugnancy, are controlled by later statutes. 41 Op. Att'y Gen. No. 48 at 200, 202 (1986), citing State ex rel. Wiley v. District Court, 118 Mont. 50, 55, 164 P.2d 358, 361 (1946). Accordingly, I conclude that the later statutes under part 3, including MCA §§ 7-3-304 and 7-3-305, control the scope of a city manager's authority to appoint employees under the commission-manager form of government. Id.

This conclusion is also supported by statutory language found in MCA § 7-3-114. The municipal commission-manager forms of government enacted under parts 43 and 44, that did not adopt an alternative form of government, are controlled by the statutes listed under MCA § 7-3-114. See 41 Op. Att'y Gen. No. 48 (1986). MCA § 7-3-114 states:

> **Statutory basis for municipal commission-manager government.** (1) For the purpose of determining the statutory basis of existing units of local government after May 2, 1977, each unit of local government organized under the general statutes authorizing the municipal commission-manager form of government shall be governed by the following sections:
>
> (a) 7-3-301;
> (b) 7-3-302(1);
> (c) 7-3-303;
> (d) 7-3-304;
> (e) 7-3-305;
> (f) 7-3-312(3);
> (g) 7-3-313(1);
> (h) 7-3-314(2);
> (i) 7-3-315(2);

(j) 7-3-316(2);
(k) 7-3-317(2);
(l) 7-3-318.

(2) This form has terms of 4 years for all elected officials. The size of the commission shall be established by ordinance, but it may not exceed five members. [Emphasis added.]

Accordingly, municipal commission-manager forms of government authorized under MCA Title 7, chapter 3, parts 43 and 44, are controlled by MCA § 7-3-114 and governed by the specific sections listed under MCA § 7-3-114. Two of these sections, MCA §§ 7-3-304 and 7-3-305, allow the city council to limit the city manager's authority to appoint heads of city departments.

THEREFORE, IT IS MY OPINION:

A city council in a council-manager form of government may adopt an ordinance authorizing the council rather than the city manager to appoint heads of city departments.

Sincerely,

JOSEPH P. MAZUREK
Attorney General

BEFORE THE BOARD OF NURSING
DEPARTMENT OF COMMERCE
STATE OF MONTANA

In the matter of the petition for declaratory ruling on the role of registered professional nurses in inserting peripherally inserted central catheters	)))))	NOTICE OF PETITION FOR DECLARATORY RULING

1. On May 21, 1993, at 8:00 a.m., in the Rimini Room of the Park Plaza Hotel, 22 N. Last Chance Gulch, Helena, Montana, the Board of Nursing will consider a petition for declaratory ruling on the authority of registered professional nurses to insert peripherally inserted central catheters within the scope of their practice.

2. The petitioners are:

Deborah Gaspar, RN, MS, MPA
Director of Nursing
Manager
Deaconess Medical Center
P.O. Box 37000
Billings, MT 59107

Peggy Wharton, RN, BS
Ambulatory Srvs Nurse
Deaconess Medical Center
P. O. Box 37000
Billings, MT 59107

Kim Sorenson, RN, BSN
Trauma Services Coordinator
Deaconess Medical Center
P.O. Box 37000
Billings, MT 59107

Jan Hollingworth, RN, BSN
Nursing Educator
Deaconess Medical Center
P.O. Box 37000
Billings, MT 59107

Janice Bechtold, RN, BSN
ICU Nurse Manager
Deaconess Medical Center
P.O. Box 37000
Billings, MT 59107

Julie Gee, RN, BSN
ICU Assistant Nurse Manager
Deaconess Medical Center
P.O. Box 37000
Billings, MT 59107

Joyce Dombrouski, RN, MHSA
Deacare Nurse Manager
Deaconess Medical Center
P.O. Box 37000
Billings, MT 59107

Sherry Ewen, RN, BSN
Discharge Nurse Clinician
Deaconess Medical Center
P.O. Box 37000
Billings, MT 59107

William Norton, RN, BSN
Emergency Department Staff Nurse
Deaconess Medical Center
P.O. Box 37000
Billings, MT 59107

3. The Petitioners represent Deaconess Medical Center. The hospital wants to use registered professional nurses to insert peripherally inserted central catheters. The Petitioners are concerned about whether this activity fits within the scope of practice of a registered professional nurse.

4. The rules as to which Petitioners request a ruling are as follows:

ARM 8.32.1401(2): "Competency" - performing skillfully and proficiently the functions that are within the role of the licensee; and demonstrating the interrelationship of essential knowledge, judgment and skills.

ARM 8.32.1401(4): "Nursing process" - the traditional systematic method nurses use when they provide nursing care, including assessment, nursing analysis, planning, nursing intervention and evaluation.

ARM 8.32.1401(6): "Prescribing" - specifying nursing intervention(s) intended to implement the defined strategy of care. This includes the nursing behaviors that nurses shall perform when delivering nursing care, though not necessarily sequentially or all in each given situation: assessment, nursing analysis, planning, nursing intervention and evaluation.

ARM 8.32.1401(7): "Standard" - an authoritative statement by which the board can judge the quality of nursing education or practice.

ARM 8.32.1401(8): "Strategy of care" - the goal-oriented plan developed to assist individuals or groups to achieve optimum health potential. This includes initiating and maintaining comfort measures, promoting and supporting human functions and responses, establishing an environment conducive to well being, providing health counseling and teaching, and collaborating on certain aspects of the medical regimen, including but not limited to the administration of medications.

ARM 8.32.1402: PURPOSE OF STANDARDS OF NURSING PRACTICE FOR THE REGISTERED NURSE The purpose of the standards is

(1) to establish minimal acceptable levels of safe effective practice for the registered nurse.

(2) to serve as a guide for the board to evaluate safe and effective nursing care.

ARM 8.32.1403: STANDARDS RELATED TO THE REGISTERED NURSE'S RESPONSIBILITY TO APPLY THE NURSING PROCESS The registered nurse shall:

(1) conduct and document nursing assessments of the health status of individuals and groups by:

(a) collecting objective and subjective data from observations, examinations, interviews, and written records in an accurate and timely manner. The data includes but is not limited to:

(i) biophysical, emotional and mental status,

(ii) growth and development,

(iii) cultural, spiritual and socio-economic background,

(iv) family health history,

(v) information collected by other health team members,

(vi) client knowledge and perception about health status and potential, or maintaining health status, ,
(vii) ability to perform activities of daily living,
(viii) patterns of coping and interacting,
(ix) consideration of client's health goals,
(x) environmental factors (e.g. physical, social, emotional and ecological), and
(xi) available and accessible human and material resources.
(b) sorting, selecting, reporting and recording the data;
(c) validating, refining and modifying the data by utilizing available resources, including interactions with the client, family, significant others, and health team members.
(2) establish and document nursing analysis which serves as the basis for the strategy of care;
(3) develop the strategy of care based upon data gathered in the assessment and conclusions drawn in the nursing analysis. This includes:
(a) identifying priorities in the strategy of care;
(b) collaboration with the client to set realistic and measurable goals to implement the strategy of care;
(c) prescribing nursing intervention(s) based on the nursing analysis;
(d) identifying measures to maintain comfort, to support human functions and positive responses, to maintain an environment conducive to teaching to include appropriate usage of health care facilities.
(4) implement the strategy of care by:
(a) initiating nursing interventions through;
(i) giving direct care,
(ii) assisting with care,
(iii) delegating care,
(iv) collaboration and/or referral when appropriate.
(b) providing an environment conducive to safety and health,
(c) documenting nursing interventions and responses to care to other members of the health team;
(d) communicating nursing interventions and responses to care to other members of the health team.
(5) evaluate the responses of individuals or groups to nursing interventions. Evaluation shall involve the client, family, significant others and health team members of the health team.
(a) Evaluation data shall be documented and communicated to appropriate members of the health care team.
(b) Evaluation data shall be used as a basis for reassessing client health status, modifying nursing analysis, revising strategies of care, and prescribing changes in nursing interventions.
(c) Research data shall be utilized in nursing practice.

ARM 8.32.1404(1), (2), (3) and (7): STANDARDS RELATED TO THE REGISTERED NURSE'S RESPONSIBILITIES AS A MEMBER OF THE NURSING PROFESSION The registered nurse shall:

(1) have knowledge of the statutes and regulations governing nursing and function within the legal boundaries of nursing practice;

(2) accept responsibility for individual nursing actions and competence and base practice on validated data;

(3) obtain instruction and supervision as necessary when implementing nursing techniques or practices;

(7) contribute to the formulation, interpretation, implementation and evaluation of the objectives and policies related to nursing practice within the employment setting;

5. The question presented for declaratory ruling by the agency is whether it is within the registered professional nurses' practice to insert peripherally inserted central catheters, as provided in the above-referenced rules.

6. The Petitioners have indicated that they believe that a Montana State Board of Nursing ruling that would sanction qualified registered professional nurses to insert peripherally inserted central catheters would help provide improved value, quality, and effective treatment to patients.

7. The Petitioners noted the following to be interested parties:

Total Pharmaceutical Care
Linda Bierbach, Manager
2110 Overland Avenue
Suite 122
Billings, Montana 59102

Medical Innovations
Dwight Redd
935 Lake Elmo Drive
Billings, Montana 59101

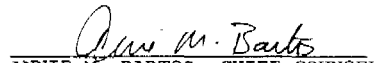
Carbon County Memorial Hospital
600 W. 20th St.
P.O. Box 590
Red Lodge, Montana 59068-0590

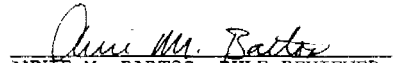
Western Temporary Services
Transwestern II
Suite 307
490 N. 31st
Billings, Montana 59101

Visiting Nurse Service
P.O. Box 35033
Billings, Montana 59107

The Board also notes that other hospitals, physicians, and registered nurses may be similarly affected.

BOARD OF NURSING

By: 
ANNIE M. BARTOS, CHIEF COUNSEL
DEPARTMENT OF COMMERCE


ANNIE M. BARTOS, RULE REVIEWER

Certified to the Secretary of State, March 10, 1993.

NOTICE OF FUNCTIONS OF ADMINISTRATIVE CODE COMMITTEE

The Administrative Code Committee reviews all proposals for adoption of new rules, amendment or repeal of existing rules filed with the Secretary of State, except rules proposed by the Department of Revenue. Proposals of the Department of Revenue are reviewed by the Revenue Oversight Committee.

The Administrative Code 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 lists 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 Administrative Procedure Act for inclusion in the ARM. The ARM is updated through December 31, 1992. This table includes those rules adopted during the period January 1, 1993 through March 31, 1993 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 December 31, 1992, this table and the table of contents of this issue of the MAR.

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BOARD APPOINTEES AND VACANCIES

House Bill 424, passed by the 1991 Legislature, directed that all appointing authorities of all appointive boards, commissions, committees and councils of state government take positive action to attain gender balance and proportional representation of minority residents to the greatest extent possible.

One directive of HB 424 was that the Secretary of State publish monthly in the *Montana Administrative Register* a list of appointees and upcoming or current vacancies on those boards and councils.

In this issue, appointments made in February, 1993, are published. Vacancies scheduled to appear from April 1, 1993, through June 30, 1993, are also listed, as are current recent vacancies due to resignations or other reasons.

Individuals interested in serving on a new board should refer to the bill that created the board for details about the number of members to be appointed and qualifications necessary.

Each month, the previous month's appointees are printed, and current and upcoming vacancies for the next three months are published.

IMPORTANT

Membership on boards and commissions changes constantly. The following lists are current as of March 2, 1993.

For the most up-to-date information of the status of membership, or for more detailed information on the qualifications and requirements to serve on a board, contact the appointing authority.

BOARD AND COUNCIL APPOINTEES: FEBRUARY, 1993

Appointee	Appointed by	Succeeds	Appointment/End Date
Agriculture Development Council (Agriculture)			
Mr. Leo Giacometto	Governor	Snortland	2/4/1993
Helena			7/1/1995
Qualifications (if required): Director of Agriculture			
Mr. Jon D. Noel	Governor	Brooke	2/4/1993
Helena			7/1/1995
Qualifications (if required): Director of Commerce			
Board of Crime Control (Justice)			
Mr. Randy H. Bellingham	Governor	Johnson	2/25/1993
Billings			1/1/1995
Qualifications (if required): represents Youth Justice Council			
Mr. Don Bjertness	Governor	reappointed	2/25/1993
Billings			1/1/1997
Qualifications (if required): public member			
Mayor Fred A. Brown	Governor	Aiken	2/25/1993
Libby			1/1/1995
Qualifications (if required): represents local executives			
Mr. Gary Buchanan	Governor	Browder	2/25/1993
Billings			1/1/1995
Qualifications (if required): public member			
Mr. Rick Day	Governor	Chisholm	2/25/1993
Helena			1/1/1997
Qualifications (if required): represents Department of Corrections & Human Services			
Mr. John Flynn	Governor	reappointed	2/25/1993
Townsend			1/1/1997
Qualifications (if required): represents county attorneys			

BOARD AND COUNCIL APPOINTEES: FEBRUARY, 1993

Appointee	Appointed by	Succeeds	Appointment/End Date
Board of Crime Control (Justice) cont.			
Ms. Donna Heggem Winifred Qualifications (if required): county commissioner	Governor	Peterson	2/25/1993 1/1/1997
Ms. Nancy Keenan Helena Qualifications (if required): represents schools	Governor	none specified	2/25/1993 1/1/1997
Senator Joseph P. Mazurek Helena Qualifications (if required): represents office of Attorney General	Governor	Racicot	2/25/1993 1/1/1997
Judge Dorothy B. McCarter Helena Qualifications (if required): judge	Governor	Barz	2/25/1993 1/1/1997
Judge Gregory P. Mohr Sidney Qualifications (if required): represents lower courts	Governor	Bjertness	2/25/1993 1/1/1995
Rep. Mary Lou Peterson Eureka Qualifications (if required): represents House of Representatives	Governor	reappointed	2/25/1993 1/1/1995
Mr. J. "John" Pfaff Jr. Great Falls Qualifications (if required): private citizen	Governor	reappointed	2/25/1993 1/1/1997
Chief Mike Shortell Havre Qualifications (if required): represents Chief of Police	Governor	reappointed	2/25/1993 1/1/1997

BOARD AND COUNCIL APPOINTEES: FEBRUARY, 1993

Appointee	Appointed by	Succeeds	Appointment/End Date
Board of Crime Control (Justice) cont.			
Sheriff Bill Slaughter Bozeman Qualifications (if required): represents sheriffs	Governor	Butorovich	2/25/1993 1/1/1997
Mr. Jean A. Turnage Helena Qualifications (if required): represents Supreme Court	Governor	reappointed	2/25/1993 1/1/1997
Board of Investments (Commerce)			
Mr. James E. Cowan Seeley Lake Qualifications (if required): represents Teachers' Retirement Board	Governor	reappointed	2/5/1993 1/1/1997
Mr. Troy W. McGee, Sr. Helena Qualifications (if required): represents public employee retirement	Governor	Pratt	2/5/1993 1/1/1997
Mr. Bill Price Lewistown Qualifications (if required): public member	Governor	Connors	2/5/1993 1/1/1997
Mr. Warren Vaughan Billings Qualifications (if required): public member	Governor	reappointed	2/5/1993 1/1/1997
Ms. Sharon Walker Helena Qualifications (if required): public member	Governor	Aageson	2/5/1993 1/1/1997

BOARD AND COUNCIL APPOINTEES: FEBRUARY, 1993

Appointee	Appointed by	Succeeds	Appointment/End Date
Board of Natural Resources and Conservation (Natural Resources and Conservation)			
Mr. Barton Cooper Boulder Qualifications (if required): public member	Governor	McHatton	2/23/1993 1/1/1997
Ms. Mary L. Hinebauch Rosebud Qualifications (if required): public member	Governor	Booth	2/23/1993 1/1/1997
Ms. Mary Ann Sharon Dillon Qualifications (if required): attorney	Governor	reappointed	2/23/1993 1/1/1997
Board of Pardons (Corrections and Human Services)			
Mr. Patrick T. Fleming Butte Qualifications (if required): attorney and auxilary member	Governor	Fleury	2/25/1993 1/2/1997
Ms. Julene P. Kennerly Browning Qualifications (if required): has knowledge of Native American issues	Governor	Elliot	2/25/1993 1/2/1997
Mr. John G. Thomas Helena Qualifications (if required): none specified	Governor	reappointed	2/25/1993 1/2/1997

BOARD AND COUNCIL APPOINTEES: FEBRUARY, 1993

Appointee	Appointed by	Succeeds	Appointment/End Date
Milk Control Board (Commerce)			
Mr. Jesse Russell Gleason Fairfield Qualifications (if required): Republican from Congressional District 2	Governor	reappointed	2/23/1993 1/1/1997
Ms. Dixie Hertel Moore Qualifications (if required): Republican from Congressional District 2	Governor	reappointed	2/23/1993 1/1/1997
Mr. Milton Olson Whitewater Qualifications (if required): Republican from Congressional District 2	Governor	reappointed	2/23/1993 1/1/1997
Montana Science and Technology Development Board (Commerce)			
Mr. Tom Breum Missoula Qualifications (if required): from private sector	Governor	reappointed	2/23/1993 1/1/1997
Mr. Will Brooke Bozeman Qualifications (if required): from private sector and an attorney	Governor	Bartos	2/23/1993 1/1/1997
Mr. Raymon F. Thompson Kalispell Qualifications (if required): from public sector and expert in technology development	Governor	Brower	2/23/1993 1/1/1997
Mr. Ken Thuerbach Victor Qualifications (if required): from private sector	Governor	reappointed	2/23/1993 1/1/1997
Mr. Ray Tillman Butte Qualifications (if required): from private sector	Governor	reappointed	2/23/1993 1/1/1997

BOARD AND COUNCIL APPOINTEES: FEBRUARY, 1993

Appointee	Appointed by	Succeeds	Appointment/End Date
Montana State Historical Preservation Officer (Education)			
Ms. Marcella Sherfy	Governor	reappointed	2/24/1993
Helena			0/0/0
Qualifications (if required): none specified			
State Lottery Commission (Commerce)			
Sheriff Cliff Brophy	Governor	Ware	2/5/1993
Columbus			1/1/1997
Qualifications (if required): law enforcement officer			
Ms. Becky Erickson	Governor	reappointed	2/5/1993
Glasgow			1/1/1997
Qualifications (if required): public member			
Mr. Larry O'Toole	Governor	Shanahan	2/5/1993
Plentywood			1/1/1997
Qualifications (if required): attorney			

VACANCIES ON BOARDS AND COUNCILS -- April, 1993 through June 30, 1993

Board/current position holder	Appointed by	Term end
Board of County Printing (Commerce)		
Mr. Ronald Dale Fossen, Scobey	Governor	4/1/1993
Qualifications (if required): county commissioner		
Ms. Jane Lopp, Kalispell	Governor	4/1/1993
Qualifications (if required): public member		
Ms. Mona L. Nutting, Red Lodge	Governor	4/1/1993
Qualifications (if required): county commissioner		
Mr. Verle L. Rademacher, White Sulpher Springs	Governor	4/1/1993
Qualifications (if required): printing industry representative		
Mr. Bruce Smith, Bozeman	Governor	4/1/1993
Qualifications (if required): member of printing industry		
Board of Hail Insurance (Agriculture)		
Mr. Grant Zerbe, Frazer	Governor	4/18/1993
Qualifications (if required): public member		
Board of Nursing Home Administrators (Commerce)		
Mr. Ronald Borgman, Columbus	Governor	5/28/1993
Qualifications (if required): nursing home administrator		
Board of Optometrists (Commerce)		
Dr. Kenneth R. Zuroff, Glendive	Governor	4/3/1993
Qualifications (if required): none specified		
Board of Professional Engineers and Land Surveyors (Commerce)		
Mr. Dennis F. Carver, Kalispell	Governor	4/23/1993
Qualifications (if required): professional engineer		

VACANCIES ON BOARDS AND COUNCILS -- April, 1993 through June 30, 1993

Board/current position holder	Appointed by	Term end
Board of Real Estate Appraisers (Commerce)		
Mr. Patrick Asay, Cardwell	Governor	5/1/1993
Qualifications (if required): appraiser represent Internat'l Right-of-Way Association		
Board of Realty Regulation (Commerce)		
Ms. B. Helen Garrick, Missoula	Governor	5/9/1993
Qualifications (if required): affiliated with Republican Party		
Board of Regents (Education)		
Mr. Travis M. Belcher, Helena	Governor	6/1/1993
Qualifications (if required): student at unit of higher ed. jurisdiction of bd of regents		
Board of Veterans Affairs (Military Affairs)		
Ms. Bernadette A. Opp, Missoula	Governor	5/18/1993
Qualifications (if required): none specified		
Clark Fork Rehabilitation Advisory Council (Governor)		
Mr. Vic Andersen, Helena	Governor	5/23/1993
Qualifications (if required): none specified		
Sen. Thomas Beck, Deer Lodge	Governor	5/23/1993
Qualifications (if required): none specified		
Mr. Frank Bennett, Anaconda	Governor	5/23/1993
Qualifications (if required): none specified		
Mr. Cal Christian, Anaconda	Governor	5/23/1993
Qualifications (if required): none specified		
Mr. Bob Fox, Helena	Governor	5/23/1993
Qualifications (if required): none specified		

VACANCIES ON BOARDS AND COUNCILS -- April, 1993 through June 30, 1993

Board/current position holder	Appointed by	Term end
Clark Fork Rehabilitation Advisory Council (Governor) cont.		
Mr. Pat Graham, Helena	Governor	5/23/1993
Qualifications (if required): none specified		
Mr. Glen Green, Deer Lodge	Governor	5/23/1993
Qualifications (if required): none specified		
Mr. Frank Munshower, Bozeman	Governor	5/23/1993
Qualifications (if required): none specified		
Mr. Peter Nielson, Missoula	Governor	5/23/1993
Qualifications (if required): none specified		
Mr. Steve Pilcher, Helena	Governor	5/23/1993
Qualifications (if required): none specified		
Ms. Sandy Stash, Anaconda	Governor	5/23/1993
Qualifications (if required): none specified		
Mr. Tim Sullivan, Butte	Governor	5/23/1993
Qualifications (if required): none specified		
Mr. Ray Tillman, Butte	Governor	5/23/1993
Qualifications (if required): none specified		
Education Advisory Council (Governor)		
Sen. Robert Brown, Whitefish	Governor	5/1/1993
Qualifications (if required): legislator and teacher		
Dr. Peter Carparelli, Billings	Governor	5/1/1993
Qualifications (if required): regional superintendent		

VACANCIES ON BOARDS AND COUNCILS -- April, 1993 through June 30, 1993

Board/current position holder	Appointed by	Term end
Education Advisory Council (Governor) cont.		
Mr. John Dallum, Cascade	Governor	5/1/1993
Qualifications (if required): parent of elementary student		
Mr. Bob Deming, Great Falls	Governor	5/1/1993
Qualifications (if required): serves on Board of Higher Education		
Mr. LeRoy Ensign, Bozeman	Governor	5/1/1993
Qualifications (if required): represents private schools		
Ms. Martha H. Parrish, Rexford	Governor	5/1/1993
Qualifications (if required): elementary school librarian		
Mr. Sidney Sutherland, Fairfield	Governor	5/1/1993
Qualifications (if required): guidance counselor		
Ms. Linda Vaughey, Havre	Governor	5/1/1993
Qualifications (if required): school board member		
Executive Bd of MT College of Mineral Science & Technology (Education)		
Mr. Haley Beaudry, Butte	Governor	4/19/1993
Qualifications (if required): resides in county where unit is located		
Executive Board of Eastern Montana College (Education)		
Mr. Dale Fasching, Billings	Governor	4/19/1993
Qualifications (if required): resides in county where unit is located		
Executive Board of Montana State University (Education)		
Ms. Cindy Shewey, Bozeman	Governor	4/19/1993
Qualifications (if required): resides in county where unit is located		

VACANCIES ON BOARDS AND COUNCILS -- April, 1993 through June 30, 1993

Board/current position holder	Appointed by	Term end
Executive Board of Northern Montana College (Education)		
Mr. Robert D. Morrison, Havre	Governor	4/16/1993
Qualifications (if required): public member		
Executive Board of University of Montana (Education)		
Mr. Bob Greil, Missoula	Governor	4/19/1993
Qualifications (if required): resides in county where unit is located		
Executive Board of Western Montana College (Education)		
Ms. Agnes Helle, Dillon	Governor	4/19/1993
Qualifications (if required): resides in county where unit is located		
Independent Living Advisory Council (Social and Rehabilitation Services)		
Ms. Ellen Alweis, Billings	director	4/1/1993
Qualifications (if required): none specified		
Mr. Paul Braut, Miles City	director	4/1/1993
Qualifications (if required): none specified		
Ms. Kathy Collins, Helena	director	4/1/1993
Qualifications (if required): none specified		
Ms. June Hermanson, Polson	director	4/1/1993
Qualifications (if required): none specified		
Ms. Jan LaValley-Miller, Great Falls	director	4/1/1993
Qualifications (if required): none specified		
Ms. Annette Lyman, Helena	director	4/1/1993
Qualifications (if required): none specified		
Mr. Terry Salinas, Billings	director	4/1/1993
Qualifications (if required): none specified		

VACANCIES ON BOARDS AND COUNCILS -- April, 1993 through June 30, 1993

Board/current position holder	Appointed by	Term end
Independent Living Advisory Council (Social and Rehabilitation Services) cont.		
Ms. Zana Smith, Helena	director	4/1/1993
Qualifications (if required): none specified		
Mr. Merle I. Weldele, Four Buttes	director	4/1/1993
Qualifications (if required): none specified		
Ms. Lynn Winslow, Helena	director	4/1/1993
Qualifications (if required): none specified		
Library Services Advisory Council (Education)		
Ms. Jean R. Anderson, Billings	Chairperson	5/31/1993
Qualifications (if required): rep. user of public library service in South Central Fed.		
Mr. Dave Beatty, Deer Lodge	Chairperson	5/31/1993
Qualifications (if required): rep. state agency employees and the institutionalized		
Ms. Evelyn Casterline, Culbertson	Chairperson	5/31/1993
Qualifications (if required): rep. user of public library service in Golden Plains Fed.		
Ms. Greta Chapman, Libby	Chairperson	5/31/1993
Qualifications (if required): rep. public libraries		
Mr. Bill Cochran, Billings	Chairperson	5/31/1993
Qualifications (if required): rep. federation coordinators		
Ms. Esther Dean, Forsyth	director	5/1/1993
Qualifications (if required): rep. user public library service in Sagebrush Library Fed.		
Ms. Connie Heckathorn, Whitefish	Chairperson	5/31/1993
Qualifications (if required): rep. user of public library service in Tamarack Federation		

VACANCIES ON BOARDS AND COUNCILS -- April, 1993 through June 30, 1993

Board/current position holder	Appointed by	Term end
Library Services Advisory Council (Education) cont.		
Ms. Beverly Knapp, Bozeman	Chairperson	5/31/1993
Qualifications (if required): rep. user of public library service in Broad Valleys Fed.		
Ms. Susan Long, Kalispell	Chairperson	5/31/1993
Qualifications (if required): rep. special libraries		
Mr. Al Randall, Libby	Chairperson	5/31/1993
Qualifications (if required): rep. school libraries		
Mr. Jim Reno, Billings	Chairperson	5/31/1993
Qualifications (if required): rep. disadvantaged		
Rep. Bill Strizich, Great Falls	Chairperson	5/31/1993
Qualifications (if required): rep. legislature		
Ms. Elise Thomas, Chinook	Chairperson	5/31/1993
Qualifications (if required): rep. user of public library service in Pathfinder Federation		
Mr. John Thomas, Helena	Chairperson	5/31/1993
Qualifications (if required): rep. academic libraries		
Ms. Diane VanGorden, Baker	Chairperson	5/31/1993
Qualifications (if required): rep. Montana Library Association		
Medal of Valor Advisory Council (Governor)		
Mr. Rick Bartos, Helena	Governor	4/30/1993
Qualifications (if required): not specified		
Major General Gary Blair, Helena	Governor	4/30/1993
Qualifications (if required): not specified		

Board/current position holder	Appointed by	Term end
Medal of Valor Advisory Council (Governor) cont.		
Rep. Jan Brown, Helena	Governor	4/30/1993
Qualifications (if required): not specified		
Ms. Kay Foster, Billings	Governor	4/30/1993
Qualifications (if required): not specified		
Ms. Jo Gmazel-Bartley, Hamilton	Governor	4/30/1993
Qualifications (if required): not specified		
Ms. Deola M. Shryock, Polson	Governor	4/30/1993
Qualifications (if required): not specified		
Mr. Mike Voeller, Helena	Governor	4/30/1993
Qualifications (if required): not specified		
Public Employees Retirement Board (Administration)		
Ms. Mona Jamison, Helena	Governor	4/1/1993
Qualifications (if required): at large member		
Mr. Troy W. McGee, Sr., Helena	Governor	4/1/1993
Qualifications (if required): retired public employee		
State Compensation Mutual Insurance Fund (Administration)		
Mr. James T. Harrison, Helena	Governor	4/28/1993
Qualifications (if required): at large member		
Mr. Robert S. Short, Great Falls	Governor	4/28/1993
Qualifications (if required): rep. state policy holder in private for-profit enterprise		
Mr. Clyde B. Smith, Kalispell	Governor	4/28/1993
Qualifications (if required): rep. state policy holder in private for-profit enterprise		

VACANCIES ON BOARDS AND COUNCILS -- April, 1993 through June 30, 1993

Board/current position holder	Appointed by	Term end
State Library Commission (Education)		
Ms. Anne Hauptman, Billings Qualifications (if required): public member	Governor	5/22/1993
Mr. Lloyd Wallin, Deer Lodge Qualifications (if required): public member	Governor	5/22/1993
Visual Services Advisory Council (Social and Rehabilitation Services)		
Mr. Mike Bullock, Helena Qualifications (if required): none specified	director	4/1/1993
Mr. George Gloege, Billings Qualifications (if required): none specified	director	4/1/1993
Mr. Richard James, Bozeman Qualifications (if required): none specified	director	4/1/1993
Ms. Sandra Jarvie, Helena Qualifications (if required): none specified	director	4/1/1993
Ms. June Miller, Helena Qualifications (if required): none specified	director	4/1/1993
Ms. Anita Nelson, Missoula Qualifications (if required): none specified	director	4/1/1993
Ms. Lucy Nottingham, Billings Qualifications (if required): none specified	director	4/1/1993
Ms. Virginia Sutich, Sand Coulee Qualifications (if required): none specified	director	4/1/1993

VACANCIES ON BOARDS AND COUNCILS -- April, 1993 through June 30, 1993

Board/current position holder	Appointed by	Term end
Vocational Education Advisory Council (Governor)		
Mr. Fred "Rocky" Clark, Butte Qualifications (if required): none specified	Governor	5/1/1993
Mr. Jeff Dietz, Billings Qualifications (if required): none specified	Governor	5/1/1993
Ms. Ann Haagenstad, Clancy Qualifications (if required): none specified	Governor	5/1/1993
Dr. Jon Jourdonnais, Great Falls Qualifications (if required): none specified	Governor	5/1/1993
Dr. August "Gus" Korb, Havre Qualifications (if required): none specified	Governor	5/1/1993
Dr. Dennis Lerum, Missoula Qualifications (if required): none specified	Governor	5/1/1993
Mr. Jesse O'Hara, Great Falls Qualifications (if required): none specified	Governor	5/1/1993
Dr. Robert Schaal, Kalispell Qualifications (if required): none specified	Governor	5/1/1993
Mr. James Schultz, Lewistown Qualifications (if required): none specified	Governor	5/1/1993
Colonel Gordon Simmons, Missoula Qualifications (if required): none specified	Governor	5/1/1993
Rep. Charles "Chuck" Swysgood, Dillon Qualifications (if required): none specified	Governor	5/1/1993

VACANCIES ON BOARDS AND COUNCILS -- April, 1993 through June 30, 1993

Board/current position holder	Appointed by	Term end
Vocational Education Advisory Council (Governor) cont.		
Ms. Avis Ann "Sanny" Tobin, Helena	Governor	5/1/1993
Qualifications (if required): none specified		
Mr. Howard Williams, Helena	Governor	5/1/1993
Qualifications (if required): none specified		
Western Interstate Commission for Higher Education (Governor)		
Dr. John Hutchinson, Helena	Governor	6/19/1993
Qualifications (if required): commissioner of higher education		