RESERVE

MONTANA ADMINISTRATIVE REGISTER

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MONTANA ADMINISTRATIVE REGISTER

ISSUE NO. 9

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 The notice section contains state agencies' proposed new, amended or repealed rules; the rationale for the change; date and address of public hearing; and where written comments may be submitted.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

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NOTICE SECTION

BEFORE THE DEPARTMENT OF AGRICULTURE
OF THE STATE OF MONTANA

In the matter of the proposed adoption of new rule I pertaining to license fees for commodity dealers/public warehouse operators	))))	NOTICE OF PUBLIC HEARING ON PROPOSED ADOPTION OF NEW RULE

TO: All Interested Persons:

1. On May 27, 1997, at 1:00 p.m., a public hearing will be held in the conference room #225 of the Department of Agriculture, Scott Hart building, Helena, Montana to consider the proposed adoption of new rule I licensing fees for commodity dealers and public warehouses.

The Department of Agriculture will make reasonable accommodations for persons with disabilities who wish to participate in this public hearing. If you request an accommodation, contact the department no later than 5:00 pm on May 19, 1997 to advise us of the nature of the accommodation you will need. Please contact Gary Gingery, Administrator, P.O. Box 200201, Helena, MT 59620-0201 or call (406) 444-2944.

2. The proposed new rule provides as follows:

RULE I LICENSE FEES FOR COMMODITY DEALERS AND PUBLIC WAREHOUSES (1) The annual licensing fee for each person engaged in the business of a commodity dealer is $464 per facility and for each person operating a public warehouse, the fee is $464 per location.

AUTH: 80-4-403, MCA; IMP: 80-4-503, 80-4-602, MCA

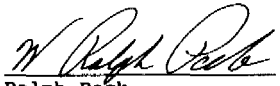
REASON: The 1997 Montana legislature through the State Appropriations Act, House Bill 2, eliminated the general fund appropriation in the amount of $93,000 for the biennium and replaced it with a like amount of state special revenue. This action requires the department to raise the licensing fees for commodity dealers and public warehouses. To maintain the revenue adequate to fund the agricultural commodities program, the fees have to be raised from $232 to $464. The Grain Standards, Storage, and Merchandising Act allows the department in 80-4-503, MCA, licensing public warehouses and 80-4-602, MCA, licensing of commodity dealers to raise the respective minimum $232 licensing fees to a maximum of $500.

3. Interested persons may submit their written data, views, or arguments either orally or in writing at the hearing. Written data, views, or arguments concerning this proposal may also be submitted to Gary Gingery,

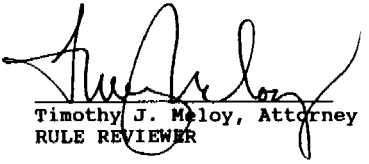
Administrator, Agricultural Sciences Division, Department of Agriculture, P.O. Box 200201, Helena, MT 59620-0201, Phone (406)444-2944, FAX (406)444-5409, or E-Mail: AGR@MT.GOV, no later than June 2, 1997.

4. Timothy J. Meloy, Department Attorney, has been designated to preside over and conduct the hearing.

DEPARTMENT OF AGRICULTURE



Ralph Peck,
DIRECTOR



Timothy J. Meloy, Attorney
RULE REVIEWER

Certified to the Secretary of State April 21, 1997.

BEFORE THE LOCAL GOVERNMENT ASSISTANCE DIVISION
DEPARTMENT OF COMMERCE
STATE OF MONTANA

In the matter of the proposed amendment of rules pertaining to the State of Montana Single Audit Act	NOTICE OF PUBLIC HEARING ON THE PROPOSED AMENDMENTS OF THE STATE OF MONTANA SINGLE AUDIT ACT

TO: All Interested Persons:

1. On May 28, 1997, at 1:30 p.m., a public hearing will be held in the large downstairs conference room at the Department of Commerce Building, 1424 Ninth Avenue, Helena, Montana, to consider the proposed amendment of rules pertaining to the report filing fee schedule and the State of Montana Single Audit Act.

2. The proposed amendments to ARM 8.94.4101, 8.94.4102, 8.94.4103, 8.94.4104, 8.94.4105, 8.94.4106, 8.94.4109 and 8.94.4111 will read as follows: (new matter underlined, deleted matter interlined)

"8.94.4101 ACCOUNTING AND FINANCIAL REPORTING STANDARDS (1) through (3) will remain the same.

(4) ~~For counties, cities and towns, the~~ The annual financial report must be on a form required by the department or, subject to the approval of the department, in a form that provides at least the same information required by the department's form.

~~(5) For local government entities required to file an annual financial report with the department other than counties, cities and towns, the report must be on a form required by the department.~~"

Auth: Sec. 2-7-504, 2-7-513, MCA; IMP, Sec. 2-7-504, 2-7-513, MCA

REASON: Under the current administrative rule, local government entities other than counties, cities, and towns must file their annual financial reports on a form required by the Department of Commerce. The proposed amendment is intended to allow the Department of Commerce to accept other financial report forms from those local government entities so long as they provide at least the same information required by the Department's prescribed report form. The current rule permits this option for counties, cities, and towns, and this amendment permits this option for all types of local government entities.

"8.94.4102 REPORT FILING FEE (1) through (6)(c) will remain the same.

(7) The annual filing fees for local government entities are as follows:

Annual Revenues Equal to or Greater Than:	Annual Revenues Less Than:		Fee
$ -0-	$ 200,000		$ -0-
~~$ 0~~	~~and federal financial assistance less than or equal to $25,000 $200,000 and federal financial assistance greater than $25,000~~		~~$ 225~~
$ 200,000	$ 500,000	~~$ 225~~	$ 175
$ 500,000	$ 1,000,000	~~$ 425~~	$ 375
$ 1,000,000	$ 1,500,000	~~$ 575~~	$ 525
$ 1,500,000	$ 2,500,000	~~$ 650~~	$ 600
$ 2,500,000	$ 5,000,000	~~$ 725~~	$ 675
$ 5,000,000	$ 10,000,000	~~$ 775~~	$ 725
$ 10,000,000		~~$ 825~~	$ 775

This filing fee schedule is effective for annual financial reports for years ended June 30, 1997, and after."

Auth: Sec. 2-7-514, MCA; IMP, Sec. 2-7-514, MCA

REASON: The proposed amendment to the fee schedule provides for a reduction in the report filing fees. The fees are set based on the requirements of 2-7-514(2), MCA. That section requires that the fees must be based upon the costs incurred by the Department in the administration of Title 2, chapter 7, part 5, MCA, and upon the local government entities' revenue amounts. A general fund loan to the Department to pay program costs for the year ended June 30, 1992, which was the initial year of the program, will be repaid in full in June, 1997. This will reduce program costs. In addition, the Department has more recent information on total local government entity revenues upon which to base the report filing fees. As a result the reduction in report filing fees is required to meet the provisions of 2-7-514, MCA. The proposed amendment also specifies an effective date for the reduced fee schedule.

"8.94.4103 PENALTY FOR FAILING TO FILE ANNUAL FINANCIAL REPORT WITHIN PRESCRIBED TIME WITHOUT APPROVED EXTENSION

(1) As provided by ~~2-17-517(1)~~ 2-7-517(1), MCA, if a local government entity, other than a school district or associated cooperative, is unable to file its annual financial report with the department within four months of the end of the local government entity's fiscal year as required by 2-7-503(1), MCA, the department may grant an extension of time in which to file the financial report if the local government entity can demonstrate to the department that it has good cause

for not submitting the report within the prescribed time. Good cause will be deemed to exist if the local government entity has exercised ordinary business care and prudence and was nevertheless unable to prepare and properly submit the annual financial report within the prescribed time. The department will determine what constitutes the exercise of ordinary business care and prudence based on the facts of each case.

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

Auth: Sec. 2-7-517, MCA; IMP, Sec. 2-7-517, MCA

REASON: The amendment to (1) is to correct an erroneous statutory reference. The first sentence of (1) refers to 2-17-517(1), MCA. There is no such statute. The reference should be to 2-7-517(1), MCA.

"8.94.4104 PENALTY FOR FAILING TO PAY FILING FEE WITHIN 60 DAYS OF DUE DATE (1) and (2) will remain the same.

(3) If the required filing fee is not submitted to the department within 60 days of receipt of the annual report, the department ~~will~~ may add to the filing fee a late payment penalty equal to 10% of the required filing fee for each month or portion of a month that the filing fee is delinquent in excess of 60 days.

(4) and (5) will remain the same."

Auth: Sec. 2-7-517, MCA; IMP, Sec. 2-7-517, MCA

REASON: The amendment to (3) is to make this provision agree with the authorizing statute. The statute, 2-7-517, MCA, provides that the Department of Commerce "may" charge a late payment penalty as provided by rule when a local government entity fails to pay the required filing fee within 60 days. The current rule states that the Department "will" impose the penalty for failure to pay the filing fee within 60 days. The amendment will make the rule agree with the statute, and will give the Department discretion as to whether the penalty should be imposed.

"8.94.4105 AUDIT AND AUDIT REPORTING STANDARDS (1) will remain the same.

(2) Audits of periods beginning on or before June 30, 1996, must conform to the requirements of the federal Single Audit Act of 1984 (P.L. 98-502) and the OMB Circular A-128, and audits of periods beginning on or after July 1, 1996, must conform to the requirements of the federal Single Audit Act of 1984 as amended by the Single Audit Act Amendments of 1996 (P.L. 104-156) and the OMB Circular A-133 (see ARM 8.94.4111(4)).

(3) will remain the same.

(4) For audits conducted under the provisions of the OMB Circular A-128 or the OMB Circular A-133, the audit reports ~~shall~~ must comply with the reporting requirements of ~~that~~ the applicable circular (see ARM 8.94.4111(4)).

Auth: Sec. 2-7-505, 2-7-513, MCA; IMP, Sec. 2-7-505, 2-7-513, MCA

REASON: The proposed amendment incorporates references to the federal Single Audit Act as amended by Congress in 1996, and to the revised federal Office of Management and Budget (OMB) Circular A-133 that will now apply to local government audits. By federal law, the amendments to the federal Single Audit Act are effective for audits of local governments for periods beginning on or after July 1, 1996. By federal regulation, the revised Circular A-133 is also effective for audits of local governments for periods beginning on or after July 1, 1996. The proposed amendment also clarifies that the original federal Single Audit Act of 1984 and OMB Circular A-128 are only effective for audits of periods beginning on or before June 30, 1996.

"8.94.4106 ROSTER OF INDEPENDENT AUDITORS AUTHORIZED TO CONDUCT AUDITS OF LOCAL GOVERNMENT ENTITIES (1) and (2) will remain the same.

~~(3) The department will be on the roster of independent auditors authorized to conduct audits of local government entities without completing the application and renewal forms and without paying the fees specified below, and will remain on the roster so long as it meets the standards specified in Government Auditing Standards as established by the comptroller general of the United States.~~

(4) through (6)(c) will remain the same, but will be renumbered (3) through (5)(c).

(d) have an external quality control review at least once every three years that meets the requirements specified in Government Auditing Standards, as established by the comptroller general of the United States, and receive an unqualified review report from the reviewing firm, team or association. ~~For purposes of being listed on the department's initial roster covering the period from July 1, 1992 through June 30, 1993 only, an independent auditor may have received a qualified review report on the auditor's last external quality control review. However, to qualify for placement on the subsequent roster covering the period from July 1, 1993 through June 30, 1994, the auditor must have another external quality control review covering a more current review period, and receive an unqualified review report on that review. This may require that the independent auditor obtain an expedited review prior to July 1, 1993.~~

(e) through (g)(iii) will remain the same.

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

~~(8)~~ (7) If an independent auditor is removed by the department from the roster as provided in ~~(7)~~ (6) above, the independent auditor must complete the application form prescribed by the department, meet the eligibility requirements set out in ~~(6)~~ (5) above, and pay the fee specified in ~~(11)~~ (10) below in order to again be placed on the roster;

(9) through (13) will remain the same, but will be renumbered (8) through (12).

~~(14)~~ (13) Upon termination of a contract for a local government entity audit, if the local government entity fails

to present a signed contract to the department for approval with the 90 day period in ~~(13)~~(12) above, the department will designate an independent auditor to perform the audit as provided by section 2-7-506 (5), MCA."

Auth: Sec. 2-7-506, MCA; IMP, Sec. 2-7-506, MCA

REASON: The proposed amendment deletes (3), which specifies that the Department of Commerce is also on the roster of independent auditors authorized to conduct audits of local government entities. The 1995 Legislature eliminated the Department of Commerce's local government audit staff. Therefore all local government audits are now conducted by private sector certified public accountants, and it is no longer appropriate to specify that the Department of Commerce is on the roster of eligible local government auditors.

The proposed amendment deletes the last two sentences of (5)(d) (previously (6)(d)). Those two sentences provided criteria regarding the eligibility of independent auditors for placement on the roster for the periods from July 1, 1992 through June 30, 1993, and from July 1, 1993 through June 30, 1994. Those were the first two years the roster was in effect. Since those periods are now past, there is no need for these provisions.

"8.94.4109 ACTIONS BY LOCAL GOVERNMENT ENTITY GOVERNING BODIES TO RESOLVE OR CORRECT AUDIT FINDINGS AND PENALTY FOR FAILURE TO DO SO (1) through (11) will remain the same.

(12) If the department does not receive an acceptable response or corrective action plan within 30 days, it ~~will issue~~ can request, pursuant to 2-7-515(3), MCA, ~~an order to all~~ that state agencies ~~requiring each agency to~~ withhold payments of financial assistance from the local government entity pending receipt of an acceptable response or corrective action plan. The department, after consultation with the appropriate state agency or agencies, may designate the financial assistance payments to be withheld.

(13) and (14) will remain the same."

Auth: Sec. 2-7-515, MCA; IMP, Sec. 2-7-515, MCA

REASON: This proposed amendment is intended to give the Department of Commerce discretion as to which financial assistance payments to withhold in cases where an entity has not provided an acceptable response or correction action plan regarding deficiencies and recommendations presented in an entity's audit report. If certain financial assistance payments were withheld, they could adversely affect other government entities or citizens not directly involved with the audited entity. Other payments, however, may have a more direct impact on the local government entity's general government operations but not directly affect other parties. This amendment will give the Department discretion in withholding payments so that parties other than the local government entity that was audited are not adversely affected.

"8.94.4111 INCORPORATION BY REFERENCE OF VARIOUS STANDARDS, ACCOUNTING POLICIES, AND FEDERAL LAWS AND REGULATIONS (1) through (3) will remain the same.

(4) The department hereby adopts and incorporates by this reference the federal Single Audit Act of 1984 (P.L. 98-502), the federal Single Audit Act of 1984 as amended by the Single Audit Act Amendments of 1996 (P.L. 104-156), ~~and~~ the OMB Circular A-128, "Audits of State and Local Governments," and the OMB Circular A-133, "Audits of States, Local Governments, and Non-Profit Organizations," as requirements to which local government audits must conform, as provided by ARM 8.94.4105.

(a) The federal Single Audit Act, the federal Single Audit Act of 1984 as amended by the Single Audit Act Amendments of 1996, the OMB Circular A-128, and the OMB Circular A-133 incorporated by reference in (4) above, relate to the following:

(i) background and purpose ~~on the Act~~,

(ii) applicability of the Act and Circulars,

(iii) audit requirements and scope of audits conducted under the Act and Circulars,

(iv) will remain the same,

(v) ~~internal control review and compliance review requirements,~~ federal agency and pass-through entity responsibilities,

(vi) requirements relating to subrecipients and vendors,

(vii) will remain the same,

(viii) ~~cognizant agency~~ auditee responsibilities,

(ix) through (xi) will remain the same,

(xii) audit ~~workpapers~~ working papers and reports,

(xiii) and (xiv) will remain the same.

(b) ~~The Act and the Circular adopted by reference in (4), above, are contained in the audit and accounting guide entitled Audits of State and Local Governmental Units, which may be obtained from the American Institute of Certified Public Accountants, Order Department, P.O. Box 1003, New York, NY 10108-1003.~~ The federal Single Audit Act of 1984 and the federal Single Audit Act as amended by the Single Audit Act Amendments of 1996 adopted by reference in (4), above, are codified as Chapter 75 of Title 31 of the United State Code. The Code is available at many public libraries and at law offices, and can be accessed on the Internet at: http://law.house.gov/uscsrch.htm.

(c) The Circulars adopted by reference in (4), above, are available from the Federal Office of Management and Budget. Hard copies can be obtained by calling (202) 395-7332. They can also be accessed on the Internet at: http://www.whitehouse.gov/WH/EOP/OMB/html/ombhome.html#docs.

(5) through (5)(b) will remain the same."

Auth: Sec. 2-7-503, 2-7-504, 2-7-505, 2-7-506, MCA; IMP, Sec. 2-7-503, 2-7-504, 2-7-505, 2-7-506, MCA

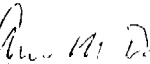
REASON: The proposed amendments incorporate by reference the Single Audit Act of 1984 as amended by the Single Audit Act Amendments of 1996 and the OMB Circular A-133, "Audits of States, Local Governments, and Non-Profit Organizations." They must be included because they are referenced as required audit and audit reporting standards under revised ARM 8.94.4105. Under federal law and regulation, the Act and Circulars are effective for audits of periods beginning on or after July 1, 1996. The proposed amendment also updates and revises the description of what the federal Single Audit Act and the OMB Circulars relate to. Updated information on where the Act and Circulars can be located is also provided under this amendment.

3. Interested persons may present their data, views or arguments, either orally or in writing, at the hearing. Written data, views or arguments may also be submitted to the Local Government Assistance Division, Department of Commerce, 1424 Ninth Avenue, Helena, Montana 59620, no later than June 2, 1997.

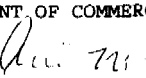
4. The Department of Commerce will make reasonable accommodations for persons with disabilities who wish to participate in the public hearing. If you wish to request an accommodation, contact the Department no later than 5:00 p.m., May 21, 1997, to advise us of the nature of the accommodation that you need. Please contact Richard M. Weddle, Local Government Assistance Division, Department of Commerce, 1424 Ninth Avenue, Helena, Montana 59620; telephone (406) 444-2781, Montana Relay 1-800-253-4091; TDD (406) 444-2978; facsimile (406) 444-2903. Persons with disabilities who need an alternative accessible format of this document in order to participate in this rule-making process should contact Richard M. Weddle.

5. Richard M. Weddle, attorney, has been designated to preside over and conduct this hearing.

LOCAL GOVERNMENT ASSISTANCE DIVISION

BY: 

ANNIE M. BARTOS, CHIEF COUNSEL
DEPARTMENT OF COMMERCE



ANNIE M. BARTOS, RULE REVIEWER

Certified to the Secretary of State, April 21, 1997.

BEFORE THE BOARD OF INVESTMENTS
DEPARTMENT OF COMMERCE
STATE OF MONTANA

In the matter of the proposed amendment of rules pertaining to the Intercap Revolving Program	NOTICE OF PUBLIC HEARING ON THE PROPOSED AMENDMENTS OF THE INTERCAP REVOLVING PROGRAM

TO: All Interested Persons:

1. On May 26, 1997, at 10:00 a.m., a public hearing will be held in the conference room at the Board of Investments, Department of Commerce, 555 Fuller Avenue, Helena, Montana, to consider the proposed amendment of rules pertaining to the Intercap Revolving Program.

2. The proposed amendments to ARM 8.97.910, 8.97.914, 8.97.916, 8.97.917, 8.97.918, 8.97.919 and 8.97.921 will read as follows: (new matter underlined, deleted matter interlined)

"8.97.910 INTERCAP PROGRAM - PURPOSE (1) will remain the same.

(a) There is no limitation to the total volume of participation in the INTERCAP program by an eligible government unit except for those limits imposed by statutory debt limitations and underwriting standards used by the board to ensure payment of loans and viability of the INTERCAP program."

Auth: Sec. 17-5-1605, MCA; IMP, Sec. 17-5-1606, MCA

"8.97.914 INTERCAP PROGRAM - ~~ACCEPTANCE AND~~ ORIGINATION FEE ~~(1) Except as provided in ARM 8.97.917, at the time the board commits to lend funds and the eligible government unit accepts the commitment, the eligible government unit shall pay an acceptance fee to the board equal to 0.5% of the requested loan amount.~~

~~(2)~~(1) Except as provided in 8.97.916 a ~~A~~ loan origination fee ~~equal to 0.5% of the requested loan amount~~ must be paid at the closing of the loan and may be capitalized as part of the loan.

~~(3)~~(2) The ~~acceptance fee and the~~ loan origination fee ~~are~~ is used to offset the board's costs in issuing the bonds and processing the loan. The amount of the loan origination fee shall be calculated on the rates approved by the board in effect at the time the commitment is issued.

Auth: Sec. 17-5-1605, MCA; IMP, Sec. 17-5-1611, 17-5-1643, MCA

"8.97.916 INTERCAP PROGRAM - SHORT-TERM LOANS (1) A short-term loan, as defined in ARM 8.97.715, in the form of a bond, grant or loan anticipation note, may be made to an eligible government unit in an amount not to exceed the lesser of:

(i) will remain the same, but will be renumbered (a).

~~(ii)~~ (b) the principle amount of the grant or loan of which the eligible government ~~entity~~ unit has obtained a binding commitment to receive or the amount of bonds authorized to be issued to provide the source or repayment for the short-term loan.

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

(5) No ~~acceptance or~~ origination fee shall be charged for short-term loans, provided, however, if the actual term of the short-term loan is extended beyond 12 months through default or a negotiated extension, the board may require payment of the ~~acceptance or~~ origination fee."

Auth: Sec. 17-5-1605, MCA; IMP, Sec. 17-5-1606, MCA

"8.97.917 INTERCAP PROGRAM - GENERAL OBLIGATION BONDED DEBT - DESCRIPTION - REQUIREMENTS (1) through (1)(a) will remain the same.

(b) The loan limit may not exceed ~~$1,000,000~~ the maximum amount established by the board for such indebtedness, not including the board's origination fee or the reserve requirement, if any."

Auth: Sec. 17-5-1605, MCA; IMP, Sec. 17-5-1606, MCA

"8.97.918 INTERCAP PROGRAM - REVENUE OBLIGATION - TAX BACKED REVENUE OBLIGATIONS - DESCRIPTION - REQUIREMENTS

(1) through (1)(e) will remain the same.

(f) The loan amount may not exceed ~~$500,000~~ the maximum amount established by the board for such indebtedness, not including the board's origination fee or the reserve requirement~~, if any, provided, however, that the principal amount of a loan to water and sewer district which has not been authorized by the voters shall not exceed $50,000, not including the board's origination fee or the reserve requirement, if any~~.

(1)(g) through (2)(e) will remain the same.

(f) The loan amount may not exceed ~~$500,000~~ the maximum amount established by the board for such indebtedness, not including the board's origination fee or the reserve requirement, if any.

(2)(g) through (2)(h) will remain the same."

Auth: Sec. 17-5-1605, MCA; IMP, Sec. 17-5-1606, MCA

"8.97.919 INTERCAP PROGRAM - SPECIAL IMPROVEMENT BOND DEBT - DESCRIPTION - REQUIREMENTS (1) through (2)(b) will remain the same.

(c) The principal amount of any special improvement district bond issue may not exceed ~~$300,000~~ the maximum amount established by the board for such indebtedness, not including the board's origination fee or the reserve requirement, if any.

(d) will remain the same."

Auth: Sec. 17-5-1605, MCA; IMP, Sec. 17-5-1606, MCA

"8.97.921 INTERCAP PROGRAM - OTHER LOANS; LIMITS

(1) will remain the same.

(a) The maximum principal amount of any loan shall not exceed ~~$500,000~~ the maximum amount established by the board for such indebtedness, not including the board's origination fee or the reserve requirement~~, if any, except for loans to the state university system, in which case the principal amount of any single loan shall not exceed $1,000,000, not including the board's origination fee or the reserve requirement, if any~~.

(b) The board determines that the source or sources from which the loan will be paid is and will be legally available to repay the obligation and will be adequate, taking into consideration other outstanding debt and the limitations (including I-105) on the eligible government unit's ability to levy taxes or impose fees and charges for the repayment of the loan."

Auth: Sec. 17-5-1605, MCA; IMP, Sec. 17-5-1606, MCA

REASON: The reason for the proposed amendment is due to the contemplated loan request by a state agency, we determined that we did not have the ability within the rules to make a loan in the amount that they would be requesting. In reviewing the rules, we determined that having arbitrary limits wasn't necessarily appropriate, for instance, setting a limit that would allow a small school to borrow the same amount that a large county could, did not make sense. Taking the maximum limits out of the rules and applying underwriting criteria approved by staff and the board seems more appropriate.

3. Interested persons may present their data, views or arguments, either orally or in writing, at the hearing. Written data, views or arguments may also be submitted to the Board of Investments, Department of Commerce, 555 Fuller Avenue, Helena, Montana 59620, no later than June 4, 1997.

4. The Department of Commerce will make reasonable accommodations for person with disabilities who wish to participate in the public hearing. If you wish to request an accommodation, contact the Department no later than 5:00 p.m., May 19, 1997, to advise us of the nature of the accommodation that you need. Please contact Board of Investments, Department of Commerce, 555 Fuller Avenue, Helena, Montana 59620; telephone (406) 444-0001, Montana Relay 1-800-253-4091; TDD (406) 444-2978; facsimile (406) 449-6579. Persons with disabilities who need an alternative accessible format of this document in order to participate in this rule-making process should contact David Ewer by the above methods.

5. David Ewer, Bond Program Officer, has been designated to preside over and conduct this hearing.

BOARD OF INVESTMENTS

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

_____
ANNIE M. BARTOS, RULE REVIEWER

Certified to the Secretary of State, April 21, 1997.

BEFORE THE BOARD OF PUBLIC EDUCATION
OF THE STATE OF MONTANA

In the matter of the amendment of Assessment	)))	NOTICE OF PUBLIC HEARING ON PROPOSED AMENDMENT TO ARM 10.56.101 STUDENT ASSESSMENT

To: All Interested Persons

1. On May 22, 1997, at 1:30 p.m., or as soon thereafter as it may be heard, a public hearing will be held at the Board of Public Education Offices, 2500 Broadway, Helena, in the matter of the proposed amendment to 10.56.101 Student Assessment.

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

10.56.101 STUDENT ASSESSMENT

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

(6) All norm-referenced test results released to the public by schools will be accompanied by a clear statement of the purposes of the test, subject areas that have been tested, how they were tested, percent of students who did not participate in the norm-referenced test, limitations of norm-referenced tests, what is meant by the results and how the results will be used.

(7) ~~Full time special education students shall not be required to participate in the norm-referenced testing program. Those students receiving only special education instruction in any of those tested academic areas shall not be required to participate in that section of the test for which they receive exclusive special education instruction.~~ Students with disabilities or limited English proficiency (LEP) shall participate in the regular assessment, unless it is determined that the student's attainment of educational goals cannot be adequately measured with the regular district assessment.

(a) For students with disabilities, the Individualized Education Program (IEP) teams have the authority to specify accommodations to be provided, as defined in (8), for participation by the student in the regular district assessment.

(i) When an IEP team determines that an accommodation for a student's disability would still not allow for adequate measurement of the student's attainment of educational goals, the IEP team may waive participation in the district norm-referenced test by providing an alternative form of testing that is appropriate to determine the student's attainment of educational goals and objectives.

(b) For students with LEP who have been identified by a team of educators as limited English proficient, those teams have the authority to specify accommodations to be provided, as defined in (8), for participation by the student in the regular district assessment.

(i) When the team of educators determines that an

accommodation for an LEP student who has had fewer than three years of instruction in English would still not allow for adequate measurement of the student's attainment of educational goals, the team of educators may waive participation in the district test by providing an alternative form of testing that is appropriate to determine the student's attainment of educational goals and objectives.

(8) Accommodations allow the student to demonstrate competence in subject matter so that test results accurately reflect the student's achievement level rather than reflecting the student's limited English language development or impaired sensory or manual skills, except where those skills are the factors which the test purports to measure.

(a) Accommodation for testing purposes is defined as modifications similar to those used to support and accommodate the student in the instructional setting.

(b) Accommodations may include, but are not limited to extended time, small group administration, facilitator reading directions, native language support, student responding orally or using required assistive technology.

AUTH: Sec. 20-2-121(12), MCA IMP: 20-7-402, MCA

3. The purpose of the amendments to this rule is to clarify standards for including students in district-wide assessments.

4. Interested persons may present their data, views, or arguments, either orally or in writing, at the hearing. Written data, views, or arguments may also be submitted to Storrs Bishop, Chairman of the Board of Public Education, 2500 Broadway, Helena, Montana 59620, and must be received no later than May 22, 1997.

5. Storrs Bishop, Chairman of the Board of Public Education, has been designated to preside over and conduct this hearing.

Wayne Buchanan

Wayne Buchanan, Executive Secretary
Board of Public Education

Certified to the Secretary of State on 4/18/97.

BEFORE THE BOARD OF PUBLIC EDUCATION
OF THE STATE OF MONTANA

In the matter of the amendment of Accreditation	))))	NOTICE OF PUBLIC HEARING ON PROPOSED AMENDMENT TO ARM 10.55.603 CURRICULUM DEVELOPMENT AND ASSESSMENT

To: All Interested Persons

1. On May 22, 1997, at 1:40 p.m., or as soon thereafter as it may be heard, a public hearing will be held at the Board of Public Education Offices, 2500 Broadway, Helena, in the matter of the proposed amendment to 10.55.603 Curriculum Development and Assessment.

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

10.55.603 CURRICULUM DEVELOPMENT AND ASSESSMENT
(1) through (6) will remain the same.

(7) All school districts shall conduct a program of student assessment in accordance with ARM 10.56.101 Student Assessment.

AUTH: Sec. 20-2-121(12), MCA IMP: 20-7-101, MCA

3. The purpose of this amendment is to correct an oversight in the rules and place student assessment into the accreditation standards where it belongs.

4. Interested persons may present their data, views, or arguments, either orally or in writing, at the hearing. Written data, views, or arguments may also be submitted to Storrs Bishop, Chairman of the Board of Public Education, 2500 Broadway, Helena, Montana 59620, and must be received no later than May 22, 1997.

5. Storrs Bishop, Chairman of the Board of Public Education, has been designated to preside over and conduct this hearing.

Wayne Buchanan, Executive Secretary
Board of Public Education

Certified to the Secretary of State on 4/18/97.

BEFORE THE BOARD OF PUBLIC EDUCATION
OF THE STATE OF MONTANA

In the matter of the amendment of Teacher Certification	)))	NOTICE OF PUBLIC HEARING ON PROPOSED AMENDMENT TO ARM 10.57.211 TEST FOR CERTIFICATION

To: All Interested Persons

1. On May 22, 1997, at 1:50 p.m., or as soon thereafter as it may be heard, a public hearing will be held at the Board of Public Education Offices, 2500 Broadway, Helena, in the matter of the proposed amendment to 10.57.211 Test for Certification.

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

10.57.211 TEST FOR CERTIFICATION

(1) will remain the same.

(2) Effective July 1, 1996, all new applicants for initial class 1, 2, or 3 certification, except those currently holding at least one of these Montana certificates, must provide evidence of having passed either the communication skills and general knowledge tests of the praxis series (formerly national teacher examination core battery), or the praxis series pre-professional skills tests, (PPST), or the praxis I: computer based academic skills test (CBT), with at least the minimum scores established by the board. Applicants for initial certification may have these requirements waived who have achieved at least the state-established minimum passing score(s) assessing the basic skills of reading, writing and mathematics required as part of the state-mandated requirements for entry into or completion of a teacher preparation program from which the applicant graduated or was required for certification in that state. Successful completion of the graduate record examination (GRE) requirement for entry into graduate level college and university programs shall be considered valid for the basic skills testing waiver.

(3) Remains the same.

(4) Individuals seeking to reinstate lapsed Montana teacher, administrative or specialist certificates ~~will also be~~ are not required to ~~satisfactorily~~ complete the basic skills testing requirement.

(5) Remains the same.

AUTH: Sec. 20-2-121(1), MCA IMP: 20-4-102 (1), MCA

3. The purpose of this amendment is to recognize other tests of general knowledge, which are equal or more comprehensive than the test for certification now required, to be accepted for certification purposes.

4. Interested persons may present their data, views, or arguments, either orally or in writing, at the hearing. Written data, views, or arguments may also be submitted to Storrs Bishop, Chairman of the Board of Public Education, 2500 Broadway, Helena, Montana 59620, and must be received no later than May 22, 1997.

5. Storrs Bishop, Chairman of the Board of Public Education, has been designated to preside over and conduct this hearing.

Wayne Buchanan, Executive Secretary
Board of Public Education

Certified to the Secretary of State on 4/18/97.

BEFORE THE BOARD OF PUBLIC EDUCATION
OF THE STATE OF MONTANA

In the matter of the amendment of Teacher Certification	)))	NOTICE OF PUBLIC HEARING ON PROPOSED AMENDMENT TO ARM 10.57.215 RENEWAL REQUIREMENTS

To: All Interested Persons

1. On May 22, 1997, at 2:00 p.m., or as soon thereafter as it may be heard, a public hearing will be held at the Board of Public Education Offices, 2500 Broadway, Helena, in the matter of the proposed amendment to 10.57.215 Renewal Requirements.

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

10.57.215 RENEWAL REQUIREMENTS
(1) through (4)(b) will remain the same.

(5) State validated professional development activities other than college/university credit earned by appropriately licensed educators from states other than Montana may be accepted for the renewal of Montana certification when the intent and structure of the process assures the meeting or exceeding of Montana renewal unit requirements for certificate.

AUTH: Sec. 20-2-121(1), MCA IMP: 20-4-102(1), MCA

3. The purpose of this amendment is to allow educators trained in other states more equitable access to Montana certification and certificate renewal.

4. Interested persons may present their data, views, or arguments, either orally or in writing, at the hearing. Written data, views, or arguments may also be submitted to Storrs Bishop, Chairman of the Board of Public Education, 2500 Broadway, Helena, Montana 59620, and must be received no later than May 22, 1997.

5. Storrs Bishop, Chairman of the Board of Public Education, has been designated to preside over and conduct this hearing.

Wayne Buchanan, Executive Secretary
Board of Public Education

Certified to the Secretary of State on 4/18/97.

BEFORE THE BOARD OF ENVIRONMENTAL REVIEW
OF THE STATE OF MONTANA

In the matter of the amendment of 17.8.302, incorporating by reference federal regulations and other materials related to air quality emission standards, and 17.8.340, regarding standards of performance for new stationary sources of air pollutants.	)))))))	NOTICE OF PUBLIC HEARING FOR PROPOSED AMENDMENT OF RULES (Air Quality)

To: All Interested Persons

1. On June 2, 1997, at 2:00 p.m., or as soon thereafter as it may be heard, the board will hold a public hearing at Room 111 of the Metcalf Building, 1520 E. 6th Ave., Helena, Montana, to consider amendment of the above-captioned rules.

2. The rules, as proposed to be amended, appear as follows (new material is underlined; material to be deleted is interlined):

17.8.302 INCORPORATION BY REFERENCE (1) For the purposes of this subchapter, the board hereby adopts and incorporates herein by reference the following:

(a)-(h) Remain the same.

(i) 40 CFR Part 63, specifying emission standards for hazardous air pollutant source categories~~.~~;

(j) 40 CFR Part 60, subpart Cc, specifying emission guidelines for existing municipal solid waste landfills that would be subject to a standard of performance if they were new sources.

(2)-(4) Remain the same.

AUTH: 75-2-111, 75-2-203, MCA; IMP: 75-2-203, MCA

17.8.340 STANDARD OF PERFORMANCE FOR NEW STATIONARY SOURCES AND EMISSION GUIDELINES FOR EXISTING SOURCES

(1)-(3) Remain the same.

(4)(a) Designated municipal solid waste landfill facilities under 40 CFR Part 60, subpart Cc shall comply with the requirements in 40 CFR 60.33c, 60.34c, and 60.35c, that are applicable to designated facilities and that must be included in a state plan for state plan approval, except that quarterly surface monitoring for methane under 60.34c is required only during the second, third, and fourth quarters of the calendar year.

(b) Designated facilities under Subpart Cc, that meet the conditions in 40 CFR 60.33c(a)(1), regarding operation or design capacity, shall submit an initial design capacity report and an initial emission rate report, in accordance with 40 CFR 60.757, within 90 days of EPA's publication in the Federal Register of approval of this rule. If the design capacity report reflects that the facility meets the condition in 40 CFR 60.33c(a)(2) and the emission rate report reflects that the facility meets the condition in 40 CFR 60.33c(a)(3), the facility shall:

(i) submit a final control plan to the department for review and final approval within 12 months after the date of EPA's publication of approval of this rule in the Federal Register, or within 12 months after the date the condition in 40 CFR 60.33c(a)(3) is met (i.e., the date of the first annual nonmethane organic compound (NMOC) report which demonstrates that NMOCs equal or exceed 50 Mg/yr), whichever occurs later;

(ii) award contracts for any necessary control systems/process changes within 15 months after the date of EPA's publication of approval of this rule in the Federal Register, or within 15 months after the date the condition in 40 CFR 60.33c(a)(3) is met, whichever occurs later;

(iii) initiate on-site construction or installation of any necessary air pollution control devices, and initiate any necessary process changes, within 18 months after the date of EPA's publication of approval of this rule in the Federal Register, or within 18 months after the date the condition in 40 CFR 60.33c(a)(3) is met, whichever occurs later;

(iv) complete on-site construction or installation of any necessary air pollution control devices, and complete any necessary process changes, within 24 months after the date of EPA's publication of approval of this rule in the Federal Register, or within 24 months after the date the condition in 40 CFR 60.33c(a)(3) is met, whichever occurs later; and

(v) achieve final compliance within 30 months after the date of EPA's publication of approval of this rule in the Federal Register, or within 30 months after the date the condition in 40 CFR 60.33c(a)(3) is met, whichever occurs later.

(c) Designated facilities under Subpart Cc shall comply with the final site-specific collection and control system design plan approved by the department and, in accordance with 40 CFR 60.8, shall demonstrate compliance with the emission standards specified in Subpart Cc, not later than 180 days following initial startup of the collection and control system.

AUTH: 75-2-111, 75-2-203, MCA; IMP: 75-2-203, MCA

3. On March 12, 1996, the Environmental Protection Agency (EPA) promulgated emission guidelines for municipal solid waste landfills that commenced construction, reconstruction or modification before May 30, 1991. The emission guidelines, found in 40 CFR Part 60, Subpart Cc, regulate emission of nonmethane organic compounds found in landfill gas. Nonmethane organic compounds in landfill gas contribute to ozone formation, which can result in adverse affects to human health and vegetation. The health effects of hazardous air pollutants in the compounds can include cancer, respiratory irritation, and damage to the nervous system. The guidelines apply to facilities for which construction, reconstruction, or modification was commenced before May 30, 1991, and that meet certain additional specified criteria. Presently, the only landfill in the state subject to the guidelines is the City of Billings Solid Waste Landfill. The Board is proposing to implement the guidelines by incorporating them by reference into the state air quality rules. Adoption of the guidelines into state law would be part of a state plan that

will implement the Subpart Cc requirements and allow the Montana Department of Environmental Quality to administer and enforce the guidelines. If the state does not adopt the guidelines, the guidelines will be administered and enforced by EPA.

4. Interested persons may submit their data, views, or arguments, either orally or in writing, at the hearing. Written data, views, or arguments may also be submitted to the Board of Environmental Review, PO Box 200901, Helena, Montana 59620-0901, no later than June 4, 1997.

5. Tim Fox has been appointed to preside over and conduct the hearing.

BOARD OF ENVIRONMENTAL REVIEW
CINDY E. YOUNKIN, Chairperson

By: Dr. Garon C. Smith

Reviewed by:

John F. North, Rule Reviewer

Certified to the Secretary of State April 21, 1997.

BEFORE THE BOARD OF ENVIRONMENTAL REVIEW
OF THE STATE OF MONTANA

In the matter of the amendment of 17.8.120, regarding variance procedures.	)))	NOTICE OF PUBLIC HEARING FOR PROPOSED AMENDMENT OF RULE

(Air Quality)

To: All Interested Persons

1. On June 5, 1997, at 9:00, a.m., or as soon thereafter as it may be heard, the board will hold a public hearing at Room 111 of the Metcalf Building, 1520 E. 6th Ave., Helena, Montana, to consider amendment of the above-captioned rule.

2. The rule, as proposed to be amended, appears as follows (new material is underlined; material to be deleted is interlined):

17.8.120 VARIANCE PROCEDURES--INITIAL APPLICATION

(1)-(3) Remain the same.

(4) ~~Public hearings held pursuant to this subchapter are adjudicatory fact hearings to consider the proposed application for variance and its conditions.~~ Hearings held pursuant to this subchapter are for the purpose of determining whether the application for exemption should be granted. In making its determination, the board shall resolve issues raised by parties, and shall consider comments submitted by the general public.

(a) Members of the general public may submit comments concerning the application for exemption. Comments must be submitted in writing to the board within 20 days after date of publication of public notice pursuant to (3) of this rule. If written comments are timely filed, a commenter may orally present those comments to the board at the hearing.

~~(a)~~(b) Any person may submit a request to be a party within 20 days after date of publication of public notice ~~as required by~~ pursuant to (3)~~(b)~~ of this rule. Requests to be a party under this section shall be directed to the ~~department~~ board and shall state:

(i)-(iv) Remain the same.

~~(b)~~(c) Except as provided in (4)(d), conduct ~~Conduct~~ of the hearing ~~shall~~ must be in accordance with "contested case" procedures of the Montana Administrative Procedure Act (MAPA) and the model rules of the attorney general promulgated in pursuance thereto.

(d) MAPA contested case procedures do not apply to that portion of the hearing conducted for the purpose of receiving comments from the general public. The board may use such public comment procedures as it finds are appropriate under the circumstances of a particular case.

~~(5) Within 30 days after completion of the hearing, the presiding officer shall certify the record to the department. If the official of the department, who is to render the final order, or if a majority of the members of the board of environmental review, which is to concur in that order, was not present at the hearing or has not read the record, the decision, if adverse to the applicant, shall not be made until a proposed order is served upon the parties and an opportunity is afforded to each party adversely affected to file exceptions and present briefs and oral arguments to the department or board respectively. Waiver of compliance with this provision may be made by stipulation of all parties. Within 30 days following certification of the record or after final submission of the matter to the department, a final decision shall be issued. The final order shall include the matters and things set forth in ARM 1.3.225 including findings of fact and conclusions, separately stated. Notice of final order is to be given parties and their attorneys within 20 days following issuance of the final order.~~

AUTH: 75-2-111, MCA; IMP: 75-2-212, MCA

3. The Board is proposing these amendments in order to ensure that contested case procedures under the Montana Administrative Procedure Act do not govern the public comment phase of a variance hearing. Less formal procedures for the public hearing facilitate public participation in the process. The requirement that the members of the public submit advance copies of their testimony protects the due process rights of the parties to the contested case. The Board will retain discretion to use such public comment procedures as it finds appropriate in a particular case.

4. Interested persons may submit their data, views, or arguments, either orally or in writing, at the hearing. Written data, views, or arguments may also be submitted to the Board of Environmental Review, PO Box 200901, Helena, Montana 59620-0901, no later than June 5, 1997.

5. Jim Madden has been appointed to preside over and conduct the hearing.

BOARD OF ENVIRONMENTAL REVIEW

by Gavin Smith PhD for Cindy E. Younkin
CINDY E. YOUNKIN, Chairperson

Reviewed by:

John F. North
John F. North, Rule Reviewer

Certified to the Secretary of State April 21, 1997.

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

In the matter of the amendment of rules 46.6.903 and 46.6.1601 through 46.6.1604 pertaining to the independent living program	))))))	NOTICE OF PUBLIC HEARING ON THE PROPOSED AMENDMENT OF RULES

TO: All Interested Persons

1. On May 28, 1997, at 9:30 a.m., a public hearing will be held in the auditorium of the Department of Public Health and Human Services Building, 111 N. Sanders, Helena, Montana to consider the proposed amendment of rules 46.6.903 and 46.6.1601 through 46.6.1604 pertaining to the independent living program.

The Department of Public Health and Human Services will make reasonable accommodations for persons with disabilities who wish to participate in this public hearing. If you request an accommodation, contact the department no later than 5:00 p.m. on May 12, 1997, to advise us of the nature of the accommodation that you need. Please contact Dawn Sliva, P.O. Box 4210, Helena, MT 59604-4210; telephone (406)444-5622; FAX (406)444-1970.

2. The rules as proposed to be amended provide as follows. New language that is being added is underlined. Language that is to be deleted is interlined.

46.6.903 STANDARDS FOR PROVIDERS; CERTIFICATION OF PROVIDERS OF PROGRAMS OR SERVICES (1) ~~A~~ An incorporated provider of services for applicants or clients of services provided through chapter 6 of Title 46 of the Administrative Rules of Montana ~~that is an incorporated corporation~~ delivering a program of vocational rehabilitation, visual rehabilitation, extended employment services or independent living services must be certified as a qualified provider by the department. ~~in order to receive certification from the department must be accredited by the appropriate accrediting body as specified on the following list:~~

(2) The department for the purposes of the certification process provided in this rule hereby adopts and incorporates by reference the following standards:

(1)(a) and (1)(b) remain the same in text but are renumbered (2)(a) and (2)(b).

(c) for providers of independent living services, the standards ~~of the national council on disability (NCD)~~ and assurances as set forth in Title VII, Section 725, of the

federal Rehabilitation Act of 1973 (29 USC 796).

(3) Copies of the standards adopted and incorporated by reference in this rule may be obtained as follows:

(a) The CARF standards may be obtained by temporary loan from the department through the Disability Services Division, Department of Public Health and Human Services, P.O. Box 4210, Helena, MT 59604-4210 or by purchase from CARF, 4891 E. Grant Road, Tucson, AZ 85712;

(b) The NAC standards may be obtained by temporary loan from the department through the Disability Services Division, Department of Public Health and Human Services, P.O. Box 4210, Helena, MT 59604-4210 or by purchase from NAC, 15 E. 40th Street, Suite 1004, New York, NY 10016; and

(c) The independent living standards and assurances may be obtained through the Disability Services Division, Department of Public Health and Human Services, P.O. Box 4210, Helena, MT 59604-4210.

~~(2)~~ (4) A provider of services that in accordance with ~~(1)~~ this rule must receive accreditation, may be provisionally certified by the department until the provider receives the appropriate accreditation. A provisional certification may not be for more than 18 months. A provider may not receive another provisional certification, consecutive with a prior provisional certification unless the department determines that the provisional recertification is necessary due to matters of process relating to the accreditation and that the provider is making a good faith effort to become accredited.

~~(3)~~ (5) The department will certify a provider of services that is not accredited as provided in ~~(1)~~ this rule and that is necessary to the delivery of services to an applicant or client, if the provider is certified or otherwise approved by a state or federal agency with which the department has a cooperative agreement concerning the coordinated delivery of services to a class of persons to which the person belongs.

(4) remains the same in text but is renumbered (6).

~~(5)~~ (7) The department will ~~provide certification of~~ certify a provider of vocational rehabilitation or similar services upon receipt from the provider of records and reports attesting to its CARF or NAC accreditation, or in the case of independent living services, the yearly 704 federal independent living report. The tenure of the certification by the department may be up to ~~three~~ 3 years.

(5)(a) remains the same in text but is renumbered (8).

AUTH: Sec. 53-7-102, 53-7-203, 53-7-206, 53-7-302 and 53-7-315, MCA
IMP: Sec. 53-7-102, 53-7-103, 53-7-203, 53-7-302 and 53-7-303, MCA

46.6.1601 INDEPENDENT LIVING ~~REHABILITATION~~ PROGRAM: PURPOSES (1) The independent living ~~rehabilitation~~ program provides ~~under~~ in accordance with Title VII of the federal

Rehabilitation Act of 1973 (29 USC 796) comprehensive services to persons with severe disabilities to enable them to live and function independently in community settings.

(2) and (3) remain the same.

AUTH: Sec. 53-7-102, 53-7-315 and 53-19-112, MCA
IMP: Sec. 53-7-102, 53-7-103, 53-7-302, 53-19-101, 53-19-103 and 53-19-105, MCA

46.6.1602 INDEPENDENT LIVING ~~REHABILITATION~~ PROGRAM: SERVICES (1) Independent living services include vocational rehabilitation services and other services that the department determines are necessary and will enhance the ability of persons with severe disabilities to live independently and to function within a community setting and, if appropriate, to secure and maintain appropriate employment.

(2) Independent living services are limited to those services specified in Montana's ~~three~~ 3 year state plan for independent living rehabilitation services submitted to and approved by the federal government. The Montana 3 year state plan for independent living services under Title VII of the federal Rehabilitation Act of 1973 (29 USC 796) is hereby adopted and incorporated by reference and may be obtained from the Disability Services Division, Department of Public Health and Human Services, P.O. Box 4210, Helena, MT 59604-4210.

(3) Services may include, but are not limited to:

(a) counseling ~~services~~;

(b) services to secure housing or shelter including housing adaptation ~~services~~;

(c) physical and mental restoration ~~services~~;

(d) transportation ~~and~~ including transportation training, ~~and~~ assistance and referral;

(e) ~~attendant care and attendant training services~~ personal assistance, including attendant care and the training of personnel providing services;

(f) ~~assistive services~~ services and training for persons with cognitive and sensory disabilities, including life skills training, and interpreter and reader services;

(g) services to family members and dependents;

(h) vocational assistance and other training ~~services~~;

(i) information and referral ~~services~~;

(j) services for children ~~of pre-school age~~ with significant disabilities;

(k) advocacy and legal assistance ~~services~~;

(l) independent living skill ~~instruction services~~ training;

(m) peer counseling, including cross-disability peer counseling ~~services~~;

(n) individual and group social and recreational ~~services~~ activities;

(o) outreach and recruitment ~~services~~;

(p) ~~visual screening services~~ mobility training; ~~and~~

(q) therapeutic ~~services~~ treatment;

(r) rehabilitation technology;

(s) surveys, directories, and other activities to identify appropriate housing, recreation opportunities, and accessible transportation, and other support services;

(t) consumer information programs on rehabilitation and independent living services especially for minorities and other groups of persons that have traditionally been unserved and underserved;

(u) prostheses and other appliances and devices;

(v) training for youth with significant disabilities to promote self-awareness and esteem, develop advocacy and self-empowerment skills, and explore career options;

(w) appropriate preventive services;

(x) community awareness programs to enhance the understanding and integration into society of persons with disabilities; and

(y) other services as may be necessary.

(4) remains the same.

AUTH: Sec. 53-7-102, 53-7-103, 53-7-315 and 53-19-112, MCA
IMP: Sec. 53-7-102, 53-7-302, 53-19-103 and 53-19-105, MCA

46.6.1603 INDEPENDENT LIVING ~~REHABILITATION~~ PROGRAM: ELIGIBILITY REQUIREMENTS (1) through (3) remain the same.

AUTH: Sec. 53-7-102, 53-7-103, 53-7-315 and 53-19-112, MCA
IMP: Sec. 53-7-102, 53-7-302, 53-19-103, 53-19-105 and 53-19-106, MCA

46.6.1604 INDEPENDENT LIVING ~~REHABILITATION~~ PROGRAM: PROVISION OF SERVICES (1) The department may, within its discretion, provide services to a person who is eligible for the independent living ~~rehabilitation~~ program.

(2) Only such services as are determined appropriate in accordance with ~~an independent living plan or contract~~ the state plan for independent living may be provided to a person accepted for services.

(3) remains the same.

AUTH: Sec. 53-7-102, 53-7-315 and 53-19-112, MCA
IMP: Sec. 53-7-102, 53-7-103, 53-7-302, 53-19-103, 53-19-104 and 53-19-105, MCA

3. The Department of Public Health and Human Services administers a program of independent living services for persons with severe disabilities. The goal of the independent living services program is to enable persons with severe disabilities to live and function independently in community settings. Independent living services are authorized through the federal Rehabilitation Act of 1973 at Title VII. The independent living

program is for the most part funded with federal monies given to the State under an agreement. The agreement provides that the monies be expended through independent living centers in accord with the provisions of the agreement and the independent living plan adopted by an advisory council for the State.

The proposed amendments to ARM 46.6.903, relating to standards for providers, are necessary to provide appropriate accreditation for independent living facilities and to provide for necessary incorporations by reference of the applicable accrediting standards relied upon by the Department in the certification process. The reference stated currently in the rule, concerning accreditation by the national council on disability, is without effect since that organization did not proceed with plans to become a national certification organization for independent living entities. The set of standards and assurances with accompanying report proposed for adoption is established in federal law to specifically govern the operations and performance of federally funded independent living centers. The incorporations by reference were inadvertently left out of the rule in the prior rule adoption and amendments. Those incorporations are necessary for legal implementation of the certification process by rule in that they provide notice of the reliance upon the accrediting process and of the manner by which to obtain the applicable procedures and standards.

The proposed amendments to ARM 46.6.1601 through 46.6.1604, providing for the name change for the program, are necessary to conform the name in the rules with the current and preferred usage that also appears in the federal authorities.

The proposed amendments to ARM 46.6.1602, providing for additional services, are necessary to conform the rule with the listing of services that the federal act now requires the State to provide through the program.

The proposed amendment to ARM 46.6.1604, providing for the provision of appropriate services as determined in accordance with the state plan for independent living, is necessary to conform the rule with the requirement of the federal act.

4. Interested parties may submit their data, views, or arguments either orally or in writing at the hearing. Written data, views, or arguments may also be submitted to Dawn Sliva, Office of Legal Affairs, Department of Public Health and Human Services, P.O. Box 4210, Helena, MT 59604, no later than June 2, 1997.

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

Rule Reviewer

Director, Public Health and Human Services

Certified to the Secretary of State April 21, 1997.

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

In the matter of the amendment of rules 46.12.550, 46.12.551 and 46.12.552 pertaining to home health services	))))))	NOTICE OF PUBLIC HEARING ON THE PROPOSED AMENDMENT OF RULES

TO: All Interested Persons

1. On May 28, 1997, at 10:00 a.m., a public hearing will be held in the auditorium of the Department of Public Health and Human Services Building, 111 N. Sanders, Helena, Montana to consider the proposed amendment of rules 46.12.550, 46.12.551 and 46.12.552 pertaining to home health services.

The Department of Public Health and Human Services will make reasonable accommodations for persons with disabilities who wish to participate in this public hearing. If you request an accommodation, contact the department no later than 5:00 p.m. on May 12, 1997, to advise us of the nature of the accommodation that you need. Please contact Dawn Sliva, P.O. Box 4210, Helena, MT 59604-4210; telephone (406)444-5622; FAX (406)444-1970.

2. The rules as proposed to be amended provide as follows. New language that is being added is underlined. Language that is to be deleted is interlined.

46.12.550 HOME HEALTH SERVICES, DEFINITIONS (1) "Home-bound status" means ~~either~~ that a recipient ~~is~~:

(a) is confined on a full time, part time or intermittent basis to the person's place of residence for medical reasons; ~~and~~

(b) is unable to ~~leave home~~ obtain required medical services without ~~considerable~~ demonstrated taxing effort; or ~~the recipient~~

(c) cannot reasonably obtain medical ~~needed medical~~ services other than through a home health agency. ~~The confinement can be on a part time or intermittent basis.~~

(2) through (3)(a)(vi) remain the same.

(b) Home health services do not include:

(i) ~~services available under the~~ personal care services ~~program; and~~ as provided at 46.12.555 et seq.;

(ii) visits made by a registered nurse for evaluating the home health needs of a recipient or to review the provision of home health services by a home health aide or a licensed practical nurse~~.~~; and

(iii) maintenance therapy as provided at 46.12.525A et seq.

(4) through (5)(a) remain the same.

(b) Place of residence does not include a hospital, ~~or~~ a nursing facility~~.~~, an adult day care center, or a day habilitation facility providing developmental disabilities services.

(6) remains the same.

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

46.12.551 HOME HEALTH SERVICES, REQUIREMENTS

(1) remains the same.

(2) A home health agency must be:

(a) licensed by the Montana department of public health and ~~environmental sciences~~ human services;

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

(5) The ~~attending physician must certify in the physician's order~~ provider must maintain documentation that the ~~person is~~ recipient meets the homebound definition.

(6) Written physician orders,, ~~and~~ care plans and other recipient records must be current and available upon request of the department or its designated representative.

(7) and (7)(a) remain the same.

~~(8) Skilled nursing services may be provided by contract with a licensed registered nurse in geographic areas not covered by a licensed home health agency. The registered nurse must follow written orders from the recipient's physician and document care and services provided.~~

(9) through (9)(c) remain the same but are renumbered (8) through (8)(c).

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

46.12.552 HOME HEALTH SERVICES, REIMBURSEMENT

(1) through (5)(d)(i)(B) remain the same.

(6) For home health agencies located within the borders of the state for services provided on or after July 1, 1995 and prior to July 1, 1997, the reimbursement fee for a home health service, except for a home health aide service, is 60% of the average of the provider's medicare cost limits for skilled nursing, physical therapy, speech therapy and occupational therapy services.

~~(7) For home health agencies located outside the borders of the state, providing a home health service that meets the requirements set forth in ARM 46.12.502(3), the reimbursement fee for a home health service is the lower of:~~

~~(a) the provider's customary charges; or~~

~~(b) the rate established by the medicaid agency in the state in which the agency is located.~~

(7) For home health services provided on or after July 1, 1997, the reimbursement is the following:

(a) for a nursing or therapy service - $59.54 per visit;

(b) for a home health aide visit - $26.60;

(c) for medical supplies and equipment suitable for use in the home - 90% of the amount allowable for the specific item under medicare.

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

3. Home health services provided through the medicaid program are for the purpose of allowing persons with involved medical problems to remain in their own residence as opposed to extensive or continuous hospitalization or nursing facility residency. Home health services can prevent or minimize dislocation for older persons with health problems and for persons with serious disabilities.

Home health services may include skilled nursing care, home health aide services, physical, occupational, or speech therapy services, or medical supplies and equipment suitable for use in the home.

The proposed amendments to ARM 46.12.550, HOME HEALTH SERVICES, DEFINITIONS, stating further limitations upon the provision of the services, are necessary to assure that home health services reimbursement is not provided in lieu of other lower cost medicaid services and to preclude a recipient from receiving home health services in a setting other than their own residence. Further amendments to the rule are proposed which are necessary for purposes of clarifying text and changing inappropriate references.

The proposed amendments to ARM 46.12.551, HOME HEALTH SERVICES, REQUIREMENTS, are necessary to clarify text, to correct an inappropriate reference, and to remove a provision that is no longer necessary for the administration of the program.

The proposed amendments to ARM 46.12.552, HOME HEALTH SERVICES, REIMBURSEMENT, would adopt a reimbursement rate for professional services and provide a reimbursement methodology for medical supplies and equipment provided by home health services providers. The adoption of the new reimbursement methodology for professional services based upon a reimbursement rate is necessary to simplify administration of the program. The Department and providers will avoid the time delays that are engendered by the current system. It is anticipated that the methodology change will generally be cost neutral. The inclusion of a reimbursement methodology for medical supplies and equipment is necessary to provide formal notice to providers of what the rates for service delivery will be. Apparently, a

methodology for reimbursement of medical supplies and equipment had been overlooked in the previous adoption and amendment notices for the rule. Further amendments to the rule are proposed which are necessary for purposes of clarifying text and changing inappropriate references.

4. Interested parties may submit their data, views, or arguments either orally or in writing at the hearing. Written data, views, or arguments may also be submitted to Dawn Sliva, Office of Legal Affairs, Department of Public Health and Human Services, P.O. Box 4210, Helena, MT 59604, no later than June 2, 1997.

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

Dawn Sliva
Rule Reviewer

Michael S. Billings for
Director, Public Health and Human Services

Certified to the Secretary of State April 21, 1997.

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

In the matter of the adoption of rule I, amendment of rules 46.12.507, 46.12.522, 46.12.528, 46.12.538, 46.12.901, 46.12.902, 46.12.905, 46.12.911, 46.12.912, 46.12.915, 46.12.1441 through 46.12.1449, 46.12.2003, 46.12.2013, 46.12.2102, 46.12.4810 and 46.12.5007 and the repeal of rule 46.12.529 pertaining to medicaid reimbursement methodology	)))))))))))))))	NOTICE OF PUBLIC HEARING ON THE PROPOSED ADOPTION, AMENDMENT AND REPEAL OF RULES

TO: All Interested Persons

1. On May 28, 1997, at 2:00 p.m., a public hearing will be held in the auditorium of the Department of Public Health and Human Services Building, 111 N. Sanders, Helena, Montana to consider the proposed adoption of rule I, amendment of 46.12.507, 46.12.522, 46.12.528, 46.12.538, 46.12.901, 46.12.902, 46.12.905, 46.12.911, 46.12.912, 46.12.915, 46.12.1441 through 46.12.1449, 46.12.2003, 46.12.2013, 46.12.2102, 46.12.4810 and 46.12.5007 and the repeal of rule 46.12.529 pertaining to medicaid reimbursement methodology.

The Department of Public Health and Human Services will make reasonable accommodations for persons with disabilities who wish to participate in this public hearing. If you request an accommodation, contact the department no later than 5:00 p.m. on May 12, 1997, to advise us of the nature of the accommodation that you need. Please contact Dawn Sliva, P.O. Box 4210, Helena, MT 59604-4210; telephone (406)444-5622; FAX (406)444-1970.

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

RULE I RESOURCE BASED RELATIVE VALUE SCALE (RBRVS) REIMBURSEMENT FOR SPECIFIED PROVIDER TYPES (1) For purposes of this rule, the following definitions apply:

(a) "By report" means a rate of payment for a procedure which does not have a fee assigned to it. For all procedures for which no fees have been set, reimbursement will be based on the percentage derived by dividing the previous state fiscal year's total medicaid billings for RBRVS providers covered

services by the previous state fiscal year's total medicaid reimbursement for RBRVS providers covered services. For state fiscal year 1998, the "by report" rate is 58%;

(b) "Conversion factor" means a dollar amount by which the relative value units are multiplied in order to convert the relative value units to a fee for a service. The conversion factor used to determine the medicaid payment amount for the services covered by this rule for state fiscal year 1998 is:

(i) $34.85 for medical and surgical services;

(ii) $15.01 for anesthesia services.

(c) "Policy adjustor" means a factor by which the product of the relative value units and the conversion factor is multiplied to increase or decrease the fees paid by medicaid for certain categories of services. Subject to funding, a policy adjustor of up to 10% will be applied to:

(i) maternity related services; and

(ii) family planning services.

(d) "Relative value unit" means a numerical value assigned in the resource based relative value scale to each procedure code used to bill for services provided by a health care provider. The relative value unit assigned to a particular code expresses the relative effort and expense expended by a provider in providing one service as compared with another service;

(e) "Resource based relative value scale (RBRVS)" means the most current version of the medicare resource based relative value scale contained in the physicians' medicare fee schedule adopted by the health care financing administration of the U.S. department of health and human services and published in the federal register annually. The RBRVS reflects estimates of the actual effort and expense involved in providing different health care services.

(2) Services provided by the following health care professionals will be reimbursed in accordance with the RBRVS methodology set forth in (3):

(a) physicians;
(b) mid-level practitioners;
(c) podiatrists;
(d) physical therapists;
(e) occupational therapists;
(f) speech therapists;
(g) audiologists;
(h) optometrists;
(i) providers of oral surgery services; and
(j) providers of laboratory services.

(3) Except as set forth in (4) and (5), the fee for a covered service provided by any of the provider types specified in (2) will be determined by multiplying the relative value units by the conversion factor, and then multiplying the product by a factor of one plus or minus the applicable policy adjustor, if any; provided, however, that rates for procedure codes included in the conversion to the RBRVS reimbursement

methodology shall be:

(a) for state fiscal year 1998, no less than 85% of and no more than 140% of the medicaid fee for that procedure in state fiscal year 1997;

(b) for state fiscal year 1999, no less than 80% of and no more than 145% of the medicaid fee for that procedure in state fiscal year 1997.

(4) The fee for a covered service provided by any of the provider types specified in (2) which medicare pays by report because no fees have been set will be paid by medicaid by report.

(5) For clinical laboratory services, the department will pay the lowest of the following:

(a) the provider's usual and customary charges for the service; or

(b) 60% of the medicare fee for the service.

(6) In applying the RBRVS methodology set forth in this rule, medicaid will make reimbursement in accordance with medicare's policy on the bundling of services, as set forth in the physicians' medicare fee schedule adopted by the health care financing administration of the U.S. department of health and human services and published in the federal register annually, whereby payment for certain services constitutes payment for certain other services which are considered to be included in those services.

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

3. The rules as proposed to be amended provide as follows. New language that is being added is underlined. Language that is to be deleted is interlined.

46.12.507 OUTPATIENT HOSPITAL SERVICES, SCOPE AND REQUIREMENTS (1) through (2)(b)(iii) remain the same.

(c) outpatient physical therapy, occupational therapy, and speech therapy services that are primarily maintenance therapy as defined in ARM 46.12.525A.

(3) and (4) remain the same.

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

46.12.522 PODIATRY SERVICES, REIMBURSEMENT

(1) Reimbursement for podiatry services is that available according to the requirements, procedures and fees specified for physicians under ARM 46.12.2003~~, except that for all procedures for which no fee has been set under the provisions of ARM 46.12.2003(3)(b), the department's fee schedule amount is 70% of the provider's actual charge, regardless of whether or not the procedure is billed with a modifier~~.

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

46.12.528 THERAPIES, REIMBURSEMENT (1) through (2)(a) remain the same.

(b) ~~the department's fee schedule maintained~~ 90% of the reimbursement for physicians provided in accordance with the methodology described in ~~ARM 46.12.529~~ [RULE I] ~~;~~. ~~or~~

~~(c) the amount allowable for the same service under medicare, if the therapy services are also covered by medicare for the recipient.~~

(3) remains the same.

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

46.12.538 AUDIOLOGY SERVICES, REIMBURSEMENT (1) through (2)(a) remain the same.

(b) ~~the department's fee schedule maintained~~ 90% of the reimbursement for physicians provided in accordance with the methodology described in ~~ARM 46.12.538~~ [RULE I] ~~;~~. ~~or~~

~~(c) the amount allowable for the same item under medicare, if the services are also covered by medicare for the recipient.~~

(3) For all purposes under this rule ~~and ARM 46.12.538~~, the amount of the provider's usual and customary charge may not exceed the reasonable charge usually and customarily charged by the provider to all payers.

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

46.12.901 OPTOMETRIC SERVICES, DEFINITIONS

(1) Optometric services ~~are those~~ means services provided by ~~an~~ a licensed optometrist ~~who is licensed and which~~ that are within the scope of ~~his~~ practice ~~as defined by law~~. Optometric services include visual training.

~~(a) Visual training is the therapeutic approach to altering the relationship between the pointing system and the focusing system by means other than conventional glasses.~~

~~(b) Reimbursement under the Montana medicaid program is permitted only for optometric services listed in ARM 46.12.905.~~

(2) "Usual and customary" means those charges that the billing optometrist would charge for a particular service in a majority of cases, including medicaid and non-medicaid patients.

~~(2) The following definitions apply to optometric services:~~

~~(a) "Tonometry" means the measurement of the intraocular pressure (test for presence or absence of glaucoma) by an instrument called a tonometer.~~

~~(i) Since tonometry is usually an integral part of a general or complete examination, an independent charge for this service would usually not be appropriate.~~

~~(ii) If, on a screening examination, doubt has been raised as to the level of pressure and/or presence of glaucoma, further testing may be necessary.~~

~~(b) "Examination of the central and peripheral fields" means tests to determine the side vision in each eye and the presence or absence of ocular disease.~~

~~(i) A rough visual field test is part of a general examination. More formal testing, including tangent screen test or perimeter (either manual or automatic) are definitely not part of a routine examination and are performed only in the presence of suspected pathology.~~

~~(c) "Minimal optometric service" means a level of service supervised by an optometrist but not necessarily requiring his presence. This includes, for example, a visual acuity check or verification of lenses.~~

~~(d) "Brief optometric service" means a level of service pertaining to the evaluation and treatment of a condition of the eye or related structure requiring only an abbreviated history and examination. This includes, for example, follow up for conjunctivitis or removal of sutures from laceration (when not a post operative part of total surgical service).~~

~~(e) "Limited optometric service" means a level of service pertaining to the evaluation of a circumscribed acute illness of the eye and related structure or to the periodic re evaluation of a problem including an interval history and examination, the review of effectiveness of past medical management, the ordering and evaluation of appropriate diagnostic tests, the adjustment of therapeutic management as indicated, and the discussion of findings and/or medical management. This includes, for example, review of history, external examination of eye, initiation of treatment for acute conjunctivitis, or review of interval history, and physical and sensory status.~~

~~(f) "Intermediate optometric services" means a level of service pertaining to the evaluation of a new or existing condition of the eye and related structures complicated with a new diagnostic or management problem not necessarily relating to the primary diagnosis, including history, general medical observation, external ocular and adnexal examination and other diagnostic procedures as indicated. These services may include the use of mydriasis. Intermediate services do not usually include determination of the refractive state but may do so in an established patient (procedure 92012) who is under continuing active treatment. This includes, for example, review of history, external examination, ophthalmoscopy, biomicroscopy for an acute complicated condition (e.g., iritis) not requiring comprehensive ophthalmological services or review of interval history, external examination, ophthalmoscopy, biomicroscopy and tonometry in established patient with known cataract not requiring comprehensive optometric services.~~

~~(g) "Comprehensive optometric services" means a level of service in which a general evaluation of the complete visual system is made. The comprehensive services constitute a single~~

~~service entity but need not be performed at one session. The service includes history, general medical observation, external and ophthalmoscopic examination, gross visual fields and basic sensorimotor examination. It often includes, as indicated, biomicroscopy, examination with cycloplegia or mydriasis, tonometry, and usually determination of the refractive state unless known, or unless the condition of the media precludes this or it is otherwise contraindicated, as in presence of trauma or severe inflammation. It always includes initiation of diagnostic and treatment programs as indicated. For example, the comprehensive services required for diagnosis and treatment of a patient and symptoms indicating possible disease of the visual system or to rule out disease of the visual system, new or established patient.~~

~~(h) "Initiation of diagnostic and treatment program" includes the prescription of medication, lenses and other therapy and arranging for special optometric diagnostic or treatment services, consultations, laboratory procedures and radiological services as may be indicated. Prescription of lenses may be deferred to a subsequent visit, but in any circumstance is not reported separately. ("Prescription of lenses" does not include anatomical facial measurements or writing of laboratory specifications for spectacles. These services are covered under "dispensing services" in ARM 46.12.905.)~~

~~(i) "Determination of the refractive state" means the quantitative procedure that yields the refractive data necessary to determine the best visual acuity with lenses and to prescribe lenses. It is not a separate medical procedure, or service entity, but is an integral part of the general optometric services, carried out with reference to other diagnostic procedures. The evaluation of the need for and the prescription of lenses is never based on the refractive state alone. Determination of the refractive state is not reported separately. It is usually part of the comprehensive optometric services (procedures 92004, 92014), but may occasionally be a part of intermediate optometric services to an established patient (procedure 92012) who, under continuing active treatment with periodic observation, may not require comprehensive re-evaluation.~~

~~(j) "Special optometric services" means services in which a special evaluation of part of the visual system is made, which goes beyond the services usually included under general optometrical services, or in which special treatment is given. Medical diagnostic evaluation by the optometrist is an integral part of all optometric services. Technical procedures (which may or may not be performed by the optometrist personally) are often part of the service, but should not be mistaken to constitute the service itself. Intermediate and comprehensive optometric services constitute integrated services in which medical diagnostic evaluation cannot be separated from the examining techniques used. Itemization of service components, such as slit-lamp examination, keratometry,~~

~~ophthalmoscopy, retinoscopy, determination of refractive state, tonometry, motor evaluation, etc. is not applicable.~~

~~(k) "Consultation" means services rendered by an optometrist with a high level of expertise whose opinion or advice is requested by another practitioner for the further evaluation and/or management of the patient. When the consulting optometrist assumes responsibility for the continuing care of the patient, any subsequent service rendered by him will cease to be a consultation. Two levels of consultation are recognized:~~

~~(i) In a limited consultation (90600) the optometrist confines his service to the examination or evaluation of a single organ system. This procedure includes documentation of the complaint(s), present illness, pertinent examination, review of medical data and establishment of a plan of management relating to the specific problem.~~

~~(ii) An intermediate consultation (90605) involves examination or evaluation of an organ system, a partial review of the general history, recommendations and preparation of a report.~~

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

46.12.902 OPTOMETRIC SERVICES, REQUIREMENTS (1) These requirements are in addition to the rule provisions generally applicable to medicaid providers.

(2) The department hereby adopts and incorporates by reference the definitions found in the introduction of Physicians Current Procedural Terminology, fourth edition (CPT 4), published by the American Medical Association of Chicago, Illinois. These materials set forth meanings of terms commonly used by the Montana medicaid program in implementation of the program's optometric schedule. A copy of the definitions herein incorporated may be obtained through the Department of Public Health and Human Services, Health Policy Services Division, P.O. Box 202951, 1400 Broadway, Helena, MT 59620-2951. Providers must bill for services using the procedure codes and modifiers set forth, and according to the definitions contained in the health care financing administration's common procedure coding system (HCPCS). Information regarding billing codes, modifiers and HCPCS is available upon request from the Health Policy and Services Division at the address stated above.

~~(1) Optometric services listed in ARM 46.12.905 are available to medicaid recipients.~~

~~(2) Optometric services shall be provided only when they are medically necessary and shall be subject to review by the designated review organization.~~

(3) ~~Each~~ A medicaid recipient ~~shall be allowed~~ is limited to one eye examination for determination of refractive state per ~~12 month~~ 730 day period unless one of the following circumstances exist:

(a) following cataract surgery ~~there may be~~ more than one examination ~~per fiscal year, or~~ during the 730 day period is necessary; or

(b) the provider determines by screening that a loss of one line acuity has occurred with present glasses.

~~(4) Visual training limitations:~~

~~(a) Visual training must be prior authorized by the designated review organization.~~

~~(b) Visual training shall be limited to two one hour sessions per week up to a maximum of 24 sessions per 12 month period, if provided by a licensed optometrist.~~

(4) Visual training is retrospectively reviewed by the department.

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

46.12.905 OPTOMETRIC SERVICES, REIMBURSEMENT

(1) The department ~~will~~ pays the lowest of the following for optometric services:

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

(b) the amount allowable for the same service under medicare, if the services are also covered by medicare for the recipient ~~This amount is stated on the medicare explanation of benefits~~; or

(c) the department's fee schedule ~~as specified in this rule~~ maintained in accordance with the methodology described in [RULE I].

~~(2) Effective July 1, 1990, the reimbursement rates listed will be increased by four percent (4%). All items paid by report will remain at the rate indicated.~~

~~(3) Professional services are provided as follows:~~

~~(Procedures marked with an "*" shall be allowed only when eyeglasses are allowed.)~~

~~(Procedures listed in this rule, except those marked with an "***", shall be subject to the limits on routine eye examinations when the diagnosis is refractive error.)~~

~~Optometrists who bill for these services are certifying that they meet all licensing requirements to provide these services.~~

	~~Fee~~
~~OFFICE MEDICAL SERVICES, NEW PATIENT~~	
~~90000 Brief service~~	~~18.34~~
~~90010 Limited service~~	~~28.24~~
~~OFFICE MEDICAL SERVICES, ESTABLISHED PATIENT~~	
~~90030 Minimal services~~	~~7.54~~
~~90040 Brief service~~	~~11.30~~
~~90050 Limited service~~	~~15.07~~

~~HOME MEDICAL SERVICES~~

~~90100~~	~~Home medical service, new patient; brief service~~	~~28.24~~
~~90130~~	~~Home medical service, established patient; minimal service~~	~~14.12~~
~~90140~~	~~brief service~~	~~18.03~~

~~HOSPITAL SERVICES~~

~~90200~~	~~Initial hospital care, brief history and examination, initiation of diagnostic and treatment programs, and preparation of hospital records~~	~~29.30~~
~~90240~~	~~Subsequent hospital care, each day; brief services~~	~~12.72~~

~~NURSING HOME, BOARDING HOME, ETC. SERVICES~~

~~90300~~	~~Initial care, skilled nursing, intermediate care, or long term care facility; brief history and physical examination, initiation of diagnostic and treatment programs, and preparation of medical records~~	~~33.64~~
~~90340~~	~~Subsequent care, skilled nursing, intermediate care or long term care facility; brief service~~	~~16.50~~
~~90400~~	~~Nursing home, boarding home, domiciliary, or custodial care medical service, new patient; brief services (Payment for skilled nursing, intermediate care, long term care, nursing home, boarding home, domiciliary or custodial care services for established patient is limited to one unit per day by a provider if multiple patients are seen)~~	~~28.24~~

~~INITIAL CONSULTATION~~

~~90600~~	~~Initial consultation, limited~~	~~28.24~~
~~90605~~	~~intermediate~~	~~37.66~~
~~90610~~	~~extensive~~	~~41.03~~
~~90620~~	~~comprehensive~~	~~65.91~~

~~FOLLOW UP CONSULTATION~~

~~90640~~	~~Follow up consultation, brief~~	~~28.24~~
~~90641~~	~~limited~~	~~37.66~~
~~90642~~	~~intermediate~~	~~41.03~~

~~GENERAL OPTOMETRIC SERVICES~~

~~92002~~	~~Medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient~~	~~34.23~~
~~92004~~	~~comprehensive, new patient, one or more visits~~	~~42.80~~
~~92012~~	~~Medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient~~	~~23.54~~
~~92014~~	~~comprehensive, established patient, one or more visits~~	~~37.98~~

~~SPECIAL SERVICES~~

~~92020~~	~~Gonioscopy with medical diagnostic evaluation (separate procedure)~~	~~18.34~~
~~92060~~	~~Sensorimotor examination with medical diagnostic evaluation (separate procedure)~~	~~14.60~~

~~92065 Orthoptic and/or pleoptic training, with continuing medical direction and evaluation -- visual training. (The 24 hour per 12 month limit per hour in provided for in ARM 46.12.902 applies. The limit the office on eye examinations does not apply.) 21.79~~

~~92081 Visual field examination with medical diagnostic evaluation; limited examination (e.g., tangent screen, Autoplot, arc perimeter or single stimulus level automated test, such as Octopus 3 or 7 equivalent) 18.84~~

~~92082 intermediate examination (e.g., multistimulus level, full field, quantitative perimetry, several isopters on Goldmann perimeter or multilevel, full field automated test such as Octopus program 33 or 34 equivalent) 21.13~~

~~92083 extended examination, quantitative perimetry (e.g., manual static and kinetic perimetry on Goldmann or Tubingen perimeter or equivalent, or automated static perimetry, complex, such as Octopus program 31 + 41, or 32 + 41) 21.13~~

~~(Gross visual field testing (e.g., confrontation testing) is a part of general ophthalmological services and is not reported separately)~~

~~92100 Serial tonometry with medical diagnostic evaluation (separate procedure), one or more sessions, same day 14.12~~

~~92120 Tonography with medical diagnostic evaluation, recording indentation tonometer method or perilimbal suction method 28.24~~

~~92130 Tonography with water provocation 28.24~~

~~92140 Provocative tests for glaucoma, with medical diagnostic evaluation, without tonography 18.82~~

~~OPHTHALMOSCOPY~~

~~92225 Ophthalmoscopy, extended as for retinal detachment (may include use of contact lens, drawing or sketch, and/or fundus biomicroscopy), with medical diagnostic evaluation; initial, not to be billed if billed by surgeon 20.64~~

~~92226 subsequent, not to be billed if billed by surgeon 10.75~~

~~92250 Ophthalmoscopy with fundus photography; not to be billed in addition to general optometric services 32.96~~

~~92260 Ophthalmoscopy with ophthalmodynamometry, not to be billed in addition to general optometric services 37.66~~

~~OTHER SPECIALIZED SERVICES~~

~~92265 Oculoelectromyography, one or more extraocular muscles, one or both eyes, with medical diagnostic evaluation 15.82~~

~~92283 Color vision examination, extended, e.g., anomaloscope or equivalent 28.24~~

~~(Color vision testing with pseudoisochromatic plates (such as HRR or Ishihara) is not reported separately. It is included in the appropriate general or ophthalmological service.)~~

~~92284 Dark adaptation examination, with medical diagnostic evaluation 4.89~~

~~92285 External ocular photography with medical diagnostic evaluation for documentation of medical progress (e.g., close up photography, slit lamp photography, genie photography, stereo photography) 18.76~~

~~92286 Special anterior segment photography with medical diagnostic evaluation; with specular endothelial~~

~~microscopy and cell count; not to be billed by optometrist if billed by surgeon 37.51~~

~~CONTACT LENS SERVICES~~

~~92310 Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation, corneal lens, both eyes, except for aphakia; not in addition to codes 92002-92014 106.00~~
~~92311 corneal lens for aphakia, one eye 106.00~~
~~92312 corneal lens for aphakia, both eyes 150.00~~

~~The following codes are to be used by an optician dispensing contacts prescribed by an optometrist or opthalmologist. The prescribing optometrist should bill using the appropriate general Optometric Service Code (92002-92014)~~

~~92314* Fitting by independent technician; corneal lens, both eyes, except for aphakia 63.00~~

~~92315* corneal lens for aphakia, one eye 63.00~~
~~92316* corneal lens for aphakia, both eyes 107.00~~
~~92325* Modification of contact lens (separate procedure), with medical supervision of adaptation 9.37~~

~~DISPENSING SERVICES~~

~~92340* Fitting of spectacles, except for aphakia; monofocal 22.50~~
~~92341* bifocal 30.00~~
~~92342* multifocal, other than bifocal 37.52~~
~~92352* Fitting of spectacle prosthesis for aphakia; monofocal 56.26~~
~~92353* multifocal 56.26~~

~~DISPENSING SERVICE, LENS ONLY~~

~~29557* Measuring, verifying, single vision lens service 11.25~~
~~29554* Measuring, verifying, bifocal lens service 15.00~~
~~29555* Measuring, verifying, trifocal lens service 18.76~~
~~29556* Measuring, verifying, cataract lens service 28.13~~

~~DISPENSING SERVICE, FRAME ONLY~~

~~29557* Fitting, servicing, single vision frame service 11.25~~
~~29558* Fitting, servicing, bifocal frame service 15.00~~
~~29559* Fitting, servicing, trifocal frame service 18.76~~
~~29560* Fitting, servicing, cataract frame service 28.13~~

~~SPECIAL SERVICES AND REPORTS~~

~~99000 Handling and/or conveyance of specimen for transfer from the optometrist's office to a laboratory 5.64~~
~~99050 Services requested after office hours in addition to basic service (day time) 11.32~~
~~99052 Services requested between 10:00 PM and 8:00 AM in addition to basic service 11.73~~
~~99054 Services requested on Sundays and holidays in addition to basic service 11.26~~
~~99056 Services provided at request of patient in a location other than optometrist's office which are normally provided in the office 13.61~~
~~99080 Special reports such as insurance forms, or the review~~

~~of medical data to clarify a patient's status more than the information conveyed in the usual medical communications or standard reporting form 13.61~~

~~REMOVAL OF OCULAR FOREIGN BODY~~

~~65205** Removal of foreign body, external eye; conjunctival superficial 15.56~~
~~65210** conjunctival embedded (includes concretions, sub-conjunctival, or scleral nonperforating 15.56~~
~~65220** corneal, without slit lamp 17.26~~
~~65222** corneal, with slit lamp 21.66~~
~~67938** Removal of embedded foreign body, eyelid 15.56~~
~~68530** Removal of foreign body or dacryolith, lacrimal passages 15.56~~

~~DIAGNOSTIC ULTRASOUND~~

~~A-mode: implies a one-dimensional ultrasonic measurement procedure.~~
~~B-scan: implies a two-dimensional ultrasonic scanning procedure with a two-dimensional display.~~

~~76516** Ophthalmic biometry by ultrasound echography, a-mode 98.61~~
~~76517** B-scan 92.58~~
~~76519** With intraocular lens power calculation, not to be billed if billed by surgeon 91.90~~

~~MICROBIOLOGY~~

~~Laboratory services done in an optometrist's office~~

~~87081** Culture, bacterial, screening only, for single organisms 6.38~~
~~87205** Smear, primary source, with interpretation; routine stain for bacteria, fungi, or cell types 7.87~~

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

46.12.911 EYEGLASSES, DEFINITIONS (1) Eyeglasses ~~include lens(es) and/or~~ mean corrective lens with frames prescribed by ~~a physician skilled in the diseases of the eye~~ an ophthalmologist or by an optometrist, ~~whichever the patient may select,~~ to aid and improve vision.

~~(2) Coverage of eyeglasses is limited to those items specified in ARM 46.12.915.~~

~~(3) The date of service for measuring, verifying and fitting of eyeglasses is the date the patient is seen for the fitting and ordering of glasses.~~

~~(a) The contacts on and after the date the glasses are dispensed are considered follow up contacts and are covered by the measuring, verifying, and fitting fee.~~

~~(b) The date of service for the eyeglasses is the date the recipient receives the eyeglasses.~~

~~(c) If the recipient fails to keep an appointment to receive glasses, the date of service is either the date the~~

~~optometrist, ophthalmologist or optician sends a letter notifying the recipient that the glasses are available and will be provided to the recipient when he comes in for them or the date the glasses are mailed to the recipient. The optometrist, opthalmologist or optician will still be responsible for adjusting the glasses. The optometrist, ophthalmologist or optician must document in the recipient's record that the letter or the glasses were sent to the recipient.~~

~~(d) If glasses are supplied through a volume purchasing contract, the date of the service is the date specified in the contract with the supplier.~~

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

46.12.912 EYEGLASSES, SERVICES, REQUIREMENTS, AND RESTRICTIONS (1) These requirements are in addition to the rule provisions generally applicable to medicaid providers.

(2) Providers must bill for services using the procedure codes and modifiers set forth, and according to the definitions contained, in the health care financing administration's common procedure coding system (HCPCS). Information regarding billing codes, modifiers and HCPCS is available upon request from the Department of Public Health and Human Services, Health Policy and Services Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

~~(1)~~ (3) ~~Each~~ A recipient under 21 years of age is limited to one pair of eyeglasses per ~~12 month~~ 365 day period and each recipient 21 years of age or older is limited to one pair of eyeglasses every ~~24 months~~ 730 day period unless ~~one~~ additional pairs are necessary due to any of the following circumstances ~~exists~~:

(a) ~~a recipient has had~~ cataract surgery;

~~(b) when there is:~~

~~(i) a .50 diopter change in correction in can sphere, cylinder, vertical prism or near heading power; or~~

~~(ii) a minimum of a 5 degree change in any cylinder axis of .50 diopters or more; or~~

~~(iii) any 1 degree or more prism change in lateral prism; or~~

(b) .50 diopter change in correction in sphere;

(c) .75 diopter change in cylinder;

(d) .5 prism diopter change in vertical prism;

(e) .50 diopter change in the near reading power;

(f) a minimum of a 5 degree change in axis of any cylinder less than or equal to 3.00 diopters;

(g) a minimum of a 3 degree change in axis of any cylinder greater than 3.00 diopters;

(h) any 1 prism diopter or more change in lateral prism; or

~~(c)~~ (i) a the inability of the recipient ~~is unable~~ to wear bifocals because of a diagnosed medical condition.

(i) When this is the case, the recipient may be allowed ~~two frames and~~ two pairs of single vision ~~lenses~~ eyeglasses every ~~24 months~~ 730 day period if he is 21 years of age or over,

or every ~~12 months~~ 365 day period if he is under 21 years of age.

~~(2)~~(4) A recipient ~~shall be allowed repairs on a pair of glasses during a 12 month period not to exceed the amount of an additional pair of glasses.~~ may obtain replacement lenses after the 365 day period if the eyeglasses are unusable.

~~(3)~~(5) Contact lenses may be provided only ~~when they are~~ if medically necessary. ~~They shall not be allowed for cosmetic reasons. Claims for contact lenses must be accompanied by a statement explaining the medical reason for them.~~

(a) The limits stated in ~~subsections~~ (1) and (2) apply to contacts.

(b) The dispensing provider must receive prior authorization from the department for contact lenses with dispensing fee.

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

46.12.915 EYEGLASSES, REIMBURSEMENT (1) Reimbursement is not available for eyeglasses. Eyeglasses are prepaid by the department through a single volume purchase contract.

(2) Reimbursement for prosthetic eyes and contact lenses is as follows:

(a) The Department pays the lowest of the following:

(i) the provider's usual and customary charge for the service;

(ii) the department's fee schedule maintained in accordance with the methodology described in (2)(c); or

(iii) the amount allowable for the same service under medicare, if the services are also covered by medicare for the recipient.

(b) For all purposes under this rule, the amount of the provider's usual and customary charge may not exceed the reasonable charge usually and customarily charged by the provider to all payers.

(c) The department's fee schedule for contact lenses and prosthetic eyes includes fees set and maintained according to the following methodology:

(i) At least annually the department will review billings for services, other than those services for which a specific fee has been set under the provisions of (2)(c)(ii), to determine the total number of times each service has been billed by all providers in the aggregate within the previous 12 month period.

(ii) Upon review of the aggregate number of billings as provided in (2)(c)(i), the department will establish a fee for each service which has been billed at least 50 times by all providers in the aggregate during the previous 12 month period. The department shall set each fee at 90% of the average charge billed by all providers in the aggregate during the previous 12 month period. For purposes of determining the number of billings and the average charge, the department considers only

those billings that comply with ARM 46.12.915(2)(b).

(iii) Once the department has established a fee as provided in (2)(c)(ii), the fee will not be adjusted except as provided in (2)(c)(iv).

(iv) Except as provided in (2)(c)(v), for all services for which no fee has been set under the provisions of (2)(c)(ii), the department's fee schedule amount shall be 90% of the provider's usual and customary charge. For purposes of (5), the provider's usual and customary charge may not exceed the limit specified in (2)(c).

(v) For new procedure codes where a medicare fee is available, the department's fee schedule amount shall be the medicare allowable charge, until the department sets a fee based upon 50 billings for the procedure code as provided in (2)(c)(ii).

(3) The department may adjust the fee schedule to implement increases or decreases in reimbursement by the amount or percentage authorized or directed by the legislature.

~~The department will pay the lowest of the following for eyeglasses:~~

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

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

~~(b) the amount allowable for the same service under medicare. This amount is indicated on the medicare explanation of benefits; or~~

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

~~(i) Effective July 1, 1990, the reimbursement rates listed will be increased by four percent (4%). All items paid by report will remain at the rate indicated.~~

~~(2) Except for co-payments specified in ARM 46.12.204, providers may not charge recipients for items specified in ARM 46.12.915 if these items are also billed to medicaid.~~

~~(3) The department may contract for coverage of eyeglass materials through a volume purchasing arrangement with a supplier of materials. If the department makes a volume purchase, providers will be notified that eyeglasses may be obtained through a sole source contractor, in which case, the department's fee schedule contained in this rule would not apply.~~

~~(4) Lab costs for eyeglasses~~

~~(a) The following codes can be submitted in addition to basic lens(es) codes, except for lenticular, aniseikonic and fee variable aspheric lens(es):~~

	~~Fee~~
~~(i) Z9597, add on for plastic multifocal lens, per lens~~	~~4.69~~
~~(ii) Z9581, add on for spherical powers 7.00 diopters to 20.00 dioptors, add per lens for each full diopter over 7.00~~	~~2.00~~
~~(iii) Z9582, add on for cylinder powers or add power 4.00 to 12.00 dioptors, add per lens for each~~	

~~full diopter over 4.00 diopters 2.00~~

~~(b)~~	~~Fee~~
~~V0130 Frames, purchase (metal)~~	~~19.00~~
~~V2020 Frames, purchases (plastic)~~	~~15.00~~
~~SINGLE VISION, GLASS OR PLASTIC~~	
~~V2100 Sphere, single vision, plano to plus or minus 4.00D, per lens~~	~~11.98~~
~~V2101 Sphere, single vision, plus or minus 4.12D to plus or minus 7.00D, per lens~~	~~11.98~~
~~V2102 Sphere, single vision, plus or minus 7.12D to plus or minus 20.00D, per lens~~	~~11.98~~
~~V2103 Spherocylinder, single vision, plano to plus or minus 4.00D sphere, .12 to 2.00D cylinder, per lens~~	~~11.98~~
~~V2104 Spherocylinder, single vision, plano to plus or minus 4.00D sphere, 2.12D to 4.00D cylinder, per lens~~	~~11.98~~
~~V2105 Spherocylinder, single vision, plano to plus or minus 4.00D sphere, 4.25D to 6.00D cylinder, per lens~~	~~11.98~~
~~V2106 Spherocylinder, single vision, plano to plus or minus 4.00D sphere, over 6.00D cylinder, per lens~~	~~11.98~~
~~V2107 Spherocylinder, single vision, plus or minus 4.25D to plus or minus 7.00D sphere, .12D to 2.00D cylinder, per lens~~	~~11.98~~
~~V2108 Spherocylinder, single vision, plus or minus 4.25D to plus or minus 7.00D sphere, 2.12D to 4.00D cylinder, per lens~~	~~11.98~~
~~V2109 Spherocylinder, single vision, plus or minus 4.25D to plus or minus 7.00D sphere, 4.25D to 6.00D cylinder, per lens~~	~~11.98~~
~~V2110 Spherocylinder, single vision, plus or minus 4.25D to 7.00D sphere, over 6.00D cylinder, per lens~~	~~11.98~~
~~V2111 Spherocylinder, single vision, plus or minus 7.25D to plus or minus 12.00D sphere, .25D to 2.25D D cylinder, per lens~~	~~11.98~~
~~V2112 Spherocylinder, single vision, plus or minus 7.25D to plus or minus 12.00D sphere, 2.25D to 4.00D cylinder, per lens~~	~~11.98~~
~~V2113 Spherocylinder, single vision, plus or minus 7.25D to plus or minus 2.00D sphere, 4.25D to 6.00D cylinder, per lens~~	~~11.98~~
~~V2114 Spherocylinder, single vision, sphere over plus or minus 12.00D, per lens~~	~~11.98~~
~~V2115 Lenticular (myodisc), per lens, single vision~~	~~37.27~~
~~V2116 Lenticular lens, nonaspheric, per lens, single vision~~	~~37.27~~
~~V2117 Lenticular, aspheric, per lens, single vision~~	~~37.27~~
~~V2118 Aniseikonic lens, single vision~~	~~11.98~~
~~BIFOCAL, GLASS OR PLASTIC~~	
~~V2200 Sphere, bifocal, plano to plus or minus 4.00D, per lens~~	~~18.15~~
~~V2201 Sphere, bifocal, plus or minus 4.12D to plus or minus 7.00D, per lens~~	~~18.15~~
~~V2202 Sphere, bifocal, plus or minus 7.12D to plus or minus 20.00D, per lens~~	~~18.15~~
~~V2203 Spherocylinder, bifocal, plano to plus or minus 4.00D sphere, .12D to 2.00D cylinder, per lens~~	~~18.15~~
~~V2204 Spherocylinder, bifocal, plano to plus or minus 4.00D~~	

~~sphere, 2.12D to 4.00D cylinder, per lens 18.15~~

~~V2305 Spherocylinder, bifocal, plano to plus or minus 4.00D sphere, 4.25D to 6.00D cylinder, per lens 18.15~~

~~V2306 Spherocylinder, bifocal, plano to plus or minus 4.00D sphere, over 6.00D cylinder, per lens 18.15~~

~~V2307 Spherocylinder, bifocal, plus or minus 4.25D to plus or minus 7.00D sphere, .12D to 2.00D cylinder, per lens 18.15~~

~~V2308 Spherocylinder, bifocal, plus or minus 4.25D to plus or minus 7.00D sphere, 2.12D to 4.00D cylinder, per lens 18.15~~

~~V2309 Spherocylinder, bifocal, plus or minus 4.25D to plus or minus 7.00D sphere, 4.25D to 6.00D cylinder, per lens 18.15~~

~~V2310 Spherocylinder, bifocal, plus or minus 4.25D to plus or minus 7.00D sphere, over 6.00D cylinder, per lens 18.15~~

~~V2311 Spherocylinder, bifocal, plus or minus 7.25D to plus or minus 12.00D sphere, .25D to 2.25D cylinder, per lens 18.15~~

~~V2312 Spherocylinder, bifocal, plus or minus 7.25D to plus or minus 12.00D sphere, 2.25D to 4.00D cylinder, per lens 18.15~~

~~V2313 Spherocylinder, bifocal, plus or minus 7.25D to plus or minus 12.00D sphere, 4.25D to 6.00D cylinder, per lens 18.15~~

~~V2314 Spherocylinder, bifocal, sphere over plus or minus 12.00D, per lens 18.15~~

~~V2315 Lenticular (myodisc), per lens, bifocal 45.00~~

~~V2316 Lenticular, nonaspheric, per lens, bifocal 45.00~~

~~V2317 Lenticular, aspheric lens, bifocal 45.00~~

~~V2318 Aniseikonic, per lens, bifocal 18.15~~

~~V2320 Add ons for bifocal lenses for each full diopter over 3.00D per lens 3.00~~

~~TRIFOCAL, GLASS OR PLASTIC~~

~~V2300 Sphere, trifocal, plano to plus or minus 4.00D, per lens 21.97~~

~~V2301 Sphere, trifocal, plus or minus 4.12D to plus or minus 7.00D, per lens 21.97~~

~~V2302 Sphere, trifocal, plus or minus 7.12D to plus or minus 20.00, per lens 21.97~~

~~V2303 Spherocylinder, trifocal, plano to plus or minus 4.00D sphere, .12D to 2.00D cylinder, per lens 21.97~~

~~V2304 Spherocylinder, trifocal, plano to plus or minus 4.00D sphere, 2.25D to 4.00D cylinder, per lens 21.97~~

~~V2305 Spherocylinder, trifocal, plano to plus or minus 4.00D sphere, 4.25D to 6.00D cylinder, per lens 21.97~~

~~V2306 Spherocylinder, trifocal, plano to plus or minus 4.00D sphere, over 6.00D cylinder, per lens 21.97~~

~~V2307 Spherocylinder, trifocal, plus or minus 4.25D to plus or minus 7.00D sphere, .12D to 2.00D cylinder, per lens 21.97~~

~~V2308 Spherocylinder, trifocal, plus or minus 4.25D to plus or minus 7.00D sphere, 2.12D to 4.00D cylinder, per lens 21.97~~

~~V2309 Spherocylinder, trifocal, plus or minus 4.25D to plus or minus 7.00D sphere, 4.25D to 6.00D cylinder, per lens 21.97~~

~~V2310 Spherocylinder, trifocal, plus or minus 4.25D to plus or minus 7.00D sphere, over 6.00D cylinder, per lens 21.97~~

~~V2311 Spherocylinder, trifocal, plus or minus 7.25D to plus or minus 12.00D sphere, .25D to 2.25D cylinder, per lens 21.97~~

~~V2312 Spherocylinder, trifocal, plus or minus 7.25D to plus or minus 12.00D sphere, 2.25D to 4.00D cylinder, per lens 21.97~~

~~V2313 Spherocylinder, trifocal, plus or minus 7.25D to plus or minus 12.00D sphere, 4.25D to 6.00D cylinder, per lens 21.97~~

~~V2314 Spherocylinder, trifocal, sphere over plus or minus 12.00D, per lens 21.97~~

~~V2315 Lenticular, (myodisc), per lens, trifocal 55.00~~

~~V2316 Lenticular, nonaspheric, per lens, trifocal 55.00~~

~~V2317 Lenticular, aspheric lens, trifocal 55.00~~

~~V2318 Aniseikonic lens, trifocal 21.97~~

~~V2320 Add-ons for trifocal lenses for each full diopter over 2.00D per lens 2.00~~

~~V2410 Variable asphericity lens, single vision, full field, glass or plastic, per lens 99.03~~

~~V2430 Variable asphericity lens, bifocal, full field, glass or plastic, per lens 114.95~~

~~CONTACT LENSES~~

~~V2500 Contact lens, PMMA, spherical, per lens 21.18~~

~~V2501 Contact lens, PMMA, toric or prism ballast, per lens 68.07~~

~~V2502 Contact lens, PMMA, bifocal, per lens 114.96~~

~~V2503 Contact lens, PMMA, color vision deficiency, per lens 21.18~~

~~V2510 Contact lens, gas permeable, spherical, per lens 21.18~~

~~V2511 Contact lens, gas permeable, toric, prism ballast, per lens 68.07~~

~~V2512 Contact lens, gas permeable, bifocal, per lens 114.96~~

~~V2513 Contact lens, gas permeable, extended wear, per lens 21.18~~

~~V2520 Contact lens, hydrophilic, spherical, per lens 21.18~~

~~V2521 Contact lens, hydrophilic, toric, or prism ballast, per lens 68.07~~

~~V2522 Contact lens, hydrophilic, bifocal, per lens 114.96~~

~~V2523 Contact lens, hydrophilic, extended wear, per lens 21.18~~

~~EYE PROSTHESIS~~

~~V2630 Prosthetic, eye, glass, stock (90% of billed charges by report) BR~~

~~V2621 Prosthetic, eye, plastic, stock (90% of billed charges by report) BR~~

~~V2622 Prosthetic, eye, glass, custom (90% of billed charges by report) BR~~

~~V2623 Prosthetic, eye, plastic, custom (90% of billed charges by report) BR~~

~~V2700 Balance lens, per lens 10.98~~

~~V2710 Slab off prism, glass or plastic (one unit allowed) 42.00~~

~~V2715 Prism, per lens 1.88~~

~~V2730 Special base curve, glass or plastic, per lens 20.00~~

~~V2740 Tint, plastic, rose 1 or 2, per lens 1.88~~

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

~~29638 Neutralization of lenses for copy of prescription 5.62~~

~~REPAIR PAYMENTS~~
~~A payment for replacement of broken lens shall not exceed the allowed charge for the original lens. Use the code for the original lens plus the code for appropriate add ons. Each code should be followed by the modifier letters RP. Only two lenses with the modifier RP will be allowed in a 12 month period.~~

~~V2030 Minor frame repair - including minor parts (except bows and front piece), not in addition to V2025 or V0132 14.31 per 12 month period~~

~~V2025 Replacement of plastic frame (parts or total frame) 15.00 per 12 month period~~

~~V0132 Replacement of metal frame (parts or total frame) 19.00 per 12 month period~~

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

46.12.1441 OUTPATIENT OCCUPATIONAL THERAPY SERVICES, DEFINITION (1) Outpatient occupational therapy services are defined as provided in ARM ~~46.12.545~~ 46.12.525A, with the following addition:

(1)(a) remains the same.

AUTH: Sec. 53-2-201, 53-2-205, 53-6-113 and 53-6-402, MCA
IMP: Sec. 53-2-201, 53-5-205, 53-6-101, 53-6-111, 53-6-131, 53-6-141 and 53-6-402, MCA

46.12.1442 OUTPATIENT OCCUPATIONAL THERAPY SERVICES, REQUIREMENTS (1) Requirements for outpatient occupational therapy services are as provided in ARM ~~46.12.546~~ 46.12.525A through 46.12.527A, except that under the home and community services program:

(1)(a) and (1)(b) remain the same.

AUTH: Sec. 53-2-201, 53-2-205, 53-6-113 and 53-6-402, MCA
IMP: Sec. 53-2-201, 53-5-205, 53-6-101, 53-6-111, 53-6-131, 53-6-141 and 53-6-402, MCA

46.12.1443 OUTPATIENT OCCUPATIONAL THERAPY SERVICES, REIMBURSEMENT (1) Reimbursement for outpatient occupational therapy services is as provided for in ARM ~~46.12.547~~ 46.12.528.

AUTH: Sec. 53-2-201, 53-2-205, 53-6-113 and 53-6-402, MCA
IMP: Sec. 53-2-201, 53-5-205, 53-6-101, 53-6-111, 53-6-131, 53-6-141 and 53-6-402, MCA

46.12.1444 OUTPATIENT PHYSICAL THERAPY SERVICES, DEFINITION (1) Outpatient physical therapy services is defined as provided for in ARM 46.12.525A, with the following additions:

(1)(a) through (1)(b)(ii) remain the same.

AUTH: Sec. 53-2-201, 53-2-205, 53-6-113 and 53-6-402, MCA
IMP: Sec. 53-2-201, 53-5-205, 53-6-101, 53-6-111, 53-6-131, 53-6-141 and 53-6-402, MCA

46.12.1445 OUTPATIENT PHYSICAL THERAPY SERVICES, REQUIREMENTS (1) Requirements for outpatient physical therapy services are as provided for in ARM ~~46.12.526~~ 46.12.525A through 46.12.527A except that under the home and community services program:

(1)(a) and (1)(b) remain the same.

AUTH: Sec. 53-2-201, 53-2-205, 53-6-113 and 53-6-402, MCA
IMP: Sec. 53-2-201, 53-5-205, 53-6-101, 53-6-111, 53-6-131, 53-6-141 and 53-6-402, MCA

46.12.1446 OUTPATIENT PHYSICAL THERAPY SERVICES, REIMBURSEMENT (1) Reimbursement for outpatient physical therapy services is as provided for in ARM ~~46.12.527A~~ 46.12.528.

AUTH: Sec. 53-2-201, 53-2-205, 53-6-113 and 53-6-402, MCA
IMP: Sec. 53-2-201, 53-5-205, 53-6-101, 53-6-111, 53-6-131, 53-6-141 and 53-6-402, MCA

46.12.1447 SPEECH PATHOLOGY AND AUDIOLOGY SERVICES, DEFINITION (1) Speech pathology and audiology services are as defined in ARM ~~46.12.530 and 46.12.535~~ 46.12.525A, with the following additions:

(1)(a) through (1)(b)(vii)(C) remain the same.

AUTH: Sec. 53-2-201, 53-2-205, 53-6-113 and 53-6-402, MCA
IMP: Sec. 53-2-201, 53-5-205, 53-6-101, 53-6-111, 53-6-131, 53-6-141 and 53-6-402, MCA

46.12.1448 SPEECH PATHOLOGY AND AUDIOLOGY SERVICES, REQUIREMENTS (1) Requirements for speech pathology and audiology services are as provided in ARM ~~46.12.531,~~ 46.12.525A through 46.12.527A, ~~and ARM 46.12.536~~ 46.12.533 and 46.12.534 except that under the home and community services program:

(1)(a) and (1)(b) remain the same.

AUTH: Sec. 53-2-201, 53-2-205, 53-6-113 and 53-6-402, MCA
IMP: Sec. 53-2-201, 53-5-205, 53-6-101, 53-6-111, 53-6-131, 53-6-141 and 53-6-402, MCA

46.12.1449 SPEECH PATHOLOGY AND AUDIOLOGY SERVICES,

REIMBURSEMENT (1) Reimbursement for speech pathology and audiology services is as provided in ARM 46.12.528, 46.12.532, ~~and 46.12.537~~ and 46.12.538.

AUTH: Sec. 53-2-201, 53-2-205, 53-6-113 and 53-6-402, MCA
IMP: Sec. 53-2-201, 53-5-205, 53-6-101, 53-6-111, 53-6-131, 53-6-141 and 53-6-402, MCA

46.12.2003 PHYSICIAN SERVICES, REIMBURSEMENT GENERAL REQUIREMENTS AND MODIFIERS (1) and (2) remain the same.

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

~~(b) the amount allowable for the same service under medicare if such rate is available to medicaid; or~~

(b)~~(c)~~ the department's fee schedule maintained in accordance with the methodology described in (3) and [RULE I]. ~~(3) The department's fee schedule, referred to in subsection (2), shall include fees set and maintained according to the following methodology:~~

~~(a) At least annually, the department will review billings for procedures, except those procedures for which a specific fee has been set under the provisions of subsection (b), to determine the total number of times each such procedure has been billed by all providers in the aggregate within the previous 12-month period.~~

~~(b) Upon review of the aggregate number of billings as provided in subsection (a), the department will establish a fee for each procedure which has been billed at least 50 times by all providers in the aggregate during the previous 12 month period. The department shall set each such fee at 65.2% of the average charge billed by all providers in the aggregate for such procedure during such previous 12 month period.~~

~~(i) Once the department has established a fee as provided in subsection (3)(b), such fee will not be adjusted except as provided in subsection (d).~~

~~(ii) When billed with a modifier, payment for a procedure for which a fee has been established under the provisions of subsection (3)(b) shall be as provided in subsection (4).~~

~~(c) For all procedures for which no fee has been set under the provisions of subsection (3)(b), the department's fee schedule amount shall be 65.2% of the provider's actual charge, regardless of whether the procedure is billed with a modifier.~~

~~(d) The department shall adjust the fee schedule to implement increases or decreases in reimbursement authorized or directed by enactment of the legislature as follows:~~

~~(i) The department shall increase or decrease those fees established as provided in subsection (3)(b) by the amount or percentage authorized or directed by the legislature. Such increase or decrease shall be effective at the time provided by the legislature.~~

~~(ii) The department shall not apply any legislative increase or decrease to those procedures described in subsection~~

~~(c), unless specifically directed by legislative enactment to do so.~~

~~(4)~~(3) Subject to the provisions of ~~subsection (4)~~(3)(b), when billed with a modifier, payment for a procedure for which a fee has been established under the provisions of ~~subsection (3)(b)~~(2) will be a percentage of the fee established for the procedure under ~~subsection (3)(b)~~(2).

(4)(a) through (4)(a)(iii) remain the same in text but are renumbered (3)(a) through (3)(a)(iii).

~~(b) Regardless of the provisions of subsections (3)(b), (4) and (4)(a), when a procedure-modifier combination is so unusual as to prevent the department from gathering sufficient data to set a fee, payment for procedures billed with a modifier will be as provided in subsection (3)(c).~~

~~(c)~~(b) The department will periodically review and update the modifier percentages established under (3)(a).

(d) Subsection ~~(4)~~(3) shall not apply to any procedure for which no fee has been established under ~~subsection (3)(b)~~(2).

(5) through (5)(a) remain the same but are renumbered (4) through (4)(a).

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

46.12.2013 MID-LEVEL PRACTITIONER SERVICES, REQUIREMENTS AND REIMBURSEMENT (1) through (5)(a) remain the same.

(b) 90% of the reimbursement for physicians provided in ~~ARM 46.12.2003~~ [RULE I].

(6) through (6)(a) remain the same.

(b) 100% of the reimbursement for physicians provided in ~~ARM 46.12.2003~~ [RULE I].

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

46.12.2102 NON-HOSPITAL LABORATORY AND RADIOLOGY (X-RAY) SERVICES, REIMBURSEMENT (1) These reimbursement requirements are in addition to those contained in ARM 46.12.2003 and [RULE I].

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

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

46.12.4810 HEALTH MAINTENANCE ORGANIZATIONS: COVERED SERVICES (1) through (1)(r) remain the same.

(s) occupational therapy services as defined at ARM ~~46.12.545 and 46.12.546~~ 46.12.525A;

(t) physical therapy services as defined at ARM 46.12.525A ~~and 46.12.526~~;

(1)(u) through (1)(y) remain the same.

(z) speech therapy services as defined at ARM ~~46.12.530 and 46.12.531~~ 46.12.525A;

(1)(aa) through (5) remain the same.

AUTH: Sec. 53-2-201 and 53-6-113, MCA
IMP: Sec. 53-2-201, 53-6-101, 53-6-113 and 53-6-116, MCA

46.12.5007 PASSPORT TO HEALTH PROGRAM: SERVICES (1) through (2)(b) remain the same.

(c) outpatient physical therapy services as defined in ARM 46.12.525A;

(d) speech therapy services as defined in ARM ~~46.12.530~~ 46.12.525A;

(2)(e) and (2)(f) remain the same.

(g) occupational therapy services as defined in ARM ~~46.12.545~~ 46.12.525A;

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

AUTH: Sec. 53-2-201 and 53-6-113, MCA
IMP: Sec. 53-2-201, 53-6-101, 53-6-111, 53-6-113 and 53-6-116, MCA

4. The rule 46.12.529 as proposed to be repealed is on pages 46-1281 and 46-1282 of the Administrative Rules of Montana.

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

5. In 1995 the Montana Legislature authorized the department of Public Health and Human Services to study the feasibility of converting the Medicaid payment methodology to the resource based relative value scale (RBRVS) used by the Medicare program. On the basis of extensive data analysis and provider input, the Department determined it would be desirable to convert its antiquated fee schedule for physicians and certain non-physician providers to the RBRVS. The Fifty-fifth Montana Legislature is expected to authorize the Department in House Bill 2 to implement a RBRVS reimbursement methodology effective July 1, 1997.

In order to implement the conversion of the Medicaid payment system to the new methodology, it is necessary to adopt a rule outlining the RBRVS reimbursement methodology and the types of services to which it will apply. The proposed rule specifies that the RBRVS methodology will be used to determine Medicaid fees for the following types of services: physician, audiology, oral surgery, podiatry, optometric, laboratory, and mid-level practitioner services, as well as occupational, physical and speech therapy services. Under these types of services Medicaid pays for inpatient and outpatient health care services provided by physicians, physician assistants, advanced practice registered nurses, nurse specialists, nurse anesthetists, nurse practitioners, and certified nurse midwives. Services included

under these service types include primary health care, surgical treatment, and diagnostic and evaluation services.

Currently payments to physicians and other individual practitioners are based on a fee schedule first developed in 1980 which has proven to be anachronistic, difficult to update, and unfair to some provider types. The current payment methodology for physicians is a combination of charge based payments and fees which in some cases have not been re-evaluated for up to 15 years. The new RBRVS methodology will make Medicaid physician reimbursement substantially more rational, equitable, and maintainable because it bases payment on the relative value of the service provided as compared to other services. The RBRVS takes into consideration the resources, such as provider work effort, office expenses and malpractice insurance, needed to perform a specific service in comparison with other services.

Another advantage of the new payment system based on the Medicare RBRVS is that it will allow system wide modification as changes are made nationally. Use of the Medicare RBRVS with certain modifications also allows the Department to take advantage of Medicare's huge and on going investment in research and policy making. The relative values assigned to specific procedures which underlie the Medicare RBRVS are supported by the American Medical Association and are based on agreement as to the relative worth of a service by the varied and numerous physician and non-physician specialties. States with small populations like Montana do not have the administrative or financial resources to develop or maintain their own RBRVS. The Department therefore has decided to utilize the Medicare RBRVS to create an equitable payment methodology for certain types of services.

The proposed RBRVS rule provides that payments will be calculated by multiplying a numerical value assigned to each procedure, known as the relative value unit, by the conversion factor, which is dollar amount chosen by the Department to insure budget neutrality. The product of the relative value unit times the conversion factor is in some cases multiplied by a policy adjustor which will increase payments for certain types of services to encourage practitioners to provide these services to Medicaid recipients. For example, the proposed rule specifies that payments for obstetrical services will be increased by a factor of 10%. This is being done because 40% of all births in Montana are currently covered by Medicaid, and it is imperative to maintain access to obstetrical services for Medicaid recipients. Payments for family planning services will also be calculated based on a policy adjustor of 10%, because access to these services are also essential for the Medicaid population. The policy adjustor can also be used to decrease payments for services which are relatively less

important to the Medicaid population or which are easier for Medicaid recipients to obtain access to.

The proposed rule also specifies that payments based on the RBRVS cannot increase or decrease by more than a certain percentage over payments for the same service in the previous year in state fiscal years 1998 and 1999. These limitations were set by the Legislature in House Bill 2 to prevent either a windfall or undue hardship to providers whose payments might suddenly be unreasonably increased or decreased due to the conversion to the RBRVS system.

In addition to adopting an RBRVS reimbursement rule, the Department also must amend the reimbursement rules for certain other services, to specify that payment for those services will be made in accordance with the RBRVS methodology set forth in the new rule. The Department, in addition to amending ARM 46.12.905 to provide for reimbursement of optometric services based on the RBRVS, is also amending other rules pertaining to optometric services as follows:

The proposed amendments to ARM 46.12.901, OPTOMETRIC SERVICES, DEFINITIONS, removing various definitions, are necessary since the adoption of the new reimbursement system and the CPT codes make use of those definitions unnecessary.

The proposed amendment to ARM 46.12.902, OPTOMETRIC SERVICES, REQUIREMENTS, providing a different period of limitation for the conduct of an eye examination for an adult, is necessary to provide a more appropriate time limitation upon the provision of this service. The proposed amendment, providing for the applicability of other rule provisions, is necessary to clarify the extent of provider requirements. The proposed amendment, adopting the CPT codes and incorporating them by reference, is necessary to the implementation of the new reimbursement methodology and provides for a coding system that because of its universality will improve the billing system.

The proposed amendments to ARM 46.12.911, 46.12.912, and 46.12.915, which are rules pertaining to the provision of eyeglasses through the medicaid program, are necessary in part because of the implementation of a volume purchase contract for all eyeglasses needed by medicaid recipients. Many provisions in the current rules are unnecessary because all eyeglasses are obtained through distribution by the volume contractor.

Certain of the proposed amendments to ARM 46.12.911, EYEGLASSES SERVICES, DEFINITIONS, modifying certain provisions through changes in terminology, are necessary to provide clarity as to the scope and terms of coverage.

The proposed amendment to ARM 46.12.912, EYEGLASSES SERVICES,

REQUIREMENTS AND RESTRICTIONS, providing for the applicability of other rule provisions, is necessary to clarify the extent of provider requirements. The proposed amendments, adopting the CPT codes and incorporating them by reference, are necessary to the implementation of the new reimbursement methodology and provide for a coding system that because of its universality will improve the billing system. The proposed amendments, providing further criteria as to replacement glasses, are necessary to account for other circumstances in which it is appropriate to allow for exceptions to the time limitations upon obtaining replacement glasses. These criteria will be of benefit to the recipients falling within those circumstances. Other proposed amendments, modifying certain provisions through changes in terminology and explanation, are necessary to provide clarity as to the scope and terms of coverage.

The proposed amendments to ARM 46.12.915, EYEGLASSES SERVICES, REIMBURSEMENTS, providing that reimbursement is not available for eye glasses, is necessary to remove provisions that are contrary to the established system of providing eyeglasses through a volume purchase contract. The proposed amendments, implementing a new methodology for reimbursement of medically necessary contact lenses and prosthetic eyes, are necessary to provide a consistent methodology that will provide for cost effective purchase of these items.

6. Interested parties may submit their data, views, or arguments either orally or in writing at the hearing. Written data, views, or arguments may also be submitted to Dawn Sliva, Office of Legal Affairs, Department of Public Health and Human Services, P.O. Box 4210, Helena, MT 59604, no later than June 12, 1997.

7. The Office of Legal Affairs, Department of Public Health and Human Services has been designated to preside over and conduct the hearing.

Dawn Sliva
Rule Reviewer

Michael J. Billings for
Director, Public Health and Human Services

Certified to the Secretary of State April 21, 1997.

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

In the matter of the amendment of 16.30.102, 16.30.105, 16.30.106, 16.30.215 and 16.30.218 pertaining to emergency medical services licensure requirements and procedures	))))))	NOTICE OF PUBLIC HEARING ON THE PROPOSED AMENDMENT OF RULES

TO: All Interested Persons

1. On May 27, 1997, at 2:00 p.m., a public hearing will be held in Room C209, Side B, of the Cogswell Building, 1400 Broadway, Helena, Montana, to consider the proposed amendment of 16.30.102, 16.30.105, 16.30.106, 16.30.215 and 16.30.218 pertaining to emergency medical service licensure requirements and procedures.

The Department of Public Health and Human Services will make reasonable accommodations for persons with disabilities who wish to participate in this public hearing. If you request an accommodation, contact the department no later than 5:00 p.m. on May 12, 1997, to advise us of the nature of the accommodation that you need. Please contact Dawn Sliva, P.O. Box 4210, Helena, MT 59604-4210; telephone (406)444-5622; FAX (406)444-1970.

2. The rules as proposed to be amended provide as follows. New language that is being added is underlined. Language that is to be deleted is interlined.

16.30.102 DEFINITIONS The following definitions apply in sub-chapters 1 through 4:

(1) through (4) remain the same.

(5) "Automated external defibrillator" means a medical device heart monitor and defibrillator, with an event recorder, that is approved by the department and that:

(a) is capable of recognizing the presence or absence of ventricular fibrillation and rapid ventricular tachycardia and of determining whether defibrillation should be performed; and

(b) whenever it determines that defibrillation should be performed, charges and delivers an electrical impulse at the command of the operator.

(5) through (11) remain the same in text but are renumbered (6) through (12).

~~(12)~~(13) "Emergency medical technician-defibrillation (EMT-defibrillation) equivalent" means:

(a) from January 1, 1990, through December 31, 1992, one of the following:

(i) EMT-defibrillation;
(ii) EMT-intermediate;
(iii) EMT-paramedic;
(iv) registered nurse who has written authorization from the off-line medical director to perform defibrillation according to protocol;
(b) after January 1, 1993, one of the following:
(i) EMT-basic who has successfully completed either an EMT-basic transition course approved by the department or an EMT-basic course following the United States department of transportation's 1994 national standard curriculum;
~~(i)~~(ii) EMT-defibrillation;
~~(ii)~~(iii) EMT-intermediate;
~~(iii)~~(iv) EMT-paramedic;
~~(iv)~~(v) grandfathered nurse;
~~(v)~~(vi) registered nurse with supplemental training.
(13) through (17) remain the same in text but are renumbered (14) through (18).
~~(18)~~(19) "EMT-D defibrillation kit" means the following equipment and supplies:
(a) one defibrillator with dual channel recording capabilities or an automated external defibrillator;
(b) electrodes sufficient for two patients; and
(c) a patient cable.
(19) through (40) remain the same in text but are renumbered (20) through (41).

AUTH: Sec. 50-6-323, MCA
IMP: Sec. 50-6-323, MCA

16.30.105 WAIVERS (1) through (2) remain the same.
~~(3) If the department denies or revokes a waiver, the affected emergency medical service may appeal the decision to the board if it files a written request for a hearing with the board within 30 days after the date of service of notice of the denial or cancellation of the waiver.~~

AUTH: Sec. 50-6-323, MCA
IMP: Sec. 50-6-325, MCA

16.30.106 APPEAL FROM ORDER (1) An order issued by the department may be appealed to the ~~board of health and environmental sciences~~ department if the person named in the order submits a written request for a hearing before the ~~board~~ department.
(2) remains the same.

AUTH: Sec. 50-6-323, MCA
IMP: Sec. 50-6-323 and 50-6-327, MCA

16.30.215 RECORDS AND REPORTS (1) through (4) remain the same.

(5) In addition to the requirements in (1)(a) through (i) above, any type of service functioning at the EMT-defibrillation level or the EMT-intermediate level must assure that their medical director reviews every run necessitating use of a defibrillator ~~and that the appropriate forms, transcriptions, and EKG's are submitted to the department~~.

(6) remains the same.

AUTH: Sec. 50-6-323, MCA
IMP: Sec. 50-6-323, MCA

16.30.218 MEDICAL CONTROL: EMT-DEFIBRILLATION (1) remains the same.

(2) The medical director shall:

(a) review every EMT-defibrillation run as soon as possible~~, and send to the department, within one month after the date the run occurred, the transcription, EKG's, and completed department run report forms for the run~~;

(b) assure that the hospital medical staff~~(s)~~ most often receiving patients from the emergency medical service are aware of the EMT-defibrillation service and protocols.

AUTH: Sec. 50-6-323, MCA
IMP: Sec. 50-6-323, MCA

3. Amendment of the above rules is necessary to reflect changes in the underlying statutes, delete unnecessary reporting requirements, add an allowed type of defibrillator equipment, and allow emergency medical technicians who are certified at the EMT-basic level and who have completed specified and specialized training to lawfully use defibrillation equipment for a licensed emergency medical service.

The definitions in ARM 16.30.102 are amended to include a definition of "automated external defibrillator", which is in turn incorporated into the definition of "EMT-D defibrillation kit" as an alternative type of defibrillator. The addition is necessary to allow use of the most advanced kind of medical equipment for defibrillation. The definition of "EMT-defibrillation equivalent" was also expanded to include EMT-basics who have received specialized training in defibrillation; the expansion was necessary in order to allow an emergency medical service to utilize their training in performing defibrillation.

ARM 16.30.105 and 16.30.106 were both amended to delete references to the former Board of Health and Environmental Sciences, which was eliminated by the 1995 Legislature, and to conform those rules to the current language in the law.

The proposed deletion from ARM 16.30.215 and 16.30.218 of mandated reporting to the department was needed because the department has derived little or no use from the material reported and because the computerized system which the department is supplying the emergency medical services around

the state will generate for the department the information that it needs for quality improvement studies.

4. Interested parties may submit their data, views, or arguments either orally or in writing at the hearing. Written data, views, or arguments may also be submitted to Laura Harden, Office of Legal Affairs, Department of Public Health and Human Services, P.O. Box 202951, Helena, MT 59620-2951, no later than June 2, 1997.

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

Dawn Sliva
Rule Reviewer

Michael D. Billings for
Director, Public Health and Human Services

Certified to the Secretary of State April 21, 1997.

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

In the matter of the amendment of 46.12.1229, 46.12.1231 and 46.12.1237, pertaining to medicaid nursing facility services reimbursement	)))))))	NOTICE OF PUBLIC HEARING ON PROPOSED AMENDMENT OF RULES

TO: All Interested Persons

1. On May 27, 1997, at 10:00 a.m., a public hearing will be held in the auditorium of the Department of Public Health and Human Services Building, 111 N. Sanders, Helena, Montana to consider the proposed amendment of 46.12.1229, 46.12.1231, and 46.12.1237, pertaining to medicaid nursing facility services reimbursement.

The Department of Public Health and Human Services will make reasonable accommodations for persons with disabilities who wish to participate in this public hearing. If you request an accommodation, contact the department no later than 5:00 p.m. on May 12, 1997, to advise us of the nature of the accommodation that you need. Please contact Dawn Sliva, P.O. Box 4210, Helena, MT 59604-4210; telephone (406)444-5622; FAX (406)444-1970.

2. The rules as proposed to be amended provide as follows. New language that is being added is underlined. Language that is to be deleted is interlined.

46.12.1229 OPERATING COST COMPONENT (1) This ~~section~~ rule specifies the method used by the department to calculate the operating cost component for a specific provider. Such operating cost component is expressed in dollars and cents per patient day.

(2) As used in this ~~section~~ rule, the following definitions apply:

(2)(a) remains the same.

(i) Except as otherwise specified in ARM 46.12.1243, for rate years beginning on or after July 1, ~~1995~~ 1997, the base period is the provider's cost report period of at least 6 months with a fiscal year ending between January 1, ~~1994~~ 1996 and December 31, ~~1994~~ 1996 inclusive, if available, or, if such a cost report has not been filed on or before April 1 preceding the rate year or is otherwise unavailable, the provider's most recent cost report period of at least 6 months on file with the department as of April 1 immediately preceding the rate year.

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

(4) The operating cost limit is ~~106%~~ 102% of median operating costs.

(5) If the provider's inflated base period per diem operating cost is less than the operating cost limit calculated in accordance with (4), the provider's operating cost component shall include an incentive allowance equal to the lesser of 10% of median operating costs or ~~33%~~ 20% of the difference between the provider's inflated base year per diem operating cost and the operating cost limit.

(5)(a) remains the same.

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

46.12.1231 DIRECT NURSING PERSONNEL COST COMPONENT

(1) This ~~section~~ rule specifies the method used by the department to calculate the direct nursing personnel cost component for a specific provider. Such nursing cost component is expressed in dollars and cents per patient day.

(2) As used in this ~~section~~ rule, the following definitions apply:

(1)(a) remains the same.

(i) Except as otherwise specified in ARM 46.12.1243, for rate years beginning on or after July 1, ~~1995~~ 1997, the base period is the provider's cost report period of at least 6 months with a fiscal year ending between January 1, ~~1994~~ 1996 and December 31, ~~1994~~ 1996 inclusive, if available, or, if such a cost report has not been filed on or before April 1 preceding the rate year or is otherwise unavailable, the provider's most recent cost report period of at least 6 months on file with the department as of April 1 immediately preceding the rate year.

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

(4) The direct nursing personnel cost limit is ~~117%~~ 104% of the statewide median average wage, multiplied by the provider's most recent average patient assessment score, determined in accordance with ARM 46.12.1232.

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

46.12.1237 CALCULATED PROPERTY COST (1) This ~~section~~ rule specifies the method used by the department to calculate the property cost component for a specific provider for rate years beginning on or after July 1, ~~1996~~ 1997. Such property cost component is expressed in dollars and cents per patient day.

(2) As used in this ~~section~~ rule, the following definitions apply:

(2)(a) remains the same.

(i) Except as otherwise specified in ARM 46.12.1243, for rate years beginning on or after July 1, ~~1995~~ 1997, the base period is the provider's cost report period of at least 6 months

with a fiscal year ending between January 1, ~~1994~~ 1996 and December 31, ~~1994~~ 1996 inclusive, if available or, if such a cost report has not been timely filed or is otherwise not available, the provider's cost report period of at least 6 months on file with the department before April 1 immediately preceding the rate year.

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

(e) "~~1996~~ 1997 property component" means the provider's calculated property component determined for rate year ~~1996~~ 1997 in accordance with ARM 46.12.1237.

(i) For any provider providing nursing facility services in a facility constructed prior to June 30, 1982 and for whom a calculated property component has not been determined by the department in accordance with ARM 46.12.1237 for rate year ~~1996~~ 1997, the ~~1996~~ 1997 property component shall equal the June 30, 1985 property rate computed for the facility according to the rules in effect as of June 30, 1985 and indexed forward to the 1992 rate year according to the rules in effect for rate year 1992.

(3) For rate years beginning on or after July 1, ~~1996~~ 1997, the provider's calculated property cost component is as follows:

(a) If the provider's ~~1996~~ 1997 property component is greater than the provider's base year per diem property costs, then the provider's calculated property cost component is the lesser of the provider's ~~1996~~ 1997 property component or the property rate cap of $11.50.

(b) If the provider's base year per diem property costs exceed the provider's ~~1996~~ 1997 property component by more than $1.86, then the provider's calculated property cost component is the lesser of the sum of the provider's ~~1996~~ 1997 property component plus $1.86~~.~~ or the property rate cap of $11.50.

(c) If the provider's base year per diem property costs exceed the provider's ~~1996~~ 1997 property component by $1.86 or less, then the provider's calculated property cost component is the lesser of the provider's base year per diem property costs or the property rate cap of $11.50.

(4) through (5) remain the same.

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

3. The proposed changes to the medicaid nursing facility reimbursement rule implement legislative funding increases for medicaid nursing facility reimbursement for state fiscal year 1998.

The proposed changes to ARM 46.12.1229, 46.12.1231 and 46.12.1237 are necessary to implement legislative funding increases for nursing facility reimbursement for state fiscal year 1998. It appears that the 1997 legislature will appropriate funds under House Bill 2 for increases in medicaid

rates to nursing facilities. It is expected that funding will continue to be provided from a provider bed fee of $2.80 per patient day on all payers for fiscal year 1998. The total state and federal funding available for fiscal year 1998 is expected to be $98,203,357. The funding expected to be appropriated by the 1997 legislature results in fiscal year 1998 nursing facility reimbursement of approximately $122,688,811 of combined state funds, federal funds, and patient contributions.

The department proposes to continue to use the current reimbursement methodology with modifications to the operating, direct nursing and property cost components to adjust for base period cost changes, inflation and other factors. The changes to ARM 46.12.1229, 46.12.1231 and 46.12.1237 are necessary to revise the operating, direct nursing and property cost components to base calculation of each of these components on more current cost information. The proposed changes would change the base cost period from 1994, which is used under the current rule, to 1996, which is the most recent year for which cost reports are available. Periodic updating of base period costs for rate setting purposes is necessary to assure that cost data is sufficiently representative of provider costs and that cost projections do not become too remote from the baseline data.

The department proposes to apply the DRI McGraw-Hill Nursing Home market basket index to 1996 base period costs to project costs for rate year 1998 and adjusting the median rate arrays to set the cost limits for the 1998 rate year. With the use of more recent cost data and the application of the DRI McGraw-Hill nursing home market basket inflation index, the percentage limits and incentive factor in the operating and direct nursing cost components must be adjusted to assure that the methodology will generate rates which meet legal requirements and which meet the department's objectives related to quality patient care, access to services, and related concerns. The department proposes to set the operating cost limit at 102% of median operating costs and the direct nursing personnel cost limit at 104% of the statewide median average direct nursing costs. The department also proposes to continue to provide for an operating incentive at the lesser of 20% of the difference between the provider's indexed cost and the operating cost limit, or 10% of the indexed median operating cost.

The department proposes to rebase the property cost component to use 1996 cost report information to determine base period costs, and to continue to provide that property rates will remain at least as high as the previous year's rate. The department proposes to continue the upper property component limit of $11.50 per day. The proposed property reimbursement methodology will provide for rate increases of up to $1.86 per patient day. Providers will either remain at their 1997 property

reimbursement level or receive an increase in property reimbursement up to the lower of their cost per day, based upon their 1996 cost report, or $1.86 per day.

As of the time of filing this notice, the department does not yet have available all of the information necessary to determine the percentages that will be necessary to set 1998 rates in compliance with all applicable requirements. Information that is currently unavailable includes updated patient assessment averages and deficient facility monitor scores, updated private pay surveys, and a bed day allocation to distribute the 1,407,210 bed days appropriated across all facilities in proportion to their current utilization. Several interim rate facilities will have on file 6 month cost reports prior to the July 1, 1997 rate setting, meaning that those facilities will have rates set under the usual rate methodology and their cost data will be included in the arrays for purposes of setting the cost limits. In addition, audit results are expected to be available for rate setting, which may impact fiscal year 1996 cost reports. These cost reports must be updated before final rates can be calculated.

The department expects that further upward or downward adjustment of the percentages in the nursing and operating cost limits, after the additional data is incorporated into the reimbursement analysis, may be necessary to establish rates that meet all applicable requirements. The department will provide a rate sheet to all providers in advance of the rule hearing for verification purposes and in order to facilitate comments.

The estimated financial impact of the proposed changes is an increase of approximately $2,400,000 in state and federal funds in fiscal year 1998 when compared to the fiscal year 1997 expenditure projections. The legislature appropriated a 1.5% provider rate increase and a 1% increase in case load or bed day growth for nursing facility providers in fiscal year 1998.

To conform with the customary terminology used by the department, the word "section" has been replaced with "rule" in these rules. This change is clerical in nature only and does not alter the meaning or intent of these rules. Copies of this rule notice may be obtained from local county human services offices.

4. The proposed changes will apply to nursing facility services provided on or after July 1, 1997.

5. Interested parties may submit their data, views, or arguments either orally or in writing at the hearing. Written data, views, or arguments may also be submitted to Dawn Sliva, Office of Legal Affairs, Department of Public Health and Human Services, P.O. Box 4210, Helena, MT 59604, no later than June 2,

1997.

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

Rule Reviewer

Director, Public Health and Human Services

Certified to the Secretary of State April 21, 1997.

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

In the matter of the amendment of rules 46.12.4801, 46.12.4804, 46.12.4805, 46.12.4806, 46.12.4810, 46.12.4813, 46.12.4814, 46.12.4815, 46.12.4816, 46.12.4817, 46.12.4826 and 46.12.4827 pertaining to health maintenance organizations	)	NOTICE OF PUBLIC HEARING ON THE PROPOSED AMENDMENT OF RULES

TO: All Interested Persons

1. On May 29, 1997, at 11:00 a.m., a public hearing will be held in the auditorium of the Department of Public Health and Human Services Building, 111 N. Sanders, Helena, Montana to consider the proposed amendment of rules 46.12.4801, 46.12.4804, 46.12.4805, 46.12.4806, 46.12.4810, 46.12.4813, 46.12.4814, 46.12.4815, 46.12.4816, 46.12.4817, 46.12.4826 and 46.12.4827 pertaining to health maintenance organizations.

The Department of Public Health and Human Services will make reasonable accommodations for persons with disabilities who wish to participate in this public hearing. If you request an accommodation, contact the department no later than 5:00 p.m. on May 12, 1997, to advise us of the nature of the accommodation that you need. Please contact Dawn Sliva, P.O. Box 4210, Helena, MT 59604-4210; telephone (406)444-5622; FAX (406)444-1970.

2. The rules as proposed to be amended provide as follows. New language that is being added is underlined. Language that is to be deleted is interlined.

46.12.4801 HEALTH MAINTENANCE ORGANIZATIONS: DEFINITIONS

(1) through (17) remain the same.

(18) "Primary care provider" means a physician including obstetricians and gynecologists, a certified nurse practitioner, a certified nurse midwife, a physicians assistant, a federally qualified health center or rural health clinic with a contract to serve an HMO's enrollees that has been designated by an enrollee as the provider through whom the enrollee obtains health care benefits provided by the HMO. A primary care provider attends to an enrollee's routine medical care, supervises and coordinates all of the enrollee's health care, determines the need for and initiates all referrals, determines the provider of medical services and determines the medical necessity of the medical services to be performed.

(19) through (25) remain the same.

AUTH: Sec. 53-2-201 and 53-6-113, MCA
IMP: Sec. 53-2-201, 53-6-101, 53-6-113 and 53-6-116, MCA

46.12.4804 HEALTH MAINTENANCE ORGANIZATIONS: RECIPIENT ELIGIBILITY (1) through (1)(a) remain the same.

(b) beginning ~~January 1, 1997~~ October 1, 1997, an SSI recipient or SSI-related recipient required by ARM 46.12.5003 to participate in a primary care case management program.

(2) remains the same.

AUTH: Sec. 53-2-201 and 53-6-113, MCA
IMP: Sec. 53-2-201, 53-6-101, 53-6-113, 53-6-116 and 53-6-117, MCA

46.12.4805 HEALTH MAINTENANCE ORGANIZATIONS: ENROLLMENT (1) through (11) remain the same.

(12) The total number of enrollees and Part A and Part B medicare beneficiaries with a non-federally qualified HMO may not exceed 75% of the HMO's total enrollment, as provided in 42 CFR 434.26(a), unless the HMO is the subject of one of the exceptions provided at 42 CFR 434.26(b). The department hereby adopts and incorporates by reference 42 CFR 434.26, dated October ~~1994~~ 1996. A copy of the incorporated provision may be obtained through the Department of Public Health and Human Services, Health Policy and Services Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

AUTH: Sec. 53-2-201 and 53-6-113, MCA
IMP: Sec. 53-2-201, 53-6-101, 53-6-113, 53-6-116 and 53-6-117, MCA

46.12.4806 HEALTH MAINTENANCE ORGANIZATIONS: DISENROLLMENT (1) and (2) remain the same.

(3) Disenrollment is requested by either completing a form designated by the administrative contractor for managed care or by a written or oral request to the administrative contractor for managed care.

(3)(a) through (4)(b)(ii) remain the same.

(iii) has moved outside of the ~~geographical service~~ enrollment area of the HMO;

(4)(b)(iv) through (9) remain the same.

(10) Prior to ~~January 1, 1997~~ October 1, 1997, the date SSI recipients are eligible to enroll with an HMO, the department will retroactively disenroll a newborn enrollee if the newborn enrollee is determined retroactively SSI-eligible within 4 months of birth.

(11) through (11)(c) remain the same.

AUTH: Sec. 53-2-201 and 53-6-113, MCA
IMP: Sec. 53-2-201, 53-6-101, 53-6-113, 53-6-116 and

53-6-117, MCA

46.12.4810 HEALTH MAINTENANCE ORGANIZATIONS: COVERED SERVICES (1) through (1)(m) remain the same.

~~(n) intrauterine monitoring devices;~~

(1)(o) through (1)(ab) remain the same in text but are renumbered (1)(n) through (1)(aa).

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

(d) durable medical equipment and prosthetic supplies ~~except for intrauterine monitoring devices as defined at ARM 46.12.801 et seq.~~;

(2)(e) through (2)(n) remain the same.

(o) targeted case management services for adults with severe and disabling mental illness; for persons age 16 and over with developmental disabilities as defined at ARM 46.12.1935 et seq.; ~~and for youth with severe emotional disturbance;~~ for children at risk of abuse as defined at ARM 46.12.1959; and for children with special health care needs as defined at ARM 46.12.1969;

(p) services under the mental health access plan for the diagnoses specified by the definition of "covered diagnosis" as defined at ARM 46.20.103;

~~(p) inpatient and outpatient mental health services that have as a primary diagnosis one of the following ranges of ICD-9 diagnosis codes: 290-302, 306-314 and 316;~~

~~(q) clinical social worker services;~~

~~(r) licensed professional counselor services;~~

~~(s) psychologist services;~~

~~(t) community mental health center services;~~

~~(u) residential treatment center services;~~

~~(v) therapeutic group home services;~~

~~(w) therapeutic foster care services;~~

(2)(x) through (2)(ae) remain the same in text but are renumbered (2)(q) through (2)(x).

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

(i) for enrollees with reproductive capacity, reproductive health exams comprised of taking history and conducting a physical assessment when such an exam is necessary to obtain birth control supplies or to determine the most appropriate birth control method or supply;

(ii) patient counseling and education for the following: contraception, sexuality, infertility, pregnancy, preconceptual care, pregnancy options, disease, HIV/AIDS, sterilizations, nutrition to maximize reproductive health, the need for rubella and Hepatitis B immunizations, and other topics related to the patient's reproductive and general health;

(iii) ~~patient education;~~

~~(iv)~~ lab tests to detect the presence of conditions affecting reproductive health, such as those involving the thyroid, cholesterol/triglycerides, prolactin, pregnancy tests, and diagnosis of infertility;

~~(v)~~ (iv) sterilizations as defined at ARM 46.12.2002;

~~(vi)~~ (v) screening, testing, and treatment of and pre- and post-test counseling for sexually transmitted diseases and HIV;

~~and~~

~~(vii)~~ (vi) family planning supplies provided by Title X clinics; and

(vii) rubella and Hepatitis B immunizations.

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

AUTH: Sec. 53-2-201 and 53-6-113, MCA
IMP: Sec. 53-2-201, 53-6-101, 53-6-113, and 53-6-116, MCA

46.12.4813 HEALTH MAINTENANCE ORGANIZATIONS: CONTRACTS FOR SERVICES (1) and (2) remain the same.

(3) A contract for the provision of services through an HMO must meet the requirements of 42 CFR part 434. The department hereby adopts and incorporates by reference 42 CFR part 434, dated October ~~1994~~ 1996. A copy of the incorporated provisions may be obtained through the Department of Public Health and Human Services, Health Policy and Services Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

(4) through (12) remain the same.

(13) The department or an HMO may terminate the contract without cause by giving ~~60~~ 120 days written notice to the other party.

(14) remains the same.

AUTH: Sec. 53-2-201 and 53-6-113, MCA
IMP: Sec. 53-2-201, 53-6-101, 53-6-113, and 53-6-116, MCA

46.12.4814 HEALTH MAINTENANCE ORGANIZATIONS: PROVISION OF SERVICES (1) through (1)(a) remain the same.

(b) the preauthorization for services other than emergency services, family planning, immunizations and blood lead testing at a public health clinic;

(1)(c) through (3)(a) remain the same.

(b) the enrollee receives a family planning service provided by a family planning provider as ~~defined~~ specified in ~~the contract~~ ARM 46.12.4810(3);

(3)(c) through(8)(a) remain the same.

AUTH: Sec. 53-2-201 and 53-6-113, MCA
IMP: Sec. 53-2-201, 53-6-101, 53-6-113, 53-6-116, MCA

46.12.4815 HEALTH MAINTENANCE ORGANIZATIONS: PARTICIPATING PROVIDERS (1) and (2) remain the same.

(a) medicaid-enrolled targeted case managers for high risk pregnant women who serve recipients in the enrollment area, terms and conditions that are at least as favorable as those offered to other participating providers providing this service and that substantially meet the same access and credentialing criteria as like participating providers; and

(2)(b) through (8) remain the same.

(9) An HMO must permit obstetricians/gynecologists to become primary care providers.

(10) An HMO may not prohibit a participating provider from discussing a treatment option with an enrollee or from advocating on behalf of an enrollee within the utilization review or grievance processes established by the HMO.

AUTH: Sec. 53-2-201 and 53-6-113, MCA
IMP: Sec. 53-2-201, 53-6-101, 53-6-113 and 53-6-116, MCA

46.12.4816 HEALTH MAINTENANCE ORGANIZATIONS: REIMBURSEMENT OF PROVIDERS (1) and (2) remain the same.

(3) An HMO must reimburse medically necessary family planning services as defined ~~by contract~~ in ARM 46.12.4810(3) provided by a nonparticipating family planning provider to an enrollee who sought the services without referral.

(4) through (8) remain the same.

AUTH: Sec. 53-2-201 and 53-6-113, MCA
IMP: Sec. 53-2-201, 53-6-101, 53-6-113 and 53-6-116, MCA

46.12.4817 HEALTH MAINTENANCE ORGANIZATIONS: REIMBURSEMENT OF HMOS (1) In consideration for all services rendered by an HMO under a contract with the department, the HMO will receive a payment each month for each enrollee. This payment is the capitation rate. Except as otherwise provided in this rule, ~~The~~ the capitation rate represents the total obligation of the department with respect to the costs of medical care and services provided to each enrollee under the contract.

(1)(a) through (1)(e)(i) remain the same.

(ii) any disproportionate share payments; ~~and~~

(iii) any payments made by the department reflecting the difference between the amounts paid to participating federally qualified health centers and rural health clinics by the HMO and the reasonable cost of providing services to enrollees~~.~~; and

(iv) any payments made as a result of reinsurance purchased by an HMO from the department.

(1)(f) through (3)(a) remain the same.

(b) If an HMO becomes a subcontractor to a federally qualified health center or rural health clinic, the department is under no obligation to pay reasonable costs to the HMO, ~~only~~ Only the federally qualified health center or rural health clinic itself remains eligible for reasonable cost settlement for federally qualified health center and rural health clinic services.

(4) remains the same.

(5) Prior to ~~January 1, 1997~~ October 1, 1997, the date SSI recipients are eligible to enroll with an HMO, the department will recoup any capitation payments made to an HMO for a newborn enrollee retroactively disenrolled per ARM 46.12.4806(10).

(6) Starting ~~January 1, 1997~~ October 1, 1997, the date SSI recipients are eligible to enroll with an HMO, the department will recoup the AFDC-based capitation payments made for a newborn enrollee retroactively determined SSI eligible within 4

months of life and instead pay the SSI-based capitation rate for each month of enrollment.

(7) The department reimburses an HMO for 80% of regular medicaid reimbursement for cost above the reinsurance threshold chosen by the HMO if an HMO chooses to purchase reinsurance from the department.

AUTH: Sec. 53-2-201 and 53-6-113, MCA
IMP: Sec. 53-2-201, 53-6-101, 53-6-113 and 53-6-116, MCA

46.12.4826 HEALTH MAINTENANCE ORGANIZATIONS: RECIPIENT EDUCATION (1) An HMO must have written instructions for enrollees in the use of all services provided. The policy must include, but is not limited to, written information on service restrictions and limitations regarding appropriate use of the referral system, grievance procedure, after hours call-in system, provisions for emergency treatment, how the enrollee may obtain services that are the responsibility of the HMO under ARM 46.12.4810 and the contract between the HMO and the department but which are not available through the HMO due to religious objections and how to request a list of ~~providers for~~ the HMO's participating providers.

AUTH: Sec. 53-2-201 and 53-6-113, MCA
IMP: Sec. 53-2-201, 53-6-101, 53-6-113 and 53-6-116, MCA

46.12.4827 HEALTH MAINTENANCE ORGANIZATIONS: QUALITY ASSURANCE (1) remains the same.

(2) An internal quality assurance system must meet the requirements of 42 CFR 434.34. The department hereby adopts and incorporates by reference 42 CFR 434.34, dated October ~~1994~~ 1996.

AUTH: Sec. 53-2-201 and 53-6-113, MCA
IMP: Sec. 53-2-201, 53-6-101, 53-6-113 and 53-6-116, MCA

3. The provision of medicaid services through health maintenance organizations (HMO) allows for more comprehensive management on an individual and group basis of the delivery of services to those recipients that are enrolled with an HMO. Such management reduces the administrative burden in managing the medicaid program allowing for greater efficiency in the delivery and reimbursement of services. Currently, enrollment is generally voluntary except that persons who are in the FAIM program administered by the department are required to enroll with an HMO if there is one in their area.

The provision of medicaid services through health maintenance organizations is relatively new. The rules for the implementation were adopted in 1995. The proposed amendments to the rules encompass matters that need correction, changes in the management of the program, changes in the model HMO contract,

and changes resulting from changes to the authorizing federal law and related state law.

The proposed amendment to ARM 46.12.4801, HEALTH MAINTENANCE ORGANIZATIONS: DEFINITIONS, providing for the inclusion of obstetricians and gynecologists in the definition of primary care provider, is necessary to assure that these particular physician specialists are available to assume the role of primary care providers for HMOs and thereby increase the number of available providers and improve access for recipients enrolled with the HMOs. This implements a law recently passed by the state Legislature.

The proposed amendment to ARM 46.12.4804, HEALTH MAINTENANCE ORGANIZATIONS: RECIPIENT ELIGIBILITY, changing the date upon which SSI recipients or SSI-related recipients may enroll with an HMO, is necessary to provide more time for the medicaid program, in conjunction with HMO providers, to develop the capability of handling an increased number of enrollees.

The proposed amendments to ARM 46.12.4805, HEALTH MAINTENANCE ORGANIZATIONS: ENROLLMENT, are necessary to provide the most current publishing date for the particular citation to the Code of Federal Regulations.

The proposed amendments to ARM 46.12.4806, HEALTH MAINTENANCE ORGANIZATIONS: DISENROLLMENT, changing certain terms, will conform terminology and thereby avoid confusion on the part of HMO providers.

The proposed amendment to ARM 46.12.4810, HEALTH MAINTENANCE ORGANIZATIONS: COVERED SERVICES, adding to the list of noncovered targeted case management services those services for children at risk of abuse and children with special health care needs, is necessary to prevent inappropriate inclusion of those services under HMO management. The proposed amendments removing mental health related services from the rule and inserting a new reference to the covered diagnoses under the mental health access plan are necessary because the implementation of the new medicaid mental health access plan, providing for the delivery of all mental health services through a statewide HMO, has eliminated the currently referenced services and replaced them with services under the plan. The proposed amendments, modifying the procedures under family planning services for which a recipient may self-refer to their HMO provider or to a non-HMO provider and yet receive reimbursement from their HMO provider, are necessary to provide more direction to providers as to the scope of the health exams and the counseling and education activities and to provide improved access for recipients through these services to certain critical immunizations.

The proposed amendments to ARM 46.12.4813, HEALTH MAINTENANCE ORGANIZATIONS: CONTRACTS FOR SERVICES, are necessary to provide the most current publishing date for the particular citation to the Code of Federal Regulations. The proposed amendment, changing the notice period for the termination of an HMO contract without cause from 60 days to 120 days notice, is necessary to provide the medicaid program and the HMO provider more time in which to transition recipients along with records to a new HMO provider during a contract termination.

The proposed amendments to ARM 46.12.4814, HEALTH MAINTENANCE ORGANIZATIONS: PROVISION OF SERVICES, adding family planning and immunizations and blood testing at a public health clinic to the exceptions to the provision allowing HMOs to impose preauthorization, are necessary to allow ease of recipient access to these particular services. The proposed amendment, changing the reference for the family planning services specifications from the provider contract to ARM 46.12.4810, is necessary to direct the provider to the relevant operative rule authority.

The proposed amendment to ARM 46.12.4815, HEALTH MAINTENANCE ORGANIZATIONS: PARTICIPATING PROVIDERS, adding further criteria relating to access and credentialing that a high risk pregnant women targeted case manager must meet in order for an HMO to offer it terms and conditions at least as favorable as those offered to other participating providers, is necessary to assure that the manager provides appropriate services to warrant the favorable status accorded by the provision. The proposed amendment, directing an HMO to include obstetricians and gynecologists as primary care providers, is necessary to assure that these particular physician specialists are available to assume the role of primary care providers for HMOs and thereby increase the number of available providers and improve access for recipients enrolled with the HMOs. This implements a new state law. The proposed amendment, providing that an HMO may not prohibit a participating provider from discussing treatment options with enrollees or from advocating on behalf of enrollees, is necessary to conform the administration of the program with new federal and state statutory law prohibiting the stated practices.

The proposed amendment to ARM 46.12.4816, HEALTH MAINTENANCE ORGANIZATIONS: REIMBURSEMENT OF PROVIDERS, changing certain terms, will conform terminology and thereby avoid confusion on the part of HMO providers. The proposed amendment, changing the reference for the family planning services specifications from the provider contract to ARM 46.12.4810, is necessary to direct the provider to the relevant operative rule authority.

The proposed amendment to ARM 46.12.4817, HEALTH MAINTENANCE ORGANIZATIONS: REIMBURSEMENT OF HMOS, providing that the

capitation rate does not include payments made as a result of reinsurance purchase by an HMO from the Department, is necessary to assure that an HMO which purchases reinsurance from the department may receive any payments made for reinsurance above and beyond the capitation payments they receive. The proposed amendments, changing the referenced dates for the start for enrollment of SSI recipients or SSI-related recipients, are necessary to conform the dates with that established by the proposed amendment to ARM 46.12.4804. The proposed amendment, providing for a reimbursement formula for an HMO that has purchased reinsurance from the Department, is necessary to adopt in rule a reimbursement formula for the costs incurred by an HMO under those particular circumstances.

The proposed amendment to ARM 46.12.4826, HEALTH MAINTENANCE ORGANIZATIONS: RECIPIENT EDUCATION, changing the reference to participating provider, will conform terminology and thereby avoid confusion on the part of providers.

The proposed amendment to ARM 46.12.4827, HEALTH MAINTENANCE ORGANIZATIONS: QUALITY ASSURANCE, are necessary to provide the most current publishing date for the particular citation to the Code of Federal Regulations.

4. Interested parties may submit their data, views, or arguments either orally or in writing at the hearing. Written data, views, or arguments may also be submitted to Dawn Sliva, Office of Legal Affairs, Department of Public Health and Human Services, P.O. Box 4210, Helena, MT 59604, no later than June 2, 1997.

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

Dawn Sliva
Rule Reviewer

Michael B Billings for
Director, Public Health and Human Services

Certified to the Secretary of State April 21, 1997.

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

In the matter of the amendment of rules 46.12.204 and 46.17.121 pertaining to copayments and qualified medicare beneficiaries	))))))	NOTICE OF PUBLIC HEARING ON THE PROPOSED AMENDMENT OF RULES

TO: All Interested Persons

1. On May 29, 1997, at 9:30 a.m., a public hearing will be held in the auditorium of the Department of Public Health and Human Services Building, 111 N. Sanders, Helena, Montana to consider the proposed amendment of rules 46.12.204 and 46.17.121 pertaining to copayments and qualified medicare beneficiaries.

The Department of Public Health and Human Services will make reasonable accommodations for persons with disabilities who wish to participate in this public hearing. If you request an accommodation, contact the department no later than 5:00 p.m. on May 12, 1997, to advise us of the nature of the accommodation that you need. Please contact Dawn Sliva, P.O. Box 4210, Helena, MT 59604-4210; telephone (406)444-5622; FAX (406)444-1970.

2. The rules as proposed to be amended provide as follows. New language that is being added is underlined. Language that is to be deleted is interlined.

46.12.204 RECIPIENT REQUIREMENTS, COPAYMENTS (1) through (1)(c) remain the same.

(d) outpatient physical therapy services, ~~$1.00~~ $.50 per unit of service;

(e) speech therapy services, ~~$1.00~~ $.50 per unit of service;

(1)(f) and (1)(g) remain the same.

(h) occupational therapy services, ~~$1.00~~ $.50 per unit of service;

(1)(i) and (1)(j) remain the same.

(k) dental services, ~~$1.00~~ $2.00 per service;

(1)(l) and (1)(m) remain the same.

(n) optometric services, ~~$1.00~~ $2.00 per service;

(1)(o) through (1)(u) remain the same.

(v) chiropractor services (for qualified medicare beneficiaries only), $1.00 per service.

(2) through (4) remain the same.

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

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

46.17.121 QUALIFIED MEDICARE BENEFICIARIES, COPAYMENTS (1) A qualified medicare beneficiary is responsible for ~~the following~~ copayments to the same extent as a medicaid recipient under the provisions of ARM 46.12.204. ~~not to exceed the cost of the service:~~

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

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

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

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

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

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

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

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

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

~~(j) chiropractor services, $1.00 per service.~~

~~(2) The following recipients are exempt from copayments:~~

~~(a) persons under the age of 21;~~

~~(b) pregnant women; and~~

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

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

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

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

3. The proposed changes to ARM 46.12.204 increase the copayment amounts that medicaid recipients must pay for physical therapy (PT), occupational therapy (OT), speech therapy (ST), dental and optometric services. The proposed copayment increases are necessary to achieve cost savings in these service categories.

The proposed changes to the copayment amounts for PT, OT and ST appear to be decreases rather than increases in the copayment amount. However, the current $1.00 copayment amount was applied to a full hour of service while codes were billed in 15-minute units of service. Under changes being made in these program

areas, these services will be billable in units of service that vary according to the CPT-4 codes under which each particular service is billed. For example, the unit of service may be a 15-minute period or an entire visit, depending upon the unit specified in the applicable CPT-4 procedure code. The proposed $.50 copayment amount will apply to the unit of service specified in the CPT-4 procedure code. If the unit of service is 15-minutes, then a $.50 copayment will be required for each 15-minute unit of service. If the unit of service is the entire visit, then one $.50 copayment will be required for the entire visit.

The proposed changes to ARM 46.17.121 delete the separate copayment requirements for qualified medicare beneficiaries (QMBs) and provides that QMBs must pay the same copayments as medicaid recipients under ARM 46.12.204. The specific copayments for QMBs are different in some service categories than the copayments for medicaid recipients generally. These changes are necessary to apply the same copayment requirements to QMBs as apply to medicaid recipients generally. Because chiropractor services are reimbursable for QMBs, a reference to the copayment for chiropractor services must be added to ARM 46.12.204.

4. The proposed changes will apply to services provided on or after July 1, 1997.

5. Interested parties may submit their data, views, or arguments either orally or in writing at the hearing. Written data, views, or arguments may also be submitted to Dawn Sliva, Office of Legal Affairs, Department of Public Health and Human Services, P.O. Box 4210, Helena, MT 59604, no later than June 2, 1997.

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

Dawn Sliva
Rule Reviewer

Michael S. Billings for
Director, Public Health and Human Services

Certified to the Secretary of State April 21, 1997.

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

In the matter of the adoption of Rule I and the repeal of 16.38.301 through 16.38.304 and 16.38.306 pertaining to laboratory analysis fees	))))	NOTICE OF PUBLIC HEARING ON THE PROPOSED ADOPTION AND REPEAL OF RULES

TO: All Interested Persons

1. On May 27, 1997, at 3:00 p.m., a public hearing will be held in C209-B of the Cogswell Building, 1400 Broadway, Helena, Montana to consider the proposed repeal of 16.38.301 through 16.38.304 and 16.38.306 and the adoption of a new rule pertaining to laboratory analysis fees.

The Department of Public Health and Human Services will make reasonable accommodations for persons with disabilities who wish to participate in this public hearing. If you request an accommodation, contact the department no later than 5:00 p.m. on May 12, 1997, to advise us of the nature of the accommodation that you need. Please contact Dawn Sliva, P.O. Box 4210, Helena, MT 59604-4210; telephone (406)444-5622; FAX (406)444-1970.

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

RULE I LABORATORY FEES FOR ANALYSES (1) Effective July 1, 1997, fees for clinical analyses performed by the laboratory of the department of public health and human services are as follows, with the exception noted in (3) below:

Air mold spores	$10.00
Atypical pneumonia panel	15.00
Autoclave, sterility check	10.00
Bact. enteric panel	25.00
Bacteriology culture, identification	10.00
Blood-borne exposure panel	35.00
Blood lead	15.00
C. Difficile cytotoxin	14.00
Chlamydia, direct probe	10.00
Chlamydia, gene amplification	17.00
Chronic fatigue panel	20.00
EHEC toxin	15.00
Encephalitis panel	18.00
Exantham panel	20.00
FTA	15.00
Fungal culture	20.00
GC + chlamydia, direct probe	18.00

GC + chlamydia, amplification	30.00
Hepatitis panel (acute)	45.00
Hepatitis C	17.00
Hepatitis B, anti HbsAb	12.50
Hepatitis B, anti HBsAg	10.00
Herpes simplex culture	10.00
HIV Screen, serum	11.00
HIV screen, oral fluid	21.00
HIV viral load	150.00
HIV western blot	15.00
Misc. direct Ag detection	14.00
Misc. serologies	12.50
Misc. serologies, IgG + IgM	25.00
Newborn screening	18.50
Newborn screening + CF	23.00
Newborn screening, monitor	10.00
Parasite identification	14.00
Prenatal, short panel	25.00
Prenatal + HIV	28.00
Respiratory, long panel	15.00
Respiratory, short panel	10.00
Rubella screen	10.00
Syphilis screen	9.00
Tb direct amplification	100.00
Tb screen	20.00
Tick-borne panel	18.00
TORCH short panel	15.00
TORCH + Parvovirus	20.00
Viral culture	14.00

(2) Effective July 1, 1997, fees for environmental analyses performed by the laboratory of the department of public health and human services are as follows, with the exception noted in (3) below:

Alkalinity	$12.60
Aluminum	8.00
Ammonia	12.60
Antimony	15.00
Arsenic	15.00
Barium	8.00
Beryllium	8.00
Bismuth	8.00
BOD	30.00
Boron	8.00
Cadmium	15.00
Calcium	8.00
Carbamate pesticides	75.00
Chloride	17.40
Chlorinated pesticides	150.00
Chlorophenoxy herbicides	180.00
Chromium	15.00

Cobalt	8.00
COD	35.00
Color	20.00
Conductivity	6.00
Copper	8.00
Cyanide	35.00
Dyed fuel, combo	60.00
Dyed fuel, color	15.00
Dyed fuel, sulfur	20.00
Dyed fuel, adulteration	30.00
Fluoride	15.00
Fuels, BTEX	90.00
Hardness	16.00
Hexavalent chromium	25.00
HI-vols, sulfur + nitrate	30.00
Iron	8.00
Kjeldahl nitrogen	25.00
Lead	10.00
Lyophilize, sample	7.50
Magnesium	8.00
Manganese	8.00
Mercury	36.00
Metals scan	20.00
Microwave digestion	14.40
Molybdenum	8.00
Nickel	8.00
Nitrate + nitrite	12.60
Nitrite	12.60
Oil and grease	40.00
Organohalide pesticides	120.00
Ortho-phosphorus	12.60
PCBs	120.00
Pentachlorophenol	180.00
pH	6.00
Potassium	8.00
Residue	15.00
Selenium	15.00
Semi-volatile organics	240.00
Silicon	8.00
Silver	8.00
Sodium	8.00
Strontium	8.00
Sulfate	17.40
Sulfide	35.00
Thallium	15.00
Tin	8.00
TOC	26.00
Total suspended solids	23.00
Total phenolics	25.00
Total phosphorus	21.50
Trihalomethanes	90.00
Turbidity	6.00

Volatile organic compounds	140.00
Volatile suspended solids	22.40
Water, bacteriology	16.50
Zinc	8.00

(3) The fees specified in (1) and (2) of this rule will be lowered by the department of public health and human services to a level not exceeding the cost to the department of the test in question whenever larger batches of samples or a change of analysis method warrants lower fees.

AUTH: Sec. 50-1-202, MCA
IMP: Sec. 50-1-202, MCA

3. Rules 16.38.301, 16.38.302, 16.38.303, 16.38.304 and 16.38.306 as proposed to be repealed may be found on pages 16-1859 through 16-1865 of the Administrative Rules of Montana. The repeal of these rules is to be effective July 1, 1997.

AUTH: Sec. 50-1-202, MCA
IMP: Sec. 50-1-202, MCA

4. Revision of the fees for analyses performed by the department's laboratory is required by 50-1-202(17), MCA, to "reflect the actual costs of the tests or services provided" and to ensure, as required by the same provision of the law, that the fees do not exceed the cost of performing the tests or services. The new list of fees reflects the actual cost to the department of the analyses. The substitution of the single new rule for the five rules proposed for repeal is not a substantive change but is intended to simplify the fee structure by placing all fees in one place.

5. The proposed changes will be effective for laboratory services provided on or after July 1, 1997.

6. Interested parties may submit their data, views, or arguments either orally or in writing at the hearing. Written data, views, or arguments may also be submitted to Laura Harden, Office of Legal Affairs, Department of Public Health and Human Services, P.O. Box 202951, Helena, MT 59620-2951, no later than June 2, 1997.

7. The Office of Legal Affairs, Department of Public Health and Human Services has been designated to preside over and conduct the hearing.

Rule Reviewer

Director, Public Health and Human Services

Certified to the Secretary of State April 21, 1997.

BEFORE THE DEPARTMENT
OF PUBLIC SERVICE REGULATION
OF THE STATE OF MONTANA

In the Matter of Proposed Amendment of a Rule Pertaining to Pipeline Safety Incident Reporting Requirements.	)	NOTICE OF PROPOSED AMENDMENT TO ARM 38.5.2204
	)	NO PUBLIC HEARING CONTEMPLATED

TO: All Interested Persons

1. On June 5, 1997, the Department of Public Service Regulation proposes to amend the rule identified in the above title and described in the following paragraph and relating to pipeline safety inspections, investigations, and reporting requirements.

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

38.5.2204 INSPECTIONS, INVESTIGATIONS, AND REPORTING

(1) and (2) remain the same.

~~(3) Upon the occurrence of any incident involving the operation of an intrastate gas pipeline located in this state, each pipeline owner or operator subject to commission safety jurisdiction shall, in addition to reporting at the federal level as required by 49 CFR 191.5 through 191.9, report to the commission by telephone as soon as possible after an occurrence, not to exceed two hours, and report to the commission in writing within 20 days of the occurrence, which report shall include the time and place of the incident, the names of persons killed or injured, the names of owners of damaged property, and in concise form the nature, cause, and circumstances of the incident.~~

AUTH: Sec. 69-3-207, MCA; IMP, Sec. 69-3-207, MCA

3. Rationale: Amendment to the above rule is reasonably necessary as that part of the rule proposed for deletion is in conflict with Section 69-3-107, MCA, and therefore invalid.

4. Interested parties may submit their data, views or arguments concerning the proposed amendment in writing (original and 10 copies) to Martin Jacobson, Public Service Commission, 1701 Prospect Avenue, P.O. Box 202601, Helena, Montana 59620-2601 no later than June 5, 1997.

5. If a person who is directly affected by the proposed amendment wishes to express his data, views and arguments orally or in writing at a public hearing, he must make written request for a public hearing and submit this request along with any written comments he has (original and 10 copies) to Martin Jacobson, Public Service Commission, 1701 Prospect Avenue, P.O. Box 202601, Helena, Montana 59620-2601, no later than June 5, 1997.

6. If the agency receives requests for a public hearing on the proposed amendment from either 10% or 25, whichever is less, of the persons who are directly affected by the proposed amendment; from the Administrative Code Committee of the legislature; from a governmental subdivision or agency; or from an association having not less than 25 members who will be directly affected, a hearing will be held at a later date. Notice of the hearing will be published in the Montana Administrative Register. Ten percent of those persons directly affected has been determined to be in excess of 25 persons based on the number of utilities, pipelines, employees, consumers, and public in general affected by the amendment.

7. The Montana Consumer Counsel, 34 West Sixth Avenue, P.O. Box 201703, Helena, Montana 59620-1703, (406) 444-2771, is available and may be contacted to represent consumer interests in this matter.

Dave Fisher

Dave Fisher, Chairman

CERTIFIED TO THE SECRETARY OF STATE APRIL 21, 1997.

Robin A. McHugh

Reviewed By Robin A. McHugh

BEFORE THE COMMISSIONER OF POLITICAL PRACTICES

OF THE STATE OF MONTANA

In the matter of the proposed adoption of new Rules I and II pertaining to lobbying activities and reporting of lobbying payments by principals	))))))	**NOTICE OF PUBLIC HEARING**

TO: All Interested Persons.

1. On June 18, 1997, at 9:00 a.m., a public hearing will be held in the Old Supreme Court Chambers in the State Capitol, Helena, Montana, to consider the proposed adoption of Rules I and II pertaining to lobbying activities and reporting of lobbying payments by principals.

2. The proposed new rules provide as follows:

RULE I LOBBYING--DEFINITIONS AND SCOPE--REPORTABLE ACTIVITIES (1) For purposes of Title 5, chapter 7, MCA, and these rules:

(a) "Administrative action" means any action taken by a public official in any agency, department, division, office, board, or commission of state government with regard to any proposal for or drafting, development, or consideration of a policy, practice or rule to be published and used by the official or agency. "Administrative action" does not include actions that are quasi-judicial or ministerial in nature.

(b) "Individual" shall have the definition set forth at section 5-7-102(5), MCA.

(c) "Legislative action" means any action by a legislator with regard to introduction of a bill, resolution, or amendment, or with regard to any bill, resolution, amendment, report, appointment, recommendation, nomination, election, proposed or final proposed rule or other matter proposed for consideration by or pending in the Montana legislature or in any committee of the Montana legislature.

(d) "Lobbyist" shall have the definition set forth at section 5-7-102(8), MCA.

(e) "Official action" means legislative action or administrative action, or both, as required by the context in which the phrase is used, so that its meaning is inclusive rather than exclusive.

(f) "Payment" and "payment to influence official action" shall have the definitions set forth at sections 5-7-102(9) and (10), MCA.

(g) "Principal" shall have the definition set forth at section 5-7-102(12), MCA.

(h) "Public official" shall have the definition set forth at section 5-7-102(13), MCA.

(2) Pursuant to the definition set forth at section 5-7-102(6), MCA, "lobbying" means the practice of promoting or opposing legislative, administrative, or official action. Unless otherwise exempted from the definition of "lobbying" by ARM 44.12.101, lobbying activities shall include, without limitation:

(a) any direct communications (including but not limited to face-to-face meetings, telephone conversations or written correspondence) by a lobbyist with a public official to promote or oppose legislative or administrative action;

(b) all time spent by a lobbyist to deliver testimony promoting or opposing official action by any public official or group of public officials;

(c) all time spent by a lobbyist:

(i) at the State Capitol or other meeting location of the Montana legislature, during any regular or special legislative session, during which time the lobbyist makes personal contact with a legislator or legislators, to promote or oppose legislative action; or

(ii) at any interim legislative committee meeting at which any pending or proposed legislative action is considered, on which a principal of the lobbyist has taken or takes a position, during which time the lobbyist makes personal contact with a legislator or legislators, to promote or oppose said pending or proposed legislative action;

(d) all time spent by a lobbyist attending a meeting of, or hearing before, a public official or group of public officials at which any pending or proposed official action is considered, on which a principal of the lobbyist has taken or takes a position promoting or opposing said official action, during which time the lobbyist makes personal contact with the public official or group of public officials;

(e) all time spent by a lobbyist conducting a lobbying campaign, including time spent working with other lobbyists, for the purpose of promoting or opposing official action.

AUTH: Section 5-7-111, MCA
IMP: Section 5-7-102, 5-7-111, MCA

RULE II PRINCIPALS -- REPORTS (1) Pursuant to section 5-7-208, MCA, a principal shall report all payments made for the purpose of lobbying.

(2) Reports shall include, without limitation, all payments made to a lobbyist to influence official action (as those terms are

defined in sections 5-7-102(9) and (10), MCA), including payments made for any lobbying activity specified in these rules.

(3) In each lobbying report submitted pursuant to section 5-7-208, MCA, a principal must declare payments made to a lobbyist for the activities and the expenses set forth in section 5-7-208 (5), MCA.

(4) Even if a principal declares that it made no payments for lobbying activities during a reporting period, the principal must file a lobbying report as provided in section 5-7-208, MCA.

AUTH: Section 5-7-111, MCA
IMP: Section 5-7-208, MCA

3. The proposed new rules are necessary to implement the statutes regarding lobbying, and to clarify the reporting requirements for payment for lobbying activities.

4. Interested persons may present their data, views, or arguments, either orally or in writing, at the hearing. Written data, views, or arguments may also be submitted to Ed Argenbright, Commissioner of Political Practices, P.O. Box 202401, 1205 Eighth Avenue, Helena, Montana 59620-2401, and must be received no later than June 27, 1997.

5. Jim Scheier has been designated to preside over and conduct the hearing.

JIM SCHEIER, Rule Reviewer

ED ARGENBRIGHT, Commissioner

Certified to the Secretary of State April 18, 1997.

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

In the matter of the amendment and repeal of rules pertaining to hearing aid dispensers	)))	NOTICE OF AMENDMENT AND REPEAL OF RULES PERTAINING TO HEARING AID DISPENSERS

TO: All Interested Persons:

1. On November 21, 1996, the Board of Hearing Aid Dispensers published a notice of public hearing on the proposed amendment and repeal of rules pertaining to hearing aid dispensers at page 3009, 1996 Montana Administrative Register, issue number 22.

2. The Board has amended ARM 8.20.401, 8.20.403, 8.20.412, 8.20.416, 8.20.417 and 8.20.420 and has repealed ARM 8.20.405, 8.20.409 and 8.20.411 exactly as proposed. The Board has amended ARM 8.20.404, 8.20.407, 8.20.408 and 8.20.418 as proposed, but with the following changes: (authority and implementing sections remain the same as proposed)

"8.20.404 RENEWALS (1) and (2) will remain the same as proposed.

(3) Licensees may renew their licenses ~~for a period of~~ within three years after the expiration date of the license by paying one renewal fee, one additional late fee and submission of documentation of continuing education that would have been required had the license remained active.

(4) will remain the same as proposed."

"8.20.407 RECORD RETENTION (1) through (1)(h) will remain the same as proposed.

~~(i) a copy of all advertisements placed on behalf of the permanent place of business, including a written script of radio and television advertisements, in compliance with 37-16-301, MCA;~~

(j) and (k) will remain the same as proposed, but will be renumbered (i) and (j).

(2) will remain the same as proposed.

(3) All licensed hearing aid dispensers shall maintain all copies of advertisements, including all advertisements placed on behalf of the permanent place of business, encompassing written scripts of radio and television advertisements, in compliance with 37-16-301, MCA."

"8.20.408 UNPROFESSIONAL CONDUCT For the purpose of implementing the provisions of Title 37, chapter 1, MCA, and in addition to the unprofessional conduct provisions set forth at 37-1-316, MCA, the board defines unprofessional conduct as follows:

(1) through (14) will remain the same as proposed.

~~(15) exercising influence on, or control over, a client, including the promotion or the sale of services, goods, property or drugs for the financial gain of the licensee or a third party;~~

(16) through (23) will remain the same as proposed, but will be renumbered (15) through (22)."

"8.20.418 TRANSACTIONAL DOCUMENT REQUIREMENTS - FORM AND CONTENT (1) through (4) will remain the same as proposed.

(5) Notice of cancellation must be given to the seller in writing within 30 days of the date of delivery of the hearing aid or related device, if the hearing aid or related device is defective in fit or function, or if the dispenser has failed to correct a problem in fit or function. The notice of cancellation may be delivered by mail or in person, and must indicate the purchaser's intent not to be bound by the sale. The purchaser shall return the hearing aid or related device in substantially the same condition as it was received. Under this provision, the hearing aid dispenser shall refund to the purchaser the amount paid, minus a dispensing fee, within 30 days of receipt of the written notice of cancellation. The dispensing fee may not exceed 10% of the total cost of the hearing aid or related device, including services related to acquiring and ensuring the operation of the hearing aid. ~~IF YOU HAVE ANY QUESTIONS REGARDING YOUR CONSUMER RIGHTS, WITH RESPECT TO HEARING AIDS AND RELATED DEVICES, PLEASE CONTACT THE DEPARTMENT OF COMMERCE --- BOARD OF HEARING AID DISPENSERS.~~"

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

8.20.404(3) TRAINEESHIP REQUIREMENTS AND STANDARDS

COMMENT: Commentor suggested that the board replace the phrase "for a period of" with the word "within."

RESPONSE: The Board agrees that replacing the phrase would more accurately describe the Board's intent that licensees renew their licenses within the three-year period provided in the Uniform Licensing Act and has amended the rule as shown above.

8.20.407 RECORD RETENTION

COMMENT: One commentor asked if the purpose for the amendments was to follow the Montana Personal Solicitation Sales Act.

RESPONSE: The Board does not intend that the amendments mirror the terms of that act, but that the amendments only serve to further harmonize with the MPSSA.

COMMENT: Commentors expressed concern regarding the requirement in (1)(e), (1)(g), and (1)(h) that the consumer receives the original of the contract. Commentors stated that it was appropriate only to provide a copy of the contract.

RESPONSE: The Board, as a result of numerous disciplinary actions, has determined that consumers need to be provided additional protection with regard to claims against hearing aid dispensers. In most instances, the Board has recognized that the copy of a contract provided to a consumer is so faint with respect to information which is handwritten rather than printed, that the writing is illegible which, in turn, makes it very difficult to understand the terms of the contract. Therefore, in accordance with its charge to protect the public health, safety and welfare, the Board will continue to require that dispensers provide the original contract to a consumer.

COMMENT: Commentors suggested that the requirement in (1)(i) was more appropriate in the unprofessional conduct rule.

RESPONSE: The Board agrees that the rule does not fit within the provisions of (1) and, therefore, amends the rule as provided above.

8.20.408 UNPROFESSIONAL CONDUCT

COMMENT: One commentor objected to the addition of (13) stating that many practices in which dispensers engage may be considered outside the scope of practice, such as the use of vitamin E to desensitize the ear canal and aid in the insertion of the device.

RESPONSE: The Board disagrees with the example provided and will allow the language to remain the same. The intent of the rule is to provide for discipline against those practitioners who clearly exceed the scope of the dispenser's practice and engage in activities which are within the purview of other licensed professions.

COMMENT: Commentors state with respect to (15), that all advertising is for the financial gain of the dispenser and that the rule, read literally, would prohibit dispensers from advertising.

RESPONSE: The Board recognizes that confusion may result from the language of the subsection, particularly with respect to the area of advertising. Therefore, the Board will delete subsection (15).

8.20.412 MINIMUM TESTING AND RECORDING PROCEDURES

COMMENT: One commentor provided information regarding (1)(c) stating that it may be wise not to require SRT tests, as the test is not often valid or reliable.

RESPONSE: The Board declines to address this comment as it relates to a rule which was not proposed for amendment or repeal. The Board will consider changes to this particular subsection at a future date.

8.20.418 TRANSACTIONAL DOCUMENT REQUIREMENTS - FORM & CONTENT

COMMENT: The comments received with respect to this section focused on the language which is adopted from 37-16-304, MCA, and remarked on the thirty-day return policy, as well as the percentage fee designed to accurately reflect the dispensing fee incurred by dispensers and which the dispenser is entitled should the devices be returned.

RESPONSE: House Bill 164, introduced in the 55th Legislature, proposes to amend much of the language and the Board will revisit this rule and amend the language to accurately reflect the language in the bill.

COMMENT: One commentor stated that the language found in (5) unnecessarily repeats the language found in the statute and should be deleted.

RESPONSE: The Board agrees with commentor and amends the subsection as provided above.

BOARD OF HEARING AID DISPENSERS
DUDLEY ANDERSON, CHAIRMAN

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

Annie M. Bartos
ANNIE M. BARTOS, RULE REVIEWER

Certified to the Secretary of State, April 21, 1997.

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.

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