RESERVE

MONTANA ADMINISTRATIVE REGISTER

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MONTANA ADMINISTRATIVE REGISTER

ISSUE NO. 5

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 The notice section contains state agencies' proposed new, amended or repealed rules; the rationale for the change; date and address of public hearing; and where written comments may be submitted.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

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

In the matter of the proposed amendment of a rule pertaining to unprofessional conduct	)))))	NOTICE OF PROPOSED AMENDMENT OF ARM 8.58.419 GROUNDS FOR LICENSE DISCIPLINE - GENERAL PROVISIONS - UNPROFESSIONAL CONDUCT

NO PUBLIC HEARING CONTEMPLATED

TO: All Interested Persons:

1. On April 9, 1997, the Board of Realty Regulation proposes to amend the above-stated rule.

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

"8.58.419 GROUNDS FOR LICENSE DISCIPLINE - GENERAL PROVISIONS - UNPROFESSIONAL CONDUCT (1) through (3)(af) will remain the same.

(ag) Licensees, when advertising, shall present a true picture. Licensees shall not advertise without disclosing the licensee's name, ~~and~~ identity as a real estate licensee, and real estate brokerage. Licensees shall disclose their identity as a real estate licensee, whenever the licensee negotiates or attempts to negotiate the listing, sale, purchase, ~~or~~ exchange, rent or lease of real estate.

(4) will remain the same."

Auth: Sec. 37-1-131, 37-1-136, 37-51-102, 37-51-203, 37-51-321, MCA; IMP, Sec. 37-51-102, 37-51-201, 37-51-202, 37-51-321, 37-51-512, MCA

3. The rule as proposed would notify the consuming public that licensees must disclose the fact that they are real estate sales agents when the agents are advertising rental property or selling property.

4. Interested persons may submit their data, views or arguments concerning the proposed amendment in writing to the Board of Realty Regulation, 111 N. Jackson, P.O. Box 200513, Helena, Montana 59620-0513, or by facsimile to (406) 444-1667, to be received no later than 5:00 p.m., April 7, 1997.

5. If a person who is directly affected by the proposed amendment 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 Realty Regulation, 111 N. Jackson, P.O. Box 200513, Helena, Montana 59620-0513, or by facsimile to (406) 444-1667, to be received no later than 5:00 p.m., April 7, 1997.

6. If the Board receives requests for a public hearing on the proposed amendment from either 10 percent or 25, whichever is less, of those persons who are directly affected by the proposed amendment, from the Administrative Code Committee of the legislature, from a governmental agency or subdivision or from an association having no less than 25 members who will be directly affected, a hearing will be held at a later date. Notice of the hearing will be published in the Montana Administrative Register. Ten percent of those persons directly affected has been determined to be 530 based on the 5300 licensees in Montana.

BOARD OF REALTY REGULATION
JACK K. MOORE, CHAIRMAN

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

_____
ANNIE M. BARTOS, RULE REVIEWER

Certified to the Secretary of State, February 24, 1997.

BEFORE THE DEPARTMENT OF NATURAL RESOURCES AND CONSERVATION
OF THE STATE OF MONTANA

In the matter of new rules for the administration of the Yellowstone Controlled Groundwater Area	))))	NOTICE OF ADOPTION

TO: All Interested Persons.

1. On January 16, 1997, the Department of Natural Resources and Conservation published a notice of proposed adoption of new rules pertaining to application procedures for the Yellowstone Controlled Groundwater Area under the United States National Park Service-Montana Compact at page 22, 1997 Montana Administrative Register, Issue number 1.

2. The Department has adopted new Rule I (36.12.1201), Rule II (36.12.1202), Rule III (36.12.1203), Rule IV (36.12.1204), Rule V (36.12.1205), Rule VI (36.12.1206), Rule VII (36.12.1207), Rule VIII (36.12.1208), Rule X (36.12.1210), Rule XI (36.12.1211), and Rule XII (36.12.1212) as proposed.

3. The Department has adopted new Rule IX with the following changes:

Rule IX (36.12.1209) PERMIT CONDITIONS (1) All permits issued by the department must contain at a minimum the following specific conditions:

(a) same as proposed.

(b) The deadline to complete this permit and file a Notice of Completion of Permitted Water Development (Form No. 617) is December 31, (specify year). ~~If you cannot meet the deadline, file a Form No. 607, Application for Extension of Time, at least 30 days before the above deadline, otherwise the permit is void.~~

(i) For type "A" permit applications, the notice of completion must be filed 60 days after completion of the appropriation. If you cannot meet the deadline above, the permittee shall contact the Bozeman water resources regional office for a new deadline.

(ii) For type "B" permit applications, if you cannot meet the deadline, the permittee shall file a Form No. 607, Application for Extension of Time, at least 30 days before the above deadline, otherwise the permit is void.

(c)-(g) same as proposed.

(2) same as proposed.

4. The Department received one comment as follows:

COMMENT: Written comment was received from the regional manager of the water resources regional office in Bozeman, Montana. Rule IX (1)(b) should be amended to clarify the filing process of a notice of completion for Type A and Type B permits. Type A permits are for groundwater developments of 35 gallons per minute or less and 10 acre-feet or less. The compact simply requires them to register with the

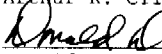
Department for a permit unlike Type B permits which are required to file for a permit according state statutes, Title 85, chapter 2, part 3. The compact requires Type A permits to file a notice of completion 60 days after completion of the well, therefore they are not required to file for an extension of time under state statutes if they can not meet the deadline. They notify the Bozeman office for a new deadline date.

RESPONSE: The Department agrees and has amended the Rule IX as above.

5. No other written comments were received.

DEPARTMENT OF NATURAL RESOURCES AND CONSERVATION

BY: 
Arthur R. Clinch, Director


Donald D. MacIntyre, Rule Reviewer

Certified to the Secretary of State, February 24, 1997.

BEFORE THE BOARD OF OIL AND GAS CONSERVATION
DEPARTMENT OF NATURAL RESOURCES AND CONSERVATION
OF THE STATE OF MONTANA

In the matter of the amendment of rule 36.22.1408, pertaining to underground injection control	)))	NOTICE OF AMENDMENT

TO: All Interested Persons

1. On December 5, 1996, the Board of Oil and Gas Conservation published notice of the proposed amendment to rule 36.22.1408, pertaining to underground injection control financial responsibility requirements at page 3107 of the 1996 Montana Administrative Register, issue number 23.

2. On January 3, 1997, a public hearing was held. One comment was received at the public hearing. Written comments were received from the U.S. Environmental Protection Agency, Region VIII (EPA). Although the EPA comments were received after the January 2, 1997, deadline for public comment the Board has elected to consider them.

3. The Board has amended rule 36.22.1408 with the following changes:

36.22.1408 FINANCIAL RESPONSIBILITY (1) The owner or operator of any injection well outside the exterior boundaries of Indian reservations must comply with the applicable bonding requirements of ARM 36.22.1308~~; provided, however, that such bonding requirements must also apply to lands owned or held in trust by the United States~~ and this sub-chapter.

Subsections (2) through (5)(b) same as proposed.

(c) it must be for a term of ~~unlimited duration~~ not less than one year, automatically renewable for additional one year period(s), and irrevocable during its term. The bank issuing the letter of credit must notify the board, by registered or certified mail, not less than 120 days prior to the expiration date of the letter of credit if it does not intend to renew the letter;

Subsections (5)(d) through (6) same as proposed.

AUTH: Sec. 82-11-111, MCA;
IMP: Sec. 82-11-111, 82-11-121, 82-11-123, 82-11-124, 82-11-127, and 82-11-137, MCA

COMMENT: EPA notes that the proposed rule amendment appears to limit the Board's authority under Rule 36.22.1308 by referring only to subsections 36.22.1308(1)(a)(i) and (ii) of the rule and thereby restricting the Board's ability to use 36.22.1308(3) to increase individual bonds on a case-by-case basis.

RESPONSE: The Board agrees. Rule 36.22.1408(1) is amended as suggested.

COMMENT: True Oil Company requested the Board amend rule 36.22.1408(5)(c) which requires a letter of credit to be issued for a "term of unlimited duration". Banking officials that were consulted by True indicate that banks generally would not issue letters of credit for unlimited terms. True points out that both EPA and the Bureau of Land Management accept letters of credit as demonstration of financial responsibility, and both allow automatically renewable letters of credit of fixed term subject to notice by the bank to the regulatory agency if a letter is not going to be reviewed.

RESPONSE: The Board agrees that the proposed amendment may severely limit the availability of letters of credit because the lack of a fixed term imposes additional risk upon the institution. The Board believes that it should require notice of impending non-renewal sufficiently in advance to allow the adequate time for notice and a show cause hearing to be held if non-compliance with the financial responsibility rules appears imminent. The Board amends rule 36.22.1408(5)(c) as suggested.

COMMENT: EPA comments that there may be a question of the Board's authority to require a demonstration of solvency of the bank issuing a letter of credit as stated in proposed subsection (6), that some arrangement should be made with the banking commission to monitor bank solvency, that rules should be adopted to provide criteria and format for demonstrating solvency, and that rules should be adopted requiring notice of suspicion of impairment of the solvency of its letter of credit by the injection well operator.

RESPONSE: The Board does not agree with these suggestions. The use of a letter of credit in lieu of a surety bond or certificate of deposit is permissive. The burden of persuading the Board that a letter of credit is an appropriate financial assurance lies with the individual or company asking that its letter be accepted. The Board may require supplemental financial assurance, further information from the operator, or may reject a letter of credit at any time, including after acceptance. The Board's statutory charge is to require a "reasonable bond with good and sufficient surety..." (82-11-123(5), MCA). The rule does not constrain the statute; the Board may, as part of its public hearing process, impose such other requirements as it finds necessary to insure that a letter of credit is "good and sufficient".

BOARD OF OIL & GAS CONSERVATION

By: _____ _____

THOMAS P. RICHMOND, ADMINISTRATOR

DON MacINTYRE, RULE REVIEWER

Certified to the Secretary of State on February 24, 1997.

BEFORE THE BOARD OF OIL AND GAS CONSERVATION
DEPARTMENT OF NATURAL RESOURCES AND CONSERVATION
OF THE STATE OF MONTANA

In the matter of the amendment of rule 36.22.1423, pertaining to injection fees and well classification	)))	NOTICE OF AMENDMENT

TO: All Interested Persons

1. On January 16, 1997, the Board of Oil and Gas Conservation published notice of the proposed amendment to rule 36.22.1423, pertaining to injection fees and well classification at page 32 of the 1997 Montana Administrative Register, issue number 1.

2. No comments or testimony were received.

3. The Board has amended rule 36.22.1423 as proposed.

BOARD OF OIL & GAS CONSERVATION

By: _____
THOMAS P. RICHMOND, ADMINISTRATOR

_____
DON MacINTYRE, RULE REVIEWER

Certified to the Secretary of State on February 24, 1997.

BEFORE THE DEPARTMENT OF PUBLIC
HEALTH AND HUMAN SERVICES OF THE
STATE OF MONTANA

In the matter of the amendment of rules 46.12.101, 46.12.102, 46.12.301, 46.12.302, 46.12.303, 46.12.304, 46.12.306, 46.12.307, 46.12.308, 46.12.407, 46.12.501, 46.12.502, 46.12.593, 46.12.1235, 46.12.1260, 46.12.1705 and 46.12.1919 pertaining to general medicaid provider requirements	NOTICE OF AMENDMENT OF RULES

TO: All Interested Persons

1. On October 24, 1996, the Department of Public Health and Human Services published notice of the proposed amendment of rules 46.12.101, 46.12.102, 46.12.301, 46.12.302, 46.12.303, 46.12.304, 46.12.306, 46.12.307, 46.12.308, 46.12.407, 46.12.501, 46.12.502, 46.12.593, 46.12.1235, 46.12.1260, 46.12.1705 and 46.12.1919 pertaining to general medicaid provider requirements at page 2724 of the 1996 Montana Administrative Register, issue number 20.

2. The Department has amended rules 46.12.304, 46.12.306, 46.12.307, 46.12.308, 46.12.407, 46.12.502, 46.12.593, 46.12.1235, 46.12.1260, 46.12.1705 and 46.12.1919 as proposed.

3. The Department has amended the following rules as proposed with the following changes from the original proposal. New language being added is underlined. Language to be deleted is interlined.

46.12.101 MEDICAL ASSISTANCE, PURPOSE (1) Subject to applicable state and federal laws, regulations, and rules ~~and policies~~, the Montana medicaid program pays for covered medically necessary services for persons determined eligible by the department or its agents.

AUTH: Sec. 53-2-201 and 53-6-113, MCA
IMP: Sec. 53-6-101, 53-6-131 and 53-6-141, MCA

46.12.102 MEDICAL ASSISTANCE, DEFINITIONS (1) through (2)(a)(v) remain as proposed.

(b) A service or item is not medically necessary if there is another ~~medically appropriate treatment for~~ service or item for the recipient that is equally safe and effective and substantially less costly including, when appropriate, no treatment at all.

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

(5) Emergency service means inpatient and outpatient hospital services that are necessary ~~on an immediate basis to prevent the death or serious impairment of the health of a recipient~~ to treat an emergency medical condition as defined in 42 CFR 489.24(b).

(6) ~~Valid and proper claim means a claim completed, signed and submitted according to all applicable requirements on a department approved billing form with all required information supplied, and for which no further information or substantiation is required for payment~~ Services means services, items and any other amounts reimbursable under the Montana medicaid program.

(7) through (37) remain as proposed.

AUTH: Sec. 53-2-201 and 53-6-113, MCA
IMP: Sec. 53-2-201, 53-6-101, 53-6-106, 53-6-107, 53-6-111, 53-6-113, 53-6-131, 53-6-141 and 53-6-155, MCA

46.12.301 PROVIDER PARTICIPATION (1) As a condition of participation in the Montana medicaid program all providers must comply with all applicable state and federal statutes, rules~~,~~ and regulations ~~and policies~~, including but not limited to federal regulations and statutes found in Title 42 of the Code of Federal Regulations and the United States Code governing the medicaid program and all applicable Montana statutes and rules governing licensure and certification.

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

46.12.302 PROVIDER ENROLLMENT AND AGREEMENTS (1) through (1)(c) remain as proposed.

(d) provide information and documentation regarding:

(i) any sanctions, suspensions, exclusions or civil monetary penalties imposed by the medicare program, ~~or~~ any state medicaid program or other federal program ~~or criminal charges brought~~ against the provider ~~or persons or entities associated with~~, a person or entity with an ownership or control interest in the provider or an agent or managing employee of the provider; and

(ii) any criminal charges brought against and any criminal convictions of the provider, a person or entity with an ownership or control interest in the provider or an agent or managing employee of the provider related to that person's or entity's involvement in medicare, medicaid or the Title XX services program; and

(1)(e) remains as proposed.

(2) Providers shall provide the department's fiscal agent with 30 days advance written notice of any change in the provider's name, address, tax identification number, group practice arrangement, business organization or ownership.

(a) An enrolled provider is not entitled to change retroactively the category of service for which the provider is enrolled, but must enroll prospectively in the new program category. The change in service category will be effective only upon approval of a completed enrollment application for the new service category and on or after the effective date of all required licenses and certifications. The change will apply only to services provided on or after the effective date of the enrollment change.

(3) ~~An~~ Except as provided in (2)(a), an approved enrollment is effective on the later of:

(3)(a) through (5)(a) remain as proposed.

(6) Providers shall not discriminate illegally in the provision of service to eligible medicaid recipients or in employment of persons on the grounds of race, creed, religion, color, sex, national origin, political ideas, marital status, age or disability. Providers shall comply with the Civil Rights Act of 1964 (42 USC 2000d, et seq.), The Age Discrimination Act of 1975 (42 USC 6101, et seq.), The Americans With Disabilities Act of 1990 (42 USC 12101, et seq.), section 504 of the Rehabilitation Act of 1973 (29 USC 794), and the applicable provisions of Title 49, MCA, as amended, and all regulations~~,~~ and rules ~~and policies~~ implementing the statutes.

AUTH: Sec. 53-2-201 and 53-6-113, MCA
IMP: Sec. 53-2-201, 53-6-101, 53-6-111, 53-6-113, 53-6-131 and 53-6-141, MCA

46.12.303 BILLING, REIMBURSEMENT, CLAIMS PROCESSING, AND PAYMENT (1) through (2)(d) remain as proposed.

(3) Claims must be submitted in accordance with this rule to be valid. In processing claims, the department or its agent may deny payment of or pend a claim upon determining that a basis exists for denial of payment or pending the claim~~,~~. ~~and no~~ No further review or processing of ~~the~~ a denied claim is required until resubmission of the claim by the provider. The department or its agent is not required to list or identify all possible grounds for denial or pending of the claim. The fact that a particular basis for denial or pending of a claim for a service or item was not identified on an earlier statement of remittance or other similar statement does not preclude denial or pending of the claim on that basis on a later submission of the claim.

(4) through (9) remain as proposed.

(10) The department is entitled to recover from the provider and the provider is obligated to repay to the department all medicaid payments made to which the provider was not entitled under applicable state and federal laws, regulations~~,~~ and rules ~~or policies~~. At the option of the department, recoveries may be accomplished by a direct payment to the department or by automatic deductions from future payments due the provider. Notice of overpayment must be made

in accordance with ARM 46.12.407.

(10)(a) and (10)(b) remain as proposed.

(11) Providers are required to accept, as payment in full, the amount paid by the Montana medicaid program for a service ~~or item~~ provided to an eligible medicaid recipient in accordance with the rules of the department. Providers shall not seek any payment in addition to or in lieu of the amount paid by the Montana medicaid program from a recipient or his representative, except as provided in these rules. A provider may bill a recipient for the co-payments specified in ARM 46.12.204 and ARM 46.17.121 and may bill certain recipients for amounts above the medicare deductibles and coinsurance as allowed in ARM 46.17.119.

(a) A provider may bill a recipient for non-covered services if the provider has informed the recipient in advance of providing the services that medicaid will not cover the services and that the recipient will be required to pay privately for the services, and if the recipient has agreed to pay privately for the services. For purposes of (11)(a), non-covered services are services that may not be ~~covered~~ reimbursed for the particular recipient by the Montana medicaid program under any circumstances, and covered services are services that may be reimbursed by the Montana medicaid program for the particular recipient if all applicable requirements, including medical necessity, are met.

(b) Except as provided in this rule, a provider may not bill a recipient after medicaid has denied payment for covered services because the services are not medically necessary for the recipient.

(i) A provider may bill a recipient ~~after~~ for covered but medically unnecessary services, including services for which medicaid has denied payment for lack of medical necessity, if the provider specifically informed the recipient in advance of providing the services that the services are not considered medically necessary under medicaid criteria, that medicaid will not pay for the services and that the recipient will be required to pay privately for the services, and the recipient has agreed to pay privately for the services. The agreement to pay privately must be based upon definite and specific information given by the provider to the recipient indicating that the service will not be paid by medicaid. The provider may not bill the recipient under this exception when the provider has informed the recipient only that medicaid may not pay or where the agreement is contained in a form that the provider routinely requires recipients to sign.

(ii) An ambulance service provider may bill a recipient after medicaid has denied payment for lack of medical necessity.

(11)(c) through (12)(b) remain as proposed.

AUTH: Sec. 53-2-201 and 53-6-113, MCA
IMP: Sec. 53-2-201, 53-6-101, 53-6-111, 53-6-113, 53-6-131 and 53-6-141, MCA

46.12.501 SERVICES PROVIDED (1) through (1)(y) remain as proposed.

(z) ~~residential treatment~~ inpatient psychiatric services; (1)(aa) through (3)(b)(ii) remain as proposed.

AUTH: Sec. 53-2-201 and 53-6-113, MCA
IMP: Sec. 53-2-201, 53-6-101, 53-6-103, 53-6-111, 53-6-113, 53-6-131 and 53-6-141, MCA

4. The Department has thoroughly considered all commentary received. The comments received and the department's response to each follow:

COMMENT #1: In the definition of "medically necessary" in ARM 46.12.102(2)(b), the department should retain the language that provides that alternative treatments must be "equally safe and effective." The proposed language would permit the department to decide that a service or item is not medically necessary if there is another treatment that is less safe and effective. Deletion of the word "equally" is inconsistent with other department policies and effectively destroys the impact of the entire sentence. For example, in the department's residential treatment services manual it provides that less restrictive settings will be appropriate if it appears that the recipient's psychiatric condition could be treated with equal or greater safety and therapeutic benefit in a less restrictive setting. The department should retain the standard of equal or greater safety and effectiveness. Section 53-6-101(8), MCA states that the services provided under the medicaid program may only be those that are medically necessary and that are the most efficient and cost effective. The proposed standard falls short of this statutory requirement.

Also, the department should retain the language that provides that alternative treatments must be "substantially less costly". The proposed language would permit the department to decide that a service or item is not medically necessary if there is another treatment that is less costly even if the difference is very minimal. It appears that the proposed language could be used to supersede level of care determinations for long term care recipients, e.g., denying a nursing home claim because a lower cost level of care is available or denying a waiver or home service because a nursing home placement would be more economical. The words "equally" and "substantially" are appropriate qualifying terms that should be retained.

RESPONSE: Although the department disagrees that the proposed language falls short of any statutory standard, the department will retain the terms "equally" and "substantially" in the final rule language.

COMMENT #2: In ARM 46.12.102(2)(b), the addition of the term "medically appropriate treatment" is undefined and increases the burden on providers and the department to prove what is or is not medically necessary.

RESPONSE: The department will replace the phrase "another medically appropriate treatment" with the phrase "another service or item."

COMMENT #3: In ARM 46.12.102(2)(a) the department deletes the word "or" from the list of circumstances under which a service might be considered medically necessary. Does the department intend to require that all of the listed circumstances be present for the service to be medically necessary? Any one of the listed circumstances should be sufficient.

RESPONSE: In the current rule, the word "or" is unnecessarily repeated after each listed circumstance. The proposal retains the word "or" before the last item in the list, indicating that only one of the listed circumstances need be present to meet the requirement in ARM 46.12.102(2)(a).

COMMENT #4: In ARM 46.12.102(2)(b), the department should provide that an alternative treatment must be reasonably available to the recipient when considering whether a service is medically necessary. An alternative treatment should not lead to denial of coverage where the alternative service either does not exist or is not reasonably available to the recipient. For example, an ambulance might be the only available medically appropriate transportation for a person in a particular region, even though a community van with specialized equipment and trained attendants would be medically appropriate if it was available in the region.

RESPONSE: The service or item provided must itself be medically necessary. The lack of appropriate alternatives does not make a higher level of service or a costlier service medically necessary.

COMMENT #5: In ARM 46.12.102(5) the department proposes to amend the definition of "emergency service." This definition should not be adopted for inpatient and outpatient hospital care. The department should reference federal regulations at 42 CFR 489.24(b) that define emergency medical conditions. The proposed rule differs substantially from the federal regulation and the department has not explained why a different definition is necessary. Regardless of what definition is adopted, hospitals are required to comply with the federal regulation.

RESPONSE: 42 CFR 489.24(b) is a medicare regulation that specifies the responsibilities of medicare providers in emergency cases. The department agrees that the medicare

definition is appropriate for purposes of this rule, and the department will revise the rule to refer to the medicare definition.

COMMENT #6: The changes proposed to ARM 46.12.102(6) are "internally redundant." If the department wants this language to be consistent with the billing requirements of ARM 46.12.303, then it ought to repeat the same definition here or simply refer to the other rule section.

RESPONSE: Because the language of current ARM 46.12.303(9) is being deleted, the definition of "valid and proper claim" in ARM 46.12.102(6) is unnecessary and will be deleted altogether.

COMMENT #7: In several places in the rules, the term "services" is used and in other places the phrase "services and items" is used. Is this difference intentional and if so, what is the significance?

RESPONSE: The difference is not intended to be significant. The term services is sometimes used to include all services, items and other amounts payable under the program. A definition of the terms "services" will be added to ARM 46.12.102 to indicate that the term includes services, items and any other amounts reimbursable under the program.

COMMENT #8: In ARM 46.12.101, 46.12.301, 46.12.302 and 46.12.303(10) the department proposes to require that providers comply with all applicable state and federal policies. The word policies should be deleted. Providers must comply with state and federal laws and regulations, but policies do not have the force and effect of law. Statutes, rules and regulations are published and known sources. Policies are subject to change without notice, without publication and without comment from interested and affected parties. If the department wants to enforce a policy it must adopt the policy as a rule under the Administrative Procedure Act, which allows those affected by the proposed rule notice an opportunity to comment before the policy is adopted.

RESPONSE: The department will delete the noted references to policies. However, department policies often are a statement of the department's interpretation of applicable state or federal laws, regulations or rules. As such, a department policy may be binding as a reasonable interpretation of the law. The department expects providers to comply with department policies of which they have been informed, e.g., provider manuals. Also, federal policies may be legally binding without being adopted formally as a regulation.

COMMENT #9: In ARM 46.12.302(1)(d), the provision concerning notice of criminal charges is too broad. We understand the need

to know about criminal charges related to medicaid, but notice of criminal charges regarding other matters is too broad. This is particularly true when one considers the fact that the criminal charges the department wants to know about are not only those brought against the provider, but also against persons or entities associated with the provider. If a child care worker were to be charged with unlawful possession of alcohol at a Halloween party, this provision would require that the charge be reported to the department.

RESPONSE: The proposed rule language regarding criminal convictions is based upon 42 CFR 455.106, which requires providers to disclose to the medicaid agency certain information regarding criminal convictions. The federal regulation requires disclosure of the identity of any person who (1) has an ownership or control interest in the provider or is an agent or managing employee of the provider, and (2) has been convicted of a criminal offense related to that person's involvement in any program under medicare, medicaid or the Title XX services program since the inception of those programs. The department's proposed rule is broader than the requirements of the federal regulation. The department will revise the language of the rule to require disclosure only with respect to the provider, a person or entity with a control or ownership interest in the provider or an agent or managing employee of the provider, and to require disclosure only when the criminal matter was related to the person's or entity's involvement in medicare, medicaid or the Title XX services program.

COMMENT #10: Are providers permitted to retroactively change the category of services for which they are enrolled? For example, a clinic enrolls in medicaid as a physician services provider, and bills and receives medicaid payment under the physician services program. The clinic later determines that it would have been more advantageous to have been reimbursed for the same services as a federally qualified health center (FQHC). Can the clinic change its enrollment category and retroactively adjust the claims to receive the higher FQHC reimbursement?

RESPONSE: No. The provider must enroll in the desired new category of service. The enrollment change will be effective only for services provided after the change in service category is approved. Language has been added to ARM 46.12.302 to clarify this point.

COMMENT #11: The proposed language in ARM 46.12.303(3) will make processing of claims too difficult. The provider's claim could be denied because the provider fails to dot an "i" and then upon resubmission denied because the provider failed to cross a "t". This process could go on and on, adversely impacting the provider's cash flow. We would like to meet with the department to try to come up with some equitable middle

ground on this issue.

RESPONSE: Under the new claims processing system expected to begin operation in the summer of 1997, statements of remittance will inform providers of multiple reasons for claim denial but will not necessarily list all possible reasons, especially where there are a large number of reasons. The department will adopt the rule as proposed (subject to the response to Comment #12 below). Moreover, the department is always willing to provide assistance to providers experiencing difficulty with the claim submission process.

COMMENT #12: The proposed language in ARM 46.12.303(3) regarding pended claims does not make sense. If a claim is denied, then the provider is required to follow up and resubmit the claim. But if a claim is pended, that means that Consultec is unsure of some aspect of the claim and that the provider must wait to see what action Consultec takes on the claim. The provider cannot resubmit the claim or both the original and the resubmitted claim will be denied as duplicates. The department cannot treat denied and pended claims the same in this respect or the claims processing system will be a mess. The rule should be revised to address properly the difference between pended and denied claims.

RESPONSE: The department agrees that the proposed rule language regarding no further review or processing of a claim until resubmission by the provider should apply only to denied claims and not to pended claims. The department will revise the rule language accordingly.

COMMENT #13: In ARM 46.12.303(9) language is being deleted that requires the department to pay 90% of all valid and proper claims within 30 days after receipt. Why is this language being deleted? Does this mean the department will no longer meet this requirement? If not, what standard does the department intend to meet? Federal regulations previously required the state to meet this standard to qualify for federal matching payments. Has this standard been removed or relaxed? What assurances do providers have that claims will not be delayed for payment? What recourse will providers have if payment of clean claims is delayed? The department consistently and without exception requires providers to submit claims within certain time frames, but now proposes that it be permitted to pay claims within any time without limitation. This is unfair and illegal. Federal statute at 42 U.S.C. 1396a(a)(37), as implemented by 42 CFR 447.45, requires the department to meet this standard. The department cannot delete this provision because it is a federal law.

RESPONSE: This change in the rule language will not result in any change in the claims processing system or the time within

which valid and proper claims are paid. The department must meet the federal claims processing standards as specified in the federal statute and regulations, and removal of this language from the administrative rule does not change the federal requirements. The department has not proposed and has no intention of proposing that it "be permitted to pay claims within any time, without limitation" as the comment has suggested. The deleted language merely restates the requirements of the federal regulation at 42 CFR 447.45. The department disagrees that the law prohibits it from deleting this language from the administrative rules. These requirements remain in federal regulations and it is unnecessary to restate the requirements in the administrative rules. The federal regulation does not establish a standard to which a provider may hold the department with respect to payment of any one particular claim, but rather states the standards to which the federal government may hold the state medicaid agency with respect to timeliness of claims payment in the aggregate. The department will be required by federal regulations to meet these requirements whether or not restated in the administrative rules. The department will delete the language as proposed.

COMMENT #14: In ARM 46.12.303(11)(b) language is being deleted stating that a provider may bill a recipient for services not covered by the medicaid program. The department has provided no explanation as to why this language is being deleted. A provider may bill a recipient for services that are not covered by the medicaid program. This language should remain part of the rule. In light of the new language proposed in ARM 46.12.303(11)(a) and (b), this is an unnecessary and unfair intrusion on the right of a provider to manage and operate their business. The department would be better served by identifying or defining what is or is not a service covered by the medicaid program so there would be no question as to what may be billed separately by the provider.

RESPONSE: The language deleted in ARM 46.12.303(11)(b) is being replaced by the new language in ARM 46.12.303(11)(a), which more specifically addresses the same subject. The department has retained the rule but has added a requirement that the provider obtain the medicaid recipient's informed payment agreement prior to service delivery. The proposed rule in fact does define "non-covered services" and the department is adding a definition of "covered services" in the final rule. The department disagrees that the rule is unnecessary or unfair. The department believes that patients presenting themselves as medicaid recipients generally expect that services will be paid for by medicaid, and that the provider is in a better position than the recipient to identify what services will not be covered. The department believes that requirement of an advance discussion of medicaid non-coverage is the most effective and least intrusive means to assure that recipients understand their

responsibilities and have an opportunity to decline services for which they cannot or do not wish to pay privately.

COMMENT #15: In ARM 46.12.303(11)(a) and (b), the proposed new restrictions on actions of providers are impossible to comply with and will put providers in an impossible situation. Subsection (11)(a) states that a provider may bill a recipient for non-covered services if the provider has informed the recipient in advance of providing the service that medicaid will not cover the service and that the recipient will be required to pay privately for the services. In (11)(b)(i) the rule impermissibly limits a provider's ability to bill for services that have been decertified by providing that a provider may bill a recipient after medicaid has denied payment for lack of medical necessity if the provider specifically informed the recipient in advance of providing the services that the services are not medically necessary under medicaid criteria, that medicaid will not pay for the services and that the recipient will be required to pay privately for the services. This language together with the new language at ARM 46.12.306(3) would put the provider in the position of never being able to bill a recipient or responsible party for services provided when medicaid determines retroactively that services are not medically necessary and recovers a previous payment. Also, there are situations where services may not be certified in advance but have not been decertified prior to provision of the service. The decertification may come long after the service is provided. The provider in some cases will know and understand what services the department considers medically unnecessary. But providers cannot know all circumstances where the department might approve or deny services. This is especially true for residential treatment for emotionally disturbed youth and other psychiatric services. These rules put too burdensome a weight on provider shoulders and may actually encourage noncompliance with the rules simply because of financial necessities. If the department insists on imposing such restrictions on providers, then it must make exceptions for those occasions when the department does not timely decertify or if it retroactively decertifies. The department should allow a provider to work with a patient to determine that, if the department refuses coverage the provider will continue to serve the patient under an alternative plan. To do otherwise creates a barrier to access for recipients and makes providers less willing to participate in medicaid.

RESPONSE: The department disagrees with the comment. The rule is about who is in the best position to make medical judgments and who is responsible between the provider and the recipient if the judgment is incorrect. Medical necessity is a medical question and one that providers are required by the rules to address. It is not a judgment that recipients generally are qualified to make, especially in cases involving psychiatric

treatment such as residential treatment services. Recipients typically rely upon providers to advise them of what is needed and assume that medicaid will pay unless informed otherwise.

The department does not routinely recover payments retroactively on medical necessity grounds. This would occur primarily in cases where the provider failed to disclose all information at its disposal. Residential treatment certification decisions are normally communicated to the provider prior to delivery of the services or within a few days of the beginning of the proposed certification period. The rule would have a very minimal financial impact as long as providers inform the recipient and discuss payment as soon as possible after a denial of certification. The medical necessity requirement is an established requirement of which providers are aware, and for a variety of reasons it is not always possible to determine medical necessity or inform providers of a certification decision prior to the commencement of service delivery. In any event, the department believes that it is the provider rather than the recipient who should bear the risk of any such post-service denial, because the provider is the party in a position to make a judgment about the medical necessity of the services and recipients generally rely upon providers' judgments.

The proposed rule encourages rather than prohibits provider efforts to work with patients to clarify payment arrangements prior to service delivery. The department will consider any noncompliance with the rule and may impose sanctions upon providers that fail to comply for "financial" or other reasons. The department does not believe that the rule is an impermissible limit on provider billing, but rather believes that these rules merely state what the federal law already requires.

COMMENT #16: We understand what the department is trying to accomplish in the first sentence of ARM 46.12.303(11)(b)(i), but the provider should be required to inform the recipient that the department's agent has determined the service not medically necessary, rather than being required to inform the recipient that the services are not medically necessary under medicaid criteria. The review agent's determinations are often challenged and often prove to be incorrect.

RESPONSE: The department will revise the rule language to allow the provider to inform the recipient that services are not considered medically necessary under medicaid criteria. The provider is free to explain to the recipient who it is that has made this judgment, and even that the provider disagrees with the judgment. The provider also may explain that an appeal is available and may explain the appeal process, as long as the provider does not induce a private pay agreement with explicit or implied assurances that the determination will be reversed.

The goal is to assure that the recipient understands that they are incurring a real and definite obligation, rather than a remote or unlikely possibility that they may have to pay.

COMMENT #17: We do not understand what the department means by the second sentence of ARM 46.12.303(11)(b)(i) when it states that the agreement to pay privately "must be based upon definite and specific information given by the provider to the recipient indicating that the services will not be paid by Medicaid." The information required to be provided under the first sentence of (11)(b)(i) is sufficient and the second sentence is superfluous and should be deleted.

The same comment applies to the third sentence of (11)(b)(i), which states that the provider must do more than inform the recipient only that medicaid may not pay and which also prohibits the use of agreements which are "contained in a form that the provider routinely requires recipients to sign." This requirement is superfluous. The first sentence requires that the recipient be informed of three things. After being so informed, the agreement the recipient will be required to sign will probably be contained in a form the provider routinely requires recipients to sign under such circumstances. At the time this action is taking place, the provider will know very little about the decertification, and in some cases the services are provided before the provider even knows about the decertification. The provider should be required to advise the recipient what the review agent has said, that medicaid will not pay for the services, and that the recipient will be required to pay privately for the services. The recipient will then have to agree to pay privately for the services. Otherwise, discharge will have to occur.

RESPONSE: The point of the rule is that the provider cannot obtain the recipient's informed agreement to pay by the use of contingency language in standard agreements that all patients sign, such as an admission form routinely required of all patients, that is signed before anyone knows that coverage will be denied. The agreement to pay privately must be an informed agreement, which means it must be one that is made after the recipient is informed that medicaid will not pay or has refused certification or payment for the service. This situation cannot be covered by a clause that requires the recipient to pay if medicaid does not, when in fact the recipient's expectation is that medicaid will pay. The rule does not prohibit the provider from using a standard agreement form to document the recipient's informed agreement to pay after the recipient has been informed that medicaid will not pay. Please see also the response to Comment #13.

COMMENT #18: In ARM 46.12.303(11) the department has deleted (11)(b), which states that "a provider may bill a recipient for

services not covered by the medicaid program." In its place has been substituted a provision that non-covered services may be billed if the recipient has been informed in advance that medicaid will not pay for it and the recipient agrees to pay for it. The proposed rule states that "non-covered services are services that may not be covered for the recipient by the Montana medicaid program under any circumstances." This provision should be changed to clarify that there may be instances where medicaid would pay for a given service "under certain circumstances" but if those circumstances do not exist with respect to a given recipient the service is non-covered and may be billed. For example, long term care facilities may bill a medicaid resident's family for the payment differential for a private room that is not medically necessary, even though medicaid would in fact cover the room if it were medically necessary. Another example would be "bed holds" which are covered by medicaid under certain circumstances but not covered under other circumstances.

With respect to long term care facilities, the department should clarify that facilities that comply with federal laws and regulations addressing what services may and may not be billed separately to nursing home residents and what the notice requirements are, meet the requirements of these state rules.

RESPONSE: The service examples described in the comment are covered services under the medicaid program. That is, they are services that are reimbursable by medicaid if medically necessary and all applicable requirements are met. The proposed rule permits the facility to bill the resident for these services, but requires simply that the provider obtain the recipient's informed payment agreement in advance of providing the service. The department believes that this is essentially the same requirement that must be met by nursing facilities under 42 CFR 483.10(c)(8) and 489.32. The department does not believe that this rule substantially changes the requirement nursing facilities must meet under federal law.

COMMENT #19: At ARM 46.12.303(11)(a) the department states that a provider may bill a recipient for non-covered services only if the provider notifies the recipient before the service is provided and the recipient agrees to pay. This refers to the services identified at ARM 46.12.502 and the rule should refer to that provision for clarity.

RESPONSE: The list in ARM 46.12.502 is not a list of the services that are "non-covered" within the meaning of this rule. Non-covered services would include the services listed in ARM 46.12.502 for some recipients. However, some of the services listed in ARM 46.12.502 may be covered services for some recipients, e.g., for recipients under age 21 according to the rules of the Early and Periodic Screening, Diagnosis and

Treatment Program (EPSDT). Some of the services described in the EPSDT rules are covered for EPSDT recipients but would be non-covered for recipients over age 21. Also, some of the services listed in ARM 46.12.501 are non-covered services for certain FAIM project recipients. The department will not insert a reference to ARM 46.12.502.

COMMENT #20: The department should amend ARM 46.12.303(11) to provide that it applies only in circumstances where the recipient has shown their medicaid identification card to the provider. For years, the department has advised providers that a patient is considered private pay until the patient shows the medicaid identification card to the provider.

RESPONSE: The department does not believe the suggested change would be appropriate. The department cannot say that the provider would not know or should not inquire regarding the payment source prior to delivery of services. The department notes that (11)(c) leaves open the possibility of the provider billing the recipient as a private pay patient if the provider is not informed of medicaid eligibility. Also, this language applies to medicaid recipients and assumes that the provider knows of the patient's medicaid eligibility.

COMMENT #21: Managed care organizations and HMOs are beginning to enroll considerable numbers of medicaid eligible persons. The department should state whether or not ARM 46.12.303(11) applies to a person enrolled in a managed care program, including Passport to Health, HMO or the mental health managed care plan.

RESPONSE: Under ARM 46.12.4815, HMOs are subject to the payment in full but not the billing requirements of ARM 46.12.303. The proposed rules for the mental health managed care plan provide that the payment in full provisions of ARM 46.12.303 apply. The payment in full provisions of ARM 46.12.303 also apply to Passport recipients.

COMMENT #22: The department should also explain how ARM 46.12.303(11) is applied to persons who have private insurance or are covered by medicare. Medicare, for example, requires a written statement of non-coverage in cases where medicare won't cover services or may not cover services. The department's policy is in conflict with medicare rules and may interfere with a third party payer's prior authorization requirements.

RESPONSE: The comment does not explain how the rules are in conflict or interfere with medicare rules or third party payer prior authorization requirements. The department is not aware of any such conflicts. The department will consider any specific conflicts that the commentor brings to the department's attention, but finds no reason to revise the rule now based upon

the comment.

COMMENT #23: ARM 46.12.303(9) and (10) clarify that the department is entitled to recover any payment to which a provider was not entitled, regardless of whose mistake or oversight caused the overpayment and regardless of when the overpayment is discovered. This is in keeping with 53-6-111, MCA, which authorizes the department to adopt rules regarding overpayments. The department should include in this rule a time limit during which such overpayments can be determined and collected. We leave to the department's discretion what would be an appropriate time limit to assure that the department has ample time to complete its normal auditing or review procedures with respect to such claims. An exception to any limit could be provided for recovery of overpayments received due to provider fraud or abuse.

RESPONSE: The department will not adopt a time limit for recovery of overpayments. Overpayments may be discovered through a variety of circumstances, ranging from routine review or audit procedures to information provided fortuitously by a person with inside information. Also, the issues involved in determining an overpayment may range from relatively simple to extremely complex. The department will not adopt a limit on its ability to recover overpayments beyond any limits that may already be provided under existing law.

COMMENT #24: ARM 46.12.306(3) provides that medical necessity may be reviewed at any time before or after payment and that the department may deny payment or recover payment even for services that the department has prior reviewed, screened or authorized. This may be longstanding department policy, but it is inappropriate for the department to retroactively review medical necessity on advance or initial screening authorizations. In these circumstances, the department or its third party review agent should have in hand a complete record of information and supporting documentation as of the particular date. If not, then no prior authorization should be given. Providers who follow the procedures and have services approved or authorized should be able to rely on such authorization. Nursing facility rules provide specific procedures for prior authorization of payment for bed hold days for hospitalization or therapeutic home visits. Providers who follow the procedures and have these bed holds authorized in fact go ahead and hold the bed based upon the department's authorization. This provision should be clarified to provide that payment for prior approved or authorized services will not be denied or recovered unless the department has evidence that the provider failed to provide pertinent information available at the time of the approval or authorization. Otherwise, providers will be penalized by this rule. The penalty should lie with the department or, more specifically, with the third party reviewer if an error has been

made on their part in authorizing services. Also, there must be some point of finality under federal medicaid regulations which should be recognized in the department's regulations.

RESPONSE: The department will not adopt a rule that constrains its ability to review the medical necessity of services or to recover medicaid payments a provider was not entitled to receive. The department does not routinely re-review the medical necessity of services that the department previously reviewed, screened or authorized. The department has no plans to increase such re-review. In some cases, the department or its review agent may have made an initial review based upon a complete record. But in many cases, the department or its review agent rely upon the provider to submit appropriate supporting documentation and information. The alternative, submission of the entire record in every case, would be extremely burdensome and in general unnecessary. Providers that submit documentation and information in the initial review that fairly and accurately portrays the recipient's condition need not be concerned about a later review. The department does not agree that this rule will penalize providers. Rather, the rule will permit payment denial or recovery in cases where medical necessity requirements are not met.

COMMENT #25: The department proposes to delete language from ARM 46.12.307(1) and (2) which assures the right of providers to exercise professional judgment and management of their business affairs. Why is this language deleted from the rules? Medicaid cannot interfere with a provider's independent professional judgment in rendering services to a medicaid recipient and providers certainly can manage their business affairs as they deem proper. Deleting these provisions implies that these provisions are no longer true. These rights are provided for by statute in 53-6-104, MCA. The department is obligated to draft rules implementing the medicaid statutes. In doing so, it should explain those statutes that are of importance to providers and that clearly fall within the subject of provider rights. These subsections further explain provider rights under the medicaid program and should be retained.

RESPONSE: The deleted language adds little, if anything, to the language of 53-6-104, MCA. The deleted language does not establish any specific rules, guidelines or standards, and merely states that providers may exercise professional judgment and may manage their business within the conditions and limitations imposed by the administrative rules. The rule could be read inaccurately by some to suggest that actions taken by the department in accordance with the rules are somehow a prohibited interference with a provider's professional judgement or business management. The department believes that the provisions of 53-6-104, MCA are implemented and interpreted in great detail in the specific provisions of ARM Title 46, chapter

12. The language of current ARM 46.12.307(1) and (2) is unnecessary and will be deleted.

COMMENT #26: The proposed change to ARM 46.12.307 provides that providers do not have a right to notice of actions affecting recipients, including eligibility determinations. This rule as it relates to a provider's right to be notified of an adverse department determination relative to a recipient's source of funding for previously certified services is illogical. If the provider has a right under this rule to a hearing for such circumstances, then the department should grant the provider a right to notification of such adverse determination. Also, while the rule may make sense for some providers, it does not make sense for nursing facility residents. In some instances, because of their condition, nursing facility residents receive important information, including eligibility determinations, and do nothing about it. This is a problem for both the resident and the facility. Nursing facilities should be entitled to notice of medicaid eligibility determinations with respect to individuals who are residents in a facility.

Subsection (3) denies providers their constitutional due process rights. Providers have the right to appeal decisions concerning an adverse action concerning the recipient's rights or entitlements under the program. If a provider has the right to appeal on behalf of a recipient, it must also be entitled to notice. Without notice, a provider has no way of implementing its appeal rights. In fact a provider's failure to timely appeal an adverse action may eliminate any appeal rights it may have had. If it has appeal rights, and it has time limitations as to when it may appeal, then it must be entitled to notice or else it is an unconstitutional deprivation of its rights to due process.

RESPONSE: The changes to ARM 46.12.307 regarding provider hearing and notice rights clarify rather than change the current rules. A provider has had and will continue under the new rules to have a right to appeal in its own right an adverse department action taken against the provider. A provider also has had and will continue under the new rules to have a right to appeal, as a representative of the recipient and in some cases as a real party in interest, an adverse action taken against a recipient. Providers are entitled to be notified, as provided in the applicable rules, of actions taken against the provider. For example, if a provider makes a prior authorization request or submits a claim for payment, notice of action on the request or claim will be made directly to the provider. If a recipient submits an application for eligibility, notice of the eligibility determination will be made directly to the recipient or the recipient's designated representative. The department is not required to investigate and identify the provider or various providers that may be providing services to the recipient or to

notify the providers of the eligibility determination. This does not mean that the department will refuse to provide information to a provider that inquires. The department maintains several systems designed to allow providers to inquire regarding the eligibility status of particular patients. Providers may learn of a determination by inquiring independently or from the patient, and may appeal according to applicable laws and rules from a determination adverse to the recipient.

The department disagrees with the argument that a provider has a due process right to notice of adverse actions taken against recipients. Providers are responsible to inquire as to the recipient's eligibility status. Other types of adverse determinations affecting recipients often will also affect the provider in a way that gives rise to an independent right of the provider to notice and appeal. For example, a provider is notified directly of denial of certification for continued stay in a residential treatment facility and is entitled to appeal that determination. However, the notice and appeal rights of the provider and the recipient are not automatically synonymous.

COMMENT #27: Also, this rule purports to remove any right a provider previously had to appeal an adverse action on behalf of a recipient except for eligibility issues. This rule is clearly inconsistent with ARM 46.12.509A which gives providers the right to appeal medicaid decertifications for residential treatment services. The rule should remain as written and a provider should have the right to appeal any adverse action against a recipient concerning the recipient's rights or entitlements under the program.

RESPONSE: The proposed rule does not repeal a provider's right to appeal adverse department actions that affect the recipient. The rule merely directs whether the appeal will be according to the recipient appeal rules or the provider appeal rules. If the action is an eligibility determination, the provider may appeal as the recipient's representative, if so authorized, or as a real party in interest. In such cases, the provider stands in the shoes of the recipient and must comply with the rules applicable to recipients. Such an appeal generally may be filed within 90 days after the determination. If the adverse action is one that the provider may appeal directly in its own right, such as a denial of prior authorization requested by the provider, then the provider may appeal subject to the rules applicable to provider appeals. This is true of a medicaid "decertification" for residential treatment services. In such cases, the provider requests the certification and receives a notice of the determination directly in its own right. The provider may then appeal a denial within 30 days. The provider is entitled to appeal, as long as the provider does so according to the appeal process established for providers. Where an

appeal process is available for providers, they are not entitled to take advantage of the more liberal rules sometimes applicable to recipients. For example, the provider could not forego appealing the decertification as a provider within 30 days and then later appeal under the recipient rules within 90 days after the determination.

COMMENT #28: ARM 46.12.307(3) appears to preclude the provider from obtaining eligibility information regarding medicaid recipients. Providers need the information to verify eligibility. Does the rule allow providers to obtain eligibility information?

RESPONSE: The rule is not intended to preclude providers from obtaining eligibility information about recipients. The rule provides simply that the department is not required to identify and notify all potential providers, which would be an impossible task. Providers that inquire are allowed to obtain eligibility information and verification.

COMMENT #29: Proposed ARM 46.12.308(1)(b) provides that the department "shall have access to all records so maintained and retained regardless of a provider's continued participation in the program." This rule should be clarified to provide that the department has access to medicaid recipient's records and not to all records of the hospital.

RESPONSE: The department believes that the rule is clear. The department will continue to have access to all records that are maintained under (1).

COMMENT #30: Why is "inpatient psychiatric services" being deleted from the list of covered services in ARM 46.12.501? It is our understanding that inpatient psychiatric services are still a medicaid benefit in acute general hospital psychiatric units and that freestanding psychiatric hospitals will be able to serve and be paid for services provided to medicaid recipients under the mental health managed care program.

RESPONSE: The proposed rule simply changed the name of the service for consistency with prior changes in the program. The service previously was called inpatient psychiatric services and the service was covered in both the freestanding psychiatric hospital setting and in residential treatment facilities. After coverage of services provided in freestanding psychiatric hospitals was eliminated, the name of the service was changed to residential treatment services. Inpatient psychiatric services provided in acute general hospital psychiatric units are covered as inpatient hospital services, not as inpatient psychiatric services. Freestanding psychiatric hospitals may be able to serve and be paid for services provided to medicaid recipients under the mental health managed care program. However, ARM

46.12.501 will not be the rule that specifies the services covered under the managed care plan. The department anticipates that, effective April 1, 1997, ARM 46.12.501 will be amended through a separate rule proceeding to eliminate altogether any references to any psychiatric services, including residential treatment services. Those services will no longer be covered under the medicaid program but rather through the mental health access plan. Because the "inpatient psychiatric services" language will be eliminated within a few months in the managed care rules, the department will retain the current language in this rule for now.

COMMENT #31: With respect to ARM 46.12.593(1)(e), the department provides no explanation or reason as to why it proposes a requirement that providers hold cost report records for six years and 3 months rather than the previous 3 year requirement. Such an increase in this time period is impermissibly burdensome and financially quite costly. It is not required by federal rules. There is no sound reason for the additional time requirement. The department should have more than enough time to consider this documentation within the existing 3-year period, because the time period does not begin to run until the later of certain events specified in the rule. This could actually total well in excess of 6 years which is more than enough time to hold this information. Without any legitimate explanation or reason for the additional time requirement, we believe that the proposed changes are simply insupportable.

RESPONSE: In fact, the department did explain the reasons for this change in the rationale section of the notice of public hearing. As stated in that document, the rule will make medicaid's record retention rule consistent with medicare's rule and will assure that records are retained for a period of time sufficient to complete reviews and to resolve disputes concerning the services or costs at issue. As also noted, overpayments are not always discovered within the 3 year period and the current rule makes it unnecessarily difficult to determine whether overpayments occurred or to recover any overpayments actually identified. The department does not agree that the proposed rule will be impermissibly burdensome or financially quite costly. Most providers already maintain records for the greater period of time for other reasons.

COMMENT #32: The proposed rules create additional paperwork, reporting and record keeping requirements for providers. As a residential treatment provider, Yellowstone Treatment Centers was required to accept a prospective payment rate from medicaid based upon the 1993-94 cost report. These rules create additional cost for YTC as a provider without consideration of compensation for the increased costs. Will the additional costs be compensated in the prospective payment system when shown in

the annual cost report?

RESPONSE: The proposed rules create very few changes from current practice in the medicaid program. The department does not expect that the proposed changes will result in substantial cost increases. To the extent that the rules do increase costs, the department believes that the increased costs will be accounted for by the annual inflationary increase provided under the prospective payment system for residential treatment service providers.

COMMENT #33: The department failed to provide official notice of the these rules to interested parties as required by 2-4-302, MCA. Parties that are supposed to be on the list to receive notice did not receive notice. The department also knew of our particular interest in the proposed rules, but yet we did not receive notice. The department should provide notice so that interested parties can comment.

RESPONSE: The department mailed notices to all parties on the mailing list, including to the commentor's client, as required by law. The department actually received comments from the commentor's client within the time provided for written comments. In addition, the department granted additional time to the commentor to submit written comments on the proposed rules and the commentor in fact submitted extensive comments, all of which were considered by the department. The department believes it fully complied with all notice requirements.

Rule Reviewer

Director, Public Health and Human Services

Certified to the Secretary of State February 24, 1997.

BEFORE THE DEPARTMENT OF PUBLIC
HEALTH AND HUMAN SERVICES OF THE
STATE OF MONTANA

In the matter of the adoption of rules I through X, the amendment of rules 46.12.1901 through 46.12.1903, 46.12.1915, 46.12.1916, 46.12.1918, 46.12.1925 through 46.12.1927, 46.12.1929, 46.12.1935 through 46.12.1937, 46.12.1939, 46.12.1940, 46.12.1945 through 46.12.1947, 46.12.1949 and the repeal of rules 46.12.1928, 46.12.1938 and 46.12.1950 pertaining to targeted case management	)	NOTICE OF ADOPTION, AMENDMENT AND REPEAL OF RULES

TO: All Interested Persons

1. On October 24, 1996, the Department of Public Health and Human Services published notice of the proposed adoption of rules I through X, the amendment of rules 46.12.1901 through 46.12.1903, 46.12.1915, 46.12.1916, 46.12.1918, 46.12.1925 through 46.12.1927, 46.12.1929, 46.12.1935 through 46.12.1937, 46.12.1939, 46.12.1940, 46.12.1945 through 46.12.1947, 46.12.1949 and the repeal of rules 46.12.1928, 46.12.1938 and 46.12.1950 pertaining to targeted case management at page 2755 of the 1996 Montana Administrative Register, issue number 20.

2. The Department has amended rules 46.12.1902, 46.12.1903, 46.12.1915, 46.12.1916, 46.12.1918, 46.12.1925 through 46.12.1927, 46.12.1929, 46.12.1935 through 46.12.1937, 46.12.1939, 46.12.1940, 46.12.1945 through 46.12.1947, 46.12.1949 and repealed rules 46.12.1928, 46.12.1938 and 46.12.1950 as proposed.

3. The Department has adopted rules [RULE I] 46.12.1956 CASE MANAGEMENT SERVICES FOR CHILDREN AT RISK OF ABUSE AND NEGLECT, DEFINITIONS; [RULE II] 46.12.1959 CASE MANAGEMENT SERVICES FOR CHILDREN AT RISK OF ABUSE AND NEGLECT, COVERAGE; [RULE III] 46.12.1960 CASE MANAGEMENT SERVICES FOR CHILDREN AT RISK OF ABUSE AND NEGLECT, ELIGIBILITY; [RULE IV] 46.12.1961 CASE MANAGEMENT SERVICES FOR CHILDREN AT RISK OF ABUSE OR NEGLECT, PROVIDER REQUIREMENTS; [RULE V] 46.12.1962 CASE MANAGEMENT SERVICES FOR CHILDREN AT RISK OF ABUSE AND NEGLECT, REIMBURSEMENT; [RULE VI] 46.12.1966 CASE MANAGEMENT SERVICES FOR CHILDREN WITH SPECIAL HEALTH CARE NEEDS, DEFINITIONS; [RULE VII] 46.12.1969 CASE MANAGEMENT SERVICES FOR CHILDREN WITH SPECIAL HEALTH CARE NEEDS, COVERAGE; [RULE VIII] 46.12.1970 CASE MANAGEMENT SERVICES FOR CHILDREN WITH SPECIAL HEALTH CARE NEEDS, ELIGIBILITY; and [RULE X] 46.12.1972 CASE MANAGEMENT SERVICES FOR CHILDREN WITH SPECIAL HEALTH CARE NEEDS,

REIMBURSEMENT as proposed.

4. The Department has amended the following rules as proposed with the following changes from the original proposal. New language being added is underlined. Language to be deleted is interlined.

46.12.1901 CASE MANAGEMENT SERVICES, GENERAL PROVISIONS (1) through (8) remain as proposed.

(9) Decisions as to which case management provider is to be a the lead case management provider for a client, except as provided in Rule VIII, are made locally ~~except as noted in Rule VIII(2)~~. If there is disagreement that cannot be resolved locally, the department contacts for each program involved are to make the necessary decision.

(10) through (10)(c) remain as proposed.

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

46.12.1939 CASE MANAGEMENT FOR PERSONS WITH DEVELOPMENTAL DISABILITIES, PROVIDER REQUIREMENTS (1) through (7) remain as proposed.

(8) A case manager must participate in a minimum of 20 hours of advanced training in services to persons with developmental disabilities each year under a training curriculum reviewed ~~and approved~~ by the developmental disabilities program of the department. On-going documentation of the qualifications of case managers and completions of mandated training must be maintained by the employer of the case manager.

(9) through (9)(b) remain as proposed.

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

5. The Department has adopted the following rule as proposed with the following changes from the original proposal. New language being added is underlined. Language to be deleted is interlined.

RULE IX 46.12.1971 CASE MANAGEMENT SERVICES FOR CHILDREN WITH SPECIAL HEALTH CARE NEEDS, PROVIDER REQUIREMENTS (1) through (3)(b) remain as proposed.

(4) The case management provider must be able to directly provide services of at least one of the professional disciplines listed in ~~(5)~~ (3) of this rule.

(5) through (7)(g) remain as proposed.

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

6. The Department has thoroughly considered all

commentary received. The comments received and the department's response to each follow:

COMMENT #1: According to the medicaid home and community waiver with the federal health care financing administration (HCFA), case management for persons with developmental disabilities are not on or eligible for medicaid. The reference in ARM 46.12.1936 (1)(a), "A Person is eligible for case management as a person with developmental disabilities if the person: (a) is receiving Medicaid", conflicts with the waiver provision.

RESPONSE: While case management services to individuals with developmental disabilities are available if a person is not receiving medicaid, the rule is providing reimbursement for those case management services that are available to persons due to their medicaid eligibility. The developmental disabilities program has worked with the medicaid services bureau to extend funding for developmental disabilities case management services by providing an opportunity for payment of services using matching federal funding sources. In this instance, the federal funding source is medicaid. In order for a service to be reimbursed by medicaid, the individual must be eligible for medicaid. This rule is addressing this situation. For those individuals not eligible for medicaid, funding for case management services is available through the developmental disabilities program.

The rule remains as proposed.

COMMENT #2: ARM 46.12.1939 - Case Management for Persons with Developmental Disabilities, Provider Requirements. Subsection (7) states, "a provider of direct care services to persons with developmental disabilities may not act as the case management provider for clients for whom the provider delivers services." This provision contradicts the requirement in Rule IX (4) (46.12.1971), requiring the case manager to be a direct service provider - "the case management provider must be able to directly provide services of at least one of the professional disciplines listed in (5) of this rule."

RESPONSE: ARM 46.12.1939(7) has not changed in this rule process. This requirement specifically prevents providers of case management services for individuals with developmental disabilities from serving individuals for whom the provider delivers direct care services. Rule IX (4) (46.12.1971) incorrectly referred to (5) in the rule. Subsection (4) has been changed to refer to subsection (3) - "Requirements for professional public health providers include:". The intention on subsection (4) is to require a provider of case management services to children with special health care needs to be a registered nurse or a social worker.

COMMENT #3: Eligibility under Rule VIII(1)(a)(ii) (46.12.1970) includes children who are "at risk for.. developmental, behavioral, or emotional conditions". This seems to be an obvious duplication with several other case management programs. Eligibility based on developmental, behavioral, or emotional conditions should be available only after denial of eligibility from systems with primary responsibility (DDP or MRM).

RESPONSE: The Department realizes there is some overlapping eligibility between different types of case management provided in each community. Because of limited budgets and availability of programs, the Department did not specify that an individual must get a denial from one program prior to acceptance into another program. ARM 46.12.1901(9) states "Decisions as to which case management provider is to be the lead case management provider for a client, except as provided in Rule VIII(2)(46.12.1970), are made locally. If there is a disagreement that cannot be resolved locally, the Department contacts for each program involved will make collectively the necessary decision."

Due to limited funding, the department allows only one provider of case management services to bill except as stated in Rule VIII(2)(46.12.1970). In the case of Rule VIII(2)(46.12.1970), while the Part H services provider is the lead case management provider, children with special health care needs providers can provide and bill for health and medical case management services. Children with special health care needs case management providers are required to incorporate the health and medical care plan within the individual family services plan.

The rules remain as proposed.

COMMENT #4: Regarding Rule VIII(3)(46.12.1970), additional language requiring referral to a Part H provider should be included.

RESPONSE: The Department did include the following language "This assessment must be followed by a referral to appropriate service providers in the community" to address this issue.

There were several discussions held concerning what referrals should be included in this rule. Because several communities have different programs, the decision was made to leave the wording as "appropriate service providers" in the rule.

In addition, if the requirement of a referral to specific programs is listed in the rule - each and every family would have to be referred to that program regardless of appropriateness. This could cause problems for families and children if they were required by rule to be referred to several programs.

Children with special health care needs providers are required in Rule IX (46.12.1972) to have on file with the Department's health policy and services division, a signed collaborative agreement with community provider of services for children with special health care needs including Part H. Requiring a referral to Part H providers could be included in this collaborative agreement.

The language in the rule remains as proposed.

COMMENT #5: Regarding Rule VIII(6)(46.12.1970), language should be added requiring case managers to have knowledge of other community service providers including, but certainly not limited to, Part H and family education and support services.

RESPONSE: The Department is unsure which rule is referred to in this comment. However, Rule IX (6)(a)(46.12.1971) requires a case manager to have knowledge of, among several other programs, the developmental disabilities family education and support services (DDFESS) of which Part H is one.

This language is already included in the rule, therefore, no change to the rule as proposed is required.

COMMENT #6: Regarding ARM 46.12.1901, in general when a child or family qualifies for more than one case management service (targeted or otherwise), language emphasizing the importance of sharing information and coordinating all services should be added. Identification of the lead case management provider as specified in the rule is critical. If more than one case management service is identified, the plan should also establish a possible time line for re-evaluating the need for dual case management and a transition plan for moving to a single case management.

RESPONSE: The Department agrees with the statement. The suggested coordination is already included in the rule. ARM 46.12.1901(7)(e)(I) specifies there has to be a designation of the lead case management service provider and ARM 46.12.1901(7)(e)(vi) states the plan of care must contain strategies for reducing case management to a single provider.

No change to the rule is required.

COMMENT #7: Regarding ARM 46.12.1901(9), this language seems very confusing. The phrase "except as provided in Rule VIII" should be stricken.

RESPONSE: The Department agrees with this statement. The second "except as provided in Rule VIII" will be deleted.

Rule Reviewer

Director, Public Health and Human Services

Certified to the Secretary of State February 24, 1997.

BEFORE THE DEPARTMENT OF PUBLIC
HEALTH AND HUMAN SERVICES OF THE
STATE OF MONTANA

In the matter of the amendment of 46.12.3803 pertaining to medically needy assistance standards	))))	NOTICE OF AMENDMENT OF RULE

TO: All Interested Persons

1. On October 24, 1996, the Department of Public Health and Human Services published notice of the proposed amendment of 46.12.3803 pertaining to medically needy assistance standards at page 2750 of the 1996 Montana Administrative Register, issue number 20.

2. The Department has amended rule 46.12.3803 as proposed.

3. No comments or testimony were received.

4. These rule amendments are applied retroactively to July 1, 1996.

Dawn Sliva
Rule Reviewer

Director, Public Health and Human Services

Certified to the Secretary of State February 24, 1997.

BEFORE THE DEPARTMENT OF PUBLIC
HEALTH AND HUMAN SERVICES OF THE
STATE OF MONTANA

In the matter of the amendment of rules 46.12.4804 through 46.12.4806, 46.12.4813, 46.12.4816, 46.12.4817 and 46.12.4827 pertaining to health maintenance organizations	)))))))	NOTICE OF AMENDMENT OF RULES

TO: All Interested Persons

1. On September 19, 1996, the Department of Public Health and Human Services published notice of the proposed amendment of rules 46.12.4804 through 46.12.4806, 46.12.4813, 46.12.4816, 46.12.4817 and 46.12.4827 pertaining to health maintenance organizations at page 2418 of the 1996 Montana Administrative Register, issue number 18.

2. The Department has amended rules 46.12.4804 through 46.12.4806, 46.12.4813, 46.12.4816, 46.12.4817 and 46.12.4827 as proposed.

3. No comments or testimony were received.

Rule Reviewer

Director, Public Health and Human Services

Certified to the Secretary of State February 24, 1997.

BEFORE THE DEPARTMENT OF PUBLIC
HEALTH AND HUMAN SERVICES OF THE
STATE OF MONTANA

In the matter of the amendment of rules 46.13.302, 46.13.303, 46.13.304, 46.13.401 and 46.13.502 pertaining to the low income energy assistance program (LIEAP)	)))))	CORRECTED NOTICE OF AMENDMENT OF RULE

TO: All Interested Persons

1. On October 24, 1996, the Department of Public Health and Human Services published notice of the proposed amendment of rules 46.13.302, 46.13.303, 46.13.304, 46.13.401 and 46.13.502 pertaining to the low income energy assistance program (LIEAP) at page 2887 of the 1996 Montana Administrative Register, issue number 20.

2. The Department inadvertently failed to change the year 1995 to 1996 in regard to the OMB poverty levels used to determine deductibility of medical and dental costs. The rule is adopted with the following changes:

46.13.304 CALCULATING INCOME (1) through (2)(c) remain as adopted.

(3) Medical and dental costs may be deducted from income only if:

(a) the household's annual gross income is between 125% and 150% of the ~~1995~~ 1996 U.S. government office of management and budget poverty level for the particular household size;

(3)(b) through (3)(c)(x) remain as adopted.

AUTH: Sec. 53-2-201, MCA
IMP: Sec. 53-2-201, MCA

Rule Reviewer

Director, Public Health and Human Services

Certified to the Secretary of State February 24, 1997.

BEFORE THE DEPARTMENT OF PUBLIC
HEALTH AND HUMAN SERVICES OF THE
STATE OF MONTANA

In the matter of the adoption of rules I through XVIII pertaining to the Montana Telecommunications Access Program	)))))	NOTICE OF ADOPTION OF RULES

TO: All Interested Persons

1. On November 7, 1996, the Department of Public Health and Human Services published notice of the proposed adoption of rules I through XVIII pertaining to the Montana Telecommunications Access Program at page 2967 of the 1996 Montana Administrative Register, issue number 21.

2. The Department has adopted the rules [Rule I] 46.19.101 DEFINITIONS; [Rule II] 46.19.201 ASSESSMENT; [Rule III] 46.19.202 EXEMPTIONS; [Rule IV] 46.19.206 REPORTING REQUIREMENTS; [Rule V] 46.19.207 EXAMINATION OF RECORDS; [Rule VI] 46.19.301 LOANS; [Rule VII] 46.19.302 OWNERSHIP; [Rule VIII] 46.19.306 SECURITY DEPOSIT; [Rule IX] 46.19.401 PROVISION OF INFORMATION; [Rule X] 46.19.402 APPLICATION PROCESS; [Rule XI] 46.19.403 ELIGIBILITY CRITERIA; [Rule XII] 46.19.406 VERIFICATION REQUIREMENTS; [Rule XIII] 46.19.407 NOTICES; [Rule XIV] 46.19.410 DETERMINATION OF APPROPRIATE TELECOMMUNICATION DEVICE; [Rule XV] 46.19.411 PRIORITIES; [Rule XVI] 46.19.412 REQUIRED TRAINING AND CONDITIONS OF ACCEPTANCE; [Rule XVII] 46.19.501 GROUNDS FOR APPEAL; [Rule XVIII] 46.19.502 APPEAL PROCEDURES as proposed.

3. No comments or testimony were received.

4. Pursuant to 2-15-121 and 2-15-2212, MCA, The Committee on Telecommunications Access Services (the Committee) is allocated to the Department of Public Health & Human Services (the Department) for administrative purposes only. It is therefore appropriate to have the chairman of the Committee as well as the Director of the Department sign the notice adopting the rules which will govern the Montana Telecommunications Access Program.

Rule Reviewer

Director, Public Health and Human Services

Edward G. Van Tighem, Chairman
of the Montana Telecommunications
Access Committee

Certified to the Secretary of State February 24, 1997.

BEFORE THE DEPARTMENT OF REVENUE
OF THE STATE OF MONTANA

IN THE MATTER OF THE ADOPTION of Rule I (ARM 42.20.155) relating to Agricultural Improvements from Property Land Classification	NOTICE OF ADOPTION

TO: All Interested Persons:

1. On December 5, 1996, the Department published notice of the proposed adoption of Rule I (ARM 42.20.155) relating to Agricultural Improvements from Property Land Classification at page 3112-3113 of the 1996 Montana Administrative Register, issue no. 23.

2. No public comments were received regarding the rule.

3. The Department has adopted the rule as proposed.

CLEO ANDERSON
Rule Reviewer

MARY BRYSON
Director of Revenue

Certified to Secretary of State February 24, 1997.

BEFORE THE DEPARTMENT OF REVENUE
OF THE STATE OF MONTANA

IN THE MATTER OF THE AMENDMENT) NOTICE OF AMENDMENT AND
of ARM 42.20.166 and ADOPTION) ADOPTION
of NEW Rule I (ARM 42.20.170))
relating to Forest Land Rules)

TO: All Interested Persons:

1. On December 19, 1996, the Department published notice of the proposed amendment of ARM 42.20.166 and adoption of NEW Rule I (ARM 42.20.170) relating to Forest Land Rules at page 3208-3209 of the 1996 Montana Administrative Register, issue no. 24.

2. A public hearing was held on January 10, 1997, where oral comments were received.

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

COMMENT: Don Allen of Montana Wood Products Association and Al Kington of Montana Tree Farm Committee were present and offered their support of the proposed amendment and adoption.

RESPONSE: The Department appreciates their attendance and support.

4. As a result of the comments received the Department has adopted Rule I (ARM 42.20.170) as proposed and amended ARM 42.20.166 as proposed.

Cleo Anderson
CLEO ANDERSON
Rule Reviewer

Mary Bryson
MARY BRYSON
Director of Revenue

Certified to Secretary of State February 24, 1997.

BEFORE THE DEPARTMENT OF JUSTICE
OF THE STATE OF MONTANA
GAMBLING CONTROL DIVISION

IN THE MATTER OF the Petition for Declaratory Ruling submitted by Cloverleaf Corporation, d.b.a. The Sailboat, License No. 02-0839, RESPONDENT.	)	**DOCKET NO. 96-212**

FINAL DECISION OF DEPARTMENT OF JUSTICE ADOPTING HEARING EXAMINER'S FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER

On April 18, 1996, the Gambling Control Division received a Petition for Declaratory Judgment in the above-referenced matter. The parties filed a statement of Agreed Facts on June 28, 1996, and subsequent briefs. Allen B. Chronister presided over this matter as Hearing Examiner pursuant to Mont. Code Ann. § 2-4-611. The Hearing Examiner entered the Findings of Fact, Conclusions of Law and Order on September 12, 1996. The Findings of Fact, Conclusions of Law and Order stated that Broadway Bingo is not an authorized game in Montana.

On September 17, 1996, the Department gave notice of the Hearing Examiner's Findings of Fact, Conclusions of Law and Order and gave all interested parties an opportunity to file written exceptions, and upon request, present oral arguments to the Attorney General's representative concerning the Findings of Fact, Conclusions of Law and Order. Written exceptions were to be submitted to the Department of Justice no later than October 7, 1996. Requests for oral argument were to be submitted to the Department of Justice no later than October 7, 1996.

The Division received no written exceptions or requests for oral argument. A review of the complete record indicates that the Hearing Examiner's Proposed Findings of Facts are based upon competent substantial evidence, that the hearing complied with the essential requirements of law, and that the Hearing Examiner properly interpreted the relevant law and regulations.

IT IS ORDERED, the Findings, Conclusions of Law and Order entered by the Hearing Examiner in the above-referenced case is adopted as the Final Decision of the Department of Justice.

DATED this 12 day of November 1996.

DEPARTMENT OF JUSTICE
GAMBLING CONTROL DIVISION

Janet Jessup
JANET JESSUP, ADMINISTRATOR

BEFORE THE DEPARTMENT OF JUSTICE
OF THE STATE OF MONTANA
GAMBLING CONTROL DIVISION

IN THE MATTER OF the Petition for Declaratory Ruling submitted by Cloverleaf Corporation, d.b.a. The Sailboat, License No. 02-0839, RESPONDENT.	))))))	**DOCKET NO. 96-212**

FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER

Introduction

This matter is before the Division on a Petition for Declaratory Ruling filed by Cloverleaf Corporation, d/b/a the Sailboat. The Petition requests a declaration that a game called Broadway Bingo is a lawful gambling game under Montana Law. The parties have filed a Statement of Agreed Facts and subsequent briefs. Pursuant to the previous scheduling order entered in this case, it is now submitted for decision.

FINDINGS OF FACT

The Statement of Agreed Facts, attached as Exhibit 1, is hereby adopted and incorporated as Findings of Fact in this case.

CONCLUSIONS OF LAW

1. The Division has jurisdiction over this matter. Sections 2-4-501 and 23-5-110, et seq., MCA.

2. In Montana all forms of gambling are prohibited unless specifically authorized by law, which must be strictly construed. Section 23-5-111, MCA. Broadway Bingo is a gambling activity. Section 23-5-112(11), MCA.

3. Live bingo is an authorized gambling game in Montana. Section 23-5-405, MCA. Live bingo must be played by using an authorized card. Numbers must be randomly drawn using authorized equipment until the game is won by the player who first covers one or more previously designated arrangements of numbers on the card. Section 23-5-112(4), MCA. The phrase "previously designated arrangements of numbers" refers to whether the winner must cover spaces in a horizontal, vertical, diagonal or other arrangement on the bingo card. It does not mean that the game's numbers can be "previously designated" or drawn prior to commencement of the game.

5. A person who is not physically present on the premises where a live bingo game is conducted may not participate as a player. Section 23-5-414, MCA.

6. The Division's rule provides that a bingo game begins when the first randomly drawn number is selected, and that it ends when an individual covers the previously designated arrangement on a card and declares bingo. Rule 23.16.2401, ARM. The Division has the authority to adopt rules, Section 23-5-115(2), MCA, and its interpretation of the statute is entitled to great deference and should be followed unless there are compelling reasons that it is wrong.

7. Broadway Bingo is not the authorized game of live bingo because at least the first 48 numbers are simultaneously predrawn and displayed (Agreed Fact 3); because at least 48 numbers are drawn before most players buy their cards (Agreed Fact 5); and because a player who has not been physically present on the premises can purchase cards and play at any time up to and after all numbers have been drawn (Agreed Fact 7).

8. Conducting a game in which a ticket or card that contains concealed numbers that may match numbers designated in advance as prize winners constitutes an illegal gambling device under Montana law. Section 23-5-112(16), MCA.

9. Broadway Bingo as described in the Agreed Facts of this case is not an authorized gambling game.

DECLARATORY RULING

Based upon the Findings of Fact and Conclusions of Law set out above, it is hereby determined and declared that Broadway Bingo is not an authorized gambling game in Montana.

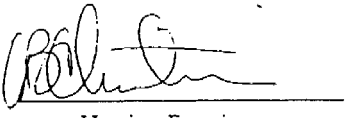
MEMORANDUM

The differences between Broadway Bingo as described in the Agreed Facts and live bingo as authorized by law may not be great, but it is clear that there are differences. Since both the Legislature and the Supreme Court have made it clear that the statutes must be strictly construed when determining whether a game is authorized, those differences must be recognized and given legal significance.

While some players might participate in Broadway Bingo almost like the authorized game of live bingo, that is clearly not true for most players. Most significant is the fact that a player can come to the premises, purchase a pack of cards, compare his numbers to the displayed winning numbers, and then leave. No play is involved, no participation is involved, and there is no apparent way to separate that game from the prohibited pull tabs under 23-5-112(16), MCA. By way of illustration, if Broadway Bingo were authorized, and while it

is not played this way, an operator could select numbers and sell premarked tickets or cards for almost any period of time including days or weeks until a winner was found. Calling the winning ticket a bingo card does not seem to remove this game from what the Legislature clearly intended to prohibit in Section 23-5-112(16), MCA.

Date: September 2, 1996



Hearing Examiner

BEFORE THE DEPARTMENT OF JUSTICE
OF THE STATE OF MONTANA
GAMBLING CONTROL DIVISION

IN THE MATTER OF the Petition for Declaratory Ruling submitted by Cloverleaf Corporation, d.b.a. The Sailboat, License No. 02-0839, RESPONDENT.	))))))	**DOCKET NO. 96-212**

STATEMENT OF AGREED FACTS

The Gambling Control Division and Cloverleaf Corporation, doing business as the Sailboat, hereby state that for the purpose of these administrative declaratory ruling proceedings the following facts are admitted, agreed to be true, and require no proof.

1. Cloverleaf Corporation is a Montana corporation engaged in the conduct of live bingo sessions daily at the Sailboat, in the City of Great Falls, Montana.

2. Evening bingo sessions are conducted at the Sailboat. Bingo players purchase one or more packets of bingo cards for a pre-determined sum. These cards allow the players to participate in the Sailboat's regular evening bingo session.

3. In addition to the regular session of bingo described above, Cloverleaf Corporation also offers the game which is currently in dispute in these administrative declaratory ruling proceedings (hereinafter "disputed game"). For the disputed game, at approximately 6:30 p.m. forty-eight numbers are simultaneously pre-drawn using authorized bingo equipment consisting of a separate blower and a separate flasher board distinct from those used in the conduct of Cloverleaf Corporation's regular session of bingo. All forty-eight pre-drawn numbers are simultaneously displayed on the flasher board.

4. Players who wish to participate in the disputed game purchase cards at the rate of three cards for $1.00. Players do not get to choose their cards, and in fact are not aware of the numbers on the cards until they have purchased them. When a player pays for cards, an employee of the Sailboat selects the cards and hands them to the player.

5. Although occasionally some players in the disputed game may purchase cards prior to the time the first forty-eight numbers are pre-drawn and displayed on the flasher board, the majority of the players purchase their cards after the first forty-eight numbers have been pre-drawn and are displayed on the flasher board.

6. Cards purchased for the disputed game (and for the regular session of bingo) contain a printed design of five columns of five squares each, twenty-five squares in all. The letters BINGO appear at the top, a letter above each of the respective columns. A number appears in each square except for the center square which is a free play. No more than seventy-five numbers are used.

7. In the disputed game, if there are no winners based on the first forty-eight numbers drawn and displayed on the flasher board, additional numbers are drawn (as described below) over the course of the evening session, which lasts approximately three hours. Prior to the mid-session break, nine additional numbers are drawn (assuming there is no winner declared based on the first eight of those additional numbers drawn). Following the mid-session break an additional two numbers are drawn (assuming there is no winner declared based on the first of those two additional numbers drawn). If no winners are declared at the end of the evening session, additional numbers are drawn until a player covers a previously designated arrangement of numbers on a card and is declared a winner. Numbers, once drawn, remain displayed on the flasher board. While the disputed game is ongoing, the regular session of bingo at the Sailboat is played on a separate blower and separate flasher board.

8. Players may purchase cards for the disputed game during the entire time that a game is in progress, up until the time that a winner is declared. As in the case of those who have already purchased cards, these players do not get to choose their cards, and are not aware of the numbers on the cards until they have purchased them.

JAMES M. SCHEIER
Agency Legal Services Bureau
Justice Building
215 North Sanders
Helena, MT 59620-1402

COUNSEL FOR GAMBLING
CONTROL DIVISION

6/27/96
DATE

LYDIA M. SHELTS
619 Strain Building
P/O. Box 3065
Great Falls, MT 59403-3065

COUNSEL FOR CLOVERLEAF
CORPORATION, d.b.a.
THE SAILBOAT

6/26/96
DATE

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, 1996. This table includes those rules adopted during the period January 1, 1997 through March 31, 1997 and any proposed rule action that was 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, 1996, this table and the table of contents of this issue of the MAR.

This table indicates the department name, title number, rule numbers in ascending order, catchphrase or the subject matter of the rule and the page number at which the action is published in the 1996 and 1997 Montana Administrative Registers.

To aid the user, the Accumulative Table includes rulemaking actions of such entities as boards and commissions listed separately under their appropriate title number. These will fall alphabetically after department rulemaking actions. Accumulative Table entries will be listed with the department name under which they were proposed, e.g., Department of Health and Environmental Sciences as opposed to Department of Environmental Quality.

STATE AUDITOR, Title 6

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