MONTANA ADMINISTRATIVE REGISTER

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PAGES 1-234
INDEX COPY

MONTANA ADMINISTRATIVE REGISTER

ISSUE NO. 1

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 The notice section contains state agencies' proposed new, amended or repealed rules; the rationale for the change; date and address of public hearing; and where written comments may be submitted.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

Inquiries regarding the rulemaking process, including material found in the Montana Administrative Register and the Administrative Rules of Montana, may be made by calling the Administrative Rules Bureau at (406) 444-2055.

Page Number

TABLE OF CONTENTS

NOTICE SECTION

THE STATE AUDITOR AND COMMISSIONER OF INSURANCE
OF THE STATE OF MONTANA

In the matter of the proposed amendment of rules 6.6.2503, 6.6.2504, 6.6.2506, 6.6.2507, 6.6.5001, 6.6.5004, 6.6.5008, 6.6.5024, 6.6.5032, 6.6.5036, 6.6.5050, 6.6.5058, 6.6.5060, 6.6.5078, and 6.6.5090, the repeal of 6.6.5020, 6.6.5028, 6.6.5044, 6.6.5054, 6.6.5062, 6.6.5066, 6.6.5070, 6.6.5074 and the adoption of new rules I - XIV pertaining to group health insurance in the large and small group markets and individual health insurance.	NOTICE OF PUBLIC HEARING ON PROPOSED AMENDMENT, REPEAL, AND ADOPTION OF RULES

TO: All Interested Persons

1. On February 13, 1998, at 2:00 p.m., a public hearing will be held in room 420 of the State Capitol, at Helena, Montana, to consider the amendment, repeal and adoption of rules.

2. The proposed amendments provide as follows (new text is underlined; text to be deleted is interlined):

6.6.2503 DEFINITIONS A contract or evidence of coverage delivered or issued for delivery to any person by a health maintenance organization required to obtain a certificate of authority in this state may not contain definitions respecting the words defined in the Montana Health Maintenance Organization Act or this rule unless the definitions comply with the definitions contained in the Montana Health Maintenance Organization Act and this rule. Definitions other than those set forth in the Montana Health Maintenance Organization Act or this rule may be used if they do not extend, modify, or conflict with the definitions contained in the Montana Health Maintenance Organization Act and this rule. All definitions used in the contract and evidence of coverage must be in alphabetical order. As used in these rules, the Montana Health Maintenance Organization Act, and for the purpose of any terms used in the contract and evidence of coverage:

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

(5) "Enrollee" means an enrollee as defined in 33-31-102~~(6)~~, MCA.

(6) "Evidence of coverage" means an evidence of coverage as defined in 33-31-102~~(7)~~, MCA.

(7) through (13) will remain the same.

(14) "Provider" means a provider as defined in 33-31-102~~(13)~~, MCA. "Person", as used in that definition, means a person as defined in 33-31-102~~(11)~~, MCA.

(15) through (17) will remain the same.

AUTH: Sec. 33-31-103, MCA
IMP: Sec. 33-31-101, 33-31-102, and 33-31-405, MCA

6.6.2504 FILING EXEMPTION FOR HEALTH MAINTENANCE OPERATED BY INSURER OR HEALTH SERVICE CORPORATION AS A PLAN (1) A health maintenance organization operated as a plan (defined in 33-31-102~~(12)~~, MCA) need not file with the commissioner, as part of its application for a certificate of authority, the financial statement required by 33-31-201(3)(d)(vi), MCA, if the same financial statement has been filed under other laws or rules administered by the commissioner.

AUTH: Sec. 33-31-103 and 33-31-201(7), MCA
IMP: Sec. 33-31-201, MCA

6.6.2506 REQUIREMENTS FOR CONTRACTS AND EVIDENCES OF COVERAGE (1) Each subscriber is entitled to a contract or evidence of coverage as approved by the commissioner. The contract or evidence of coverage must be delivered or issued for delivery to a subscriber within a reasonable time after enrollment, but not more than 15 days from the later of the effective date of coverage or the date on which the health maintenance organization is notified of enrollment.

(1) - (1)(b) will remain the same but are renumbered (2) - (2)(b).

(c) the time and date or occurrence upon which coverage takes effect, including any applicable waiting or affiliation periods, or describe how the time and date or occurrence upon which coverage takes effect is determined. The contract and evidence of coverage must contain the time and date or occurrence upon which coverage will terminate.

(1)(d) - (1)(f) will remain the same but are renumbered (2)(d) - (2)(f).

(g) a description of the copayments, limitations, or exclusions on the services, kind of services, benefits, or kind of benefits to be provided, including the copayments, limitations, or exclusions due to preexisting conditions, waiting or affiliation periods, or an enrollee's refusal of treatment;

(1)(h) through (4) will remain the same but are renumbered (2)(h) through (5).

AUTH: Sec. 33-31-103, MCA
IMP: Sec. 33-31-301(3)(c), 33-31-307, and 33-31-312(3), MCA

6.6.2507 PROHIBITED PRACTICES (1)(a) A health maintenance organization may include in its contract and evidence of coverage a provision setting forth ~~reasonable~~ exclusions or limitations of services for preexisting conditions at the time of enrollment as permitted under 33-22-246, 33-22-514, and 33-22-1811, MCA.

(1)(b) will remain the same.

~~(2) A health maintenance organization may not cancel or terminate an enrollee's coverage for services provided under a health maintenance organization contract without giving the enrollee written notice of cancellation that is effective at least 15 days from the date of mailing or, if not mailed, from the date of delivery and that includes the reason for cancellation. For cancellation due to nonpayment of premium, the grace period as required in (1)(j) of ARM 6.6.2506 applies. A written notice of cancellation is not required to be given for cancellation due to non payment of premium.~~

~~(3)(a)~~(2) A health maintenance organization may not unfairly discriminate against any enrollee or applicant for enrollment on the basis of the age, sex, race, color, creed, national origin, ancestry, religion, marital status, or lawful occupation of an enrollee, ~~or~~ because of the frequency of utilization of services of an enrollee~~.~~, or for any reason prohibited by 33-22-526, MCA.

(b) will remain the same but is renumbered (3).

AUTH: Sec. 33-31-103 and 33-22-1811, MCA
IMP: Sec. 33-18-203, 33-22-1811, 33-31-111(7), 33-31-301(3)(c), and 33-31-312, MCA

6.6.5001 DEFINITIONS For the purposes of this sub-chapter, the following terms have the following definitions:

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

(8) "Eligible employee" means any employee defined in 33-22-1803~~(12)~~(13), MCA. All employees who work an average of 30 hours a week or more shall be considered an eligible employee unless, at the sole discretion of the employer, the insurance contract has specified in an endorsement a different hourly requirement of between 20 and 40 hours a week as contemplated in ARM 6.6.5058(3). An eligible employee does not include an employee who works on a part-time~~,~~ or temporary ~~or substitute~~ basis.

(a) ~~Seasonal employees working less than 9 months a year, but at least 3 months, and who meet the hourly workweek~~

~~requirement may be included as eligible employees at the discretion of the employer~~. "Temporary" means anyone hired to work for less than nine months. At the discretion of the employer, "temporary" employment may be defined for a shorter period.

(b) Officers must be subject to the same eligibility criteria as other employees.

~~(b)~~(c) "Part-time employee~~s~~" means anyone who works less than the hourly requirement of an eligible employee.

(9) and (10) will remain the same.

~~(11) "New entrant" means an eligible employee, or the dependent of an eligible employee, who becomes part of an employer group after the initial period for enrollment in a health benefit plan.~~

~~(12)~~(11) "Risk characteristic" means the health status, claims experience, duration of coverage, or any similar characteristic related to the health status or experience of a small employer group or of any member of a small employer group.

(12) "Renewal date" means the first day of a group health plan year, or the first day of a shorter period if a plan is issued for a period shorter than one year.

(13) will remain the same.

(14) "This subchapter" means ARM Title 6, chapter 6, subchapter 50.

AUTH: Sec. 33-1-313 and 33-22-1822, MCA
IMP: Sec. 33-22-1802, 33-22-1803, and 33-22-1813, MCA

6.6.5004 APPLICABILITY, SCOPE, AND TRANSITION

(1) Except as provided ~~in (2) and ARM 6.6.5062~~elsewhere in this rule, ~~these rules apply~~this subchapter applies to any health benefit plan, whether provided on a group or individual basis which:

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

~~(2) Except as set forth in (3), the provisions of these rules do not apply to an individual health insurance policy delivered or issued for delivery prior to the effective date of these rules.~~

~~(3)~~(2) A carrier that provides individual health insurance policies to one or more of the employees of a small employer ~~must be considered a small employer carrier and must be~~ is subject to ~~the provisions of these rules~~ the act and this subchapter with respect to such policies, if the small employer contributes to the payment or reimbursement of premiums for the policies ~~and the carrier is aware or should have been aware of such contribution~~. The carrier is not considered a small employer carrier if premiums are paid entirely by contributions

from employees. A payroll deduction or list-billed premium arrangement is allowable only if premiums are paid entirely by contributions from employees.

~~(4)~~(3) ~~These rules~~The act and this subchapter do not apply to ~~all~~any health benefit plan~~s~~ provided to a small employer~~s~~ or to the employees of a small employer~~s, without regard to whether the health benefit plans are offered under, or provided through, a group policy or trust arrangement of any size sponsored by an association or employer contributions to premiums paid through cafeteria plans, as defined in section 125 of the Internal Revenue Code, unless excepted by 33-22-1803(25), MCA, or unless~~ if the plan constitutes both a multiple employer welfare arrangement as defined by section 29 USCS 1002(40)(A) and an employee welfare benefit plan under section 29 USCS 1002(1). For applicability of the act and this subchapter to health benefit plans provided through associations, see ARM 6.6.5060.

(5) will remain the same but is renumbered (4).

~~(6)~~(5) An employer ~~group~~ qualifies as a small employer ~~group~~ if it meets the definition of "small employer" in 33-22-1803~~(25)~~, MCA, and employs at least ~~3~~2 but not more than ~~25~~50 eligible employees regardless of whether ~~the~~ each eligible employee intends to enroll in the ~~group's~~ employer's health benefit plan. The number of eligible employees includes every employee who meets the hourly requirement set by the employer as defined in 33-22-1803~~(12)~~, MCA, and ARM 6.6.5001(8). A small employer group must meet a carrier's participation requirement for issuance of a policy.

~~(7)~~(6) If the small employer is issued a health benefit plan ~~under the terms of the act, these rules must~~, the act and this subchapter continue to apply to the health benefit plan in the case that the small employer subsequently employs less than 2 or more than ~~25~~50 eligible employees until the next renewal date. A carrier providing coverage to such an employer shall~~, within 60 days of becoming aware that the employer has more than 25 eligible employees, but no later than the anniversary date of the employer's health benefit plan,~~ notify the employer 60 days prior to the plan renewal date, or, if the carrier becomes aware of such an employer less than 60 days before the plan renewal date, immediately, ~~notify the employer~~ that the protections provided under the act and ~~these rules must~~this subchapter cease to apply to the employer~~ if such employer fails to renew its current health benefit plan or elects to enroll in a different benefit plan~~upon the plan renewal date.

~~(8)~~(7) Subject to (9), ~~I~~if a health benefit plan is issued to an employer that is not a small employer as defined in the act, but subsequently the employer becomes a small employer, ~~these rules must~~the act and this subchapter do not apply to the existing health benefit plan until the next renewal date. The carrier providing a health benefit plan to

such an employer must not become a small employer carrier under these rules solely because the carrier continues to provide coverage under the existing health benefit plan to the employer until the renewal date.

~~(9)~~(8) A carrier providing coverage to an employer described in (7) shall, within 60 days of becoming aware that the employer has ~~32~~ to ~~2550~~ eligible employees, but not later than the next renewal date, notify the employer of the options and protections available to the employer under the act, including the employer's option to purchase a small employer health benefit plan from any small employer carrier.

(9) A carrier providing coverage to an employer described in (7) may continue to provide coverage to the small employer without becoming a small employer carrier, according to the provisions of 33-22-1811(1)(c), MCA, but only if the carrier does not actively market coverage to any small employers. If the carrier does actively market to any small employer, then the carrier is deemed a small employer carrier subject to all the provisions of the act and this subchapter, including guaranteed issue requirements as set forth in [Rule II]. Carriers providing continuing coverage under this subsection must comply with (8).

(10) If a small employer has employees in more than one state, ~~these rules must~~the act and this subchapter apply to any health benefit plans issued to the small employer if:

(10)(a) and (10)(b) will remain the same.

(10)(c) In determining whether the laws of this state or another state apply to a health benefit plan issued to a small employer described in ~~(8)~~(7), the provisions of ~~(8)~~(7) apply as of the date the health benefit plan was issued to the small employer for the period that the health benefit plan remains in effect.

(d) If a health benefit plan is subject to ~~these rules~~ this subchapter, ~~these rules must~~ this subchapter applies to all individuals covered under the health benefit plan, whether they reside in this state or in another state.

(11) A carrier that is not operating as a small employer carrier in this state is not subject to the provisions of ~~these rules~~this subchapter solely because it issued a health benefit plan in another state to a small employer ~~that was issued a health benefit plan in another state by that carrier~~that subsequently moves to this state, until ~~coverage is renewed, extended or modified~~the plan renewal date. However, such a carrier shall, within 60 days of becoming aware that the employer has moved to this state, notify the employer of the options and protections available to the employer under the act, including the employer's option to purchase a small employer health benefit plan from any small employer carrier

authorized to do business in this state.

(12) Carriers offering individual and group health benefit plans in this state are responsible for determining whether the plans are subject to the requirements of the act and this subchapter. Carriers shall elicit the following information from applicants for such plans at the time of application:

(a) Whether any portion of the premium will be paid by or on behalf of a small employer, either directly or through wage adjustments or other means of reimbursement; and

(b) Whether the prospective policyholder, certificate holder, or any proposed insured individual intends to treat the health benefit plan as part of a plan or program for the purposes of sections 106, 125 or 162 of the Internal Revenue Code, and, if so, whether any part of the plan or program is funded by an applicant's small employer.

(13) If a small employer carrier fails to comply with (12), the small employer carrier shall be deemed to be on notice of any information that could reasonably have been attained if the small employer carrier had complied with that section.

AUTH: Sec. 33-1-313 and 33-22-1822, MCA
IMP: Sec. 33-22-1802, 33-22-1804, 33-22-1808, 33-22-1811, and 33-22-1812, MCA

6.6.5008 COVERED SERVICES OF POLICIES UNDER STANDARD PLAN

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

~~(2)(a) Charges in excess of this standard are not required to be included in the calculations under ARM 6.6.5004 and 6.6.5008, unless otherwise excepted in 33-30-102(1), MCA.~~

(2)(b) will remain the same but is renumbered (2)(a).

(3) ~~Standard health benefit plans must include at a minimum coverage for services discussed in (1) and (2) of this rule. Minimum cost sharing benefits for standard plans are specified in ARM 6.6.5020 and 6.6.5024.~~ Small employer carriers may offer a standard plan above the minimum coverage and benefit levels.

AUTH: Sec. 33-1-313 and 33-22-1822, MCA
IMP: Sec. 33-22-1802, ~~33-22-1812~~, and 33-22-1828, MCA

6.6.5024 HMO COST SHARING SCHEDULE AND EXCEPTION TO STANDARD PLAN PROVISIONS

(1) will remain the same.

(2) Standard plans offered by HMOs must offer a comparable level of benefits to a standard plan contemplated in 33-22-1828, MCA and ARM 6.6.5008 ~~and 6.6.5020~~ as determined by the ~~benefit equivalency and~~ benefit value.

AUTH: Sec. 33-1-313 and 33-22-1822, MCA
IMP: Sec. 33-22-1802, 33-22-1812, and 33-22-1828, MCA

6.6.5032 CRITERIA OF POLICIES OFFERED UNDER BASIC PLAN (1) and (2) will remain the same.

~~(3) All basic health benefit plans and basic HMO plans contemplated by 33-22-1827, MCA, must include, but are not limited to the following benefits:~~

~~(a) coverage for services and articles required by 33-22-1521(2), MCA;~~

~~(b) coverage for mental health and chemical dependency required by Title 33, chapter 22, part 7, MCA;~~

~~(c) coverage for conversion of benefits required by 33-22-508 and 33-22-510 or by 33-30-1007, MCA;~~

~~(4)~~(3) All basic health benefit plans and basic HMO plans contemplated by 33-22-1827, MCA, may exclude coverage for services of any category of licensed practitioners and any type of health care service otherwise required by law or rule, except as specified in ~~(3) above~~33-22-1827 and 33-22-1903, MCA. Basic health benefit plans must comply with 49-2-309, MCA.

AUTH: Sec. 33-1-313 and 33-22-1822, MCA
IMP: Sec. 33-22-1802, 33-22-1812, and 33-22-1827, MCA

6.6.5036 CALCULATION OF BENEFIT VALUES (1) For the purposes of determining whether a health benefit plan is a basic health benefit plan under ARM 6.6.5032, a benefit value method may be developed and used by the small employer carrier as contemplated in 33-22-1803(6), MCA. The carrier has the option to use the following computations, together with the values listed, to determine a benefit value for major medical health insurance plans. This calculation may not be used for HMO ~~rule~~health benefit plans. The values in Table I in (1)(d) of this rule may not be used for any health benefit plans with only partial medical coverage, such as hospital-only expense plans or hospital and surgical expense plans. The calculation and its result are subject to review and approval by the commissioner.

(a) will remain the same.

(b) The variables for the formula ~~must be developed in accordance with the following~~are defined as follows:

(1)(b)(i) through (1)(b)(vii) will remain the same.

(c) The following calculation of the benefit value ~~must be made as follows~~may be used:

(1)(c)(i) through (1)(c)(xii) will remain the same.

(d) The following tables, ~~must~~or other tables with actuarially sound values, may be used in calculating benefit

values under this rule:

Table I - Claim Costs by Deductible Amount *

Deductible Amount	Claims Cost	Deductible Amount	Claims Cost	Deductible Amount	Claims Cost
$ 0	$124.83	$ 750	$ 89.29	$ 10,000	$ 24.92
100	119.43	1,000	79.77	15,000	20.56
150	116.82	1,500	68.70	20,000	17.38
200	114.23	2,000	60.42	25,000	15.11
250	111.65	2,500	53.69	50,000	9.36
300	109.08	5,000	35.21	100,000	5.38
500	98.81	7,500	30.07	150,000	2.87

Table II - Utilization Rate by Coinsurance *

Coinsurance	Utilization Rate	Coinsurance	Utilization Rate
100%	1.14	70%	0.93
95%	1.10	65%	0.91
90%	1.07	60%	0.89
85%	1.03	55%	0.87
80%	1.	50% or less	0.86
75%	0.97		

Table III - Lifetime-Maximum Values by Lifetime Maximum Amount *

Lifetime Maximum Amount	Lifetime Maximum Value
$5,000,000 or more	$ 0.23
2,000,000	0.17
1,000,000	0.00
750,000	-0.28
500,000	-0.55
250,000	-1.78
100,000	-7.67
50,000	-13.34
25,000	-21.54

* Values were constructed by the Montana Insurance Department, using the 1994 Tillinghast Group Medical Insurance Rate Manual as a reference.

~~(c) Calculations must be made for each health benefit plan offered by the carrier and compared to the benefit value of the carrier's standard health benefit plan.~~

(2) ~~Filing of basic plans for approval by the department as stipulated in ARM 6.6.5044~~Calculations must be made for the standard health benefit plan and for each basic health benefit plan filed for approval by the commissioner. Each such filing must include a description of the small employer carrier's benefit value method, an actuarial certification that the formula's expected claims costs, utilization rates and values used are based on commonly accepted actuarial assumptions, and the calculation of the benefit values of the carrier's standard and basic plans.

AUTH: Sec. 33-1-313, 33-22-1812, and 33-22-1822, MCA
IMP: Sec. 33-22-1802, 33-22-1809, 33-22-1811, 33-22-1812, and 33-22-1822, MCA

6.6.5050 STATUS OF CARRIERS AS SMALL EMPLOYER CARRIERS - PERMISSION TO REENTER - ANNUAL REPORTING REQUIREMENTS

(1) ~~Any carrier who intends to provide health benefit plans to small employers in this state must file a statement with the commissioner by March 29, 1996 indicating that the carrier intends to operate as a small employer carrier in this state. (Carriers granted status as small group carriers prior to October 1, 1995 do not need to re-notify the commissioner.) Status as a small employer carrier will be granted by the commissioner when the carrier has both a standard and a basic health benefit plan approved by the commissioner.~~

~~(a) Any carrier that has not provided notice to the commissioner regarding an intent to be a small employer carrier by March 29, 1996 shall be considered as opting not to operate as a small employer carrier and subject to the provisions of (3), (4) and (5) of this rule.~~In order to participate in the small employer market, health insurance carriers must:

(a) Have prior approval by the commissioner of at least one basic and one standard health benefit plan for issuance in the small employer market; and

(b) Notify the commissioner of:

(i) All the carrier's health benefit plans intended for use in the small employer market, and the date of approval of all forms used in connection with those plans; and

(ii) The carrier's intent to comply with all provisions of the Small Employer Health Insurance Availability Act, including guaranteed issue requirements for all health benefit plans actively marketed by the carrier.

(2) will remain the same.

~~(3) Except as provided below in (4) no carrier may offer health benefit plans to small employers, or continue to provide coverage under health benefit plans previously issued to small employers in this state, unless the carrier has approved status~~

~~as a small employer carrier.~~

~~(4)~~(3) If a carrier opts ~~not~~ to ~~operate~~discontinue operating as a small employer carrier in this state, the carrier may continue to provide coverage under health benefit plans previously issued to small employers in this state ~~until September 30, 2002~~as provided in 33-22-1811(1)(c), MCA. ~~Such continued small group policies must comply with all other applicable provisions of the act and these rules, except 33-22-1810, 33-22-1813, MCA, and (2) through (4) of this rule. Such continued small group policies must not be amended or benefits or coverage altered unless required to do so by law.~~

~~(5)~~(4) If a small employer carrier opts ~~not to operate as a small employer carrier in this state, the carrier shall be precluded from operating as a small employer carrier in this state for a period of 5 years from the date of notice or March 29, 1996, whichever is earlier. Upon a written request from such a carrier, the commissioner may reduce the period provided for herein, if the commissioner finds that permitting the carrier to operate as a small employer carrier would be in the best interests of the small employers in this state.~~to discontinue offering a particular type or all group health insurance coverage in the small group market, the provisions of 33-22-524 and 33-22-1810, MCA, apply.

~~(a) Carriers who have had no small group health benefit plans in force in Montana since January 1, 1993, and file notice that the carrier does not intend to operate as a small group carrier may choose to declare intent to be a small group carrier at any time.~~

(5) A carrier that has been prohibited from writing coverage for small employers in this state pursuant to 33-22-1810(1)(g), MCA, may not resume offering health benefit plans to small employers in this state until the carrier has received permission from the commissioner to reenter the small employer market as a small employer carrier.

(6) No later than March 1 of each year, each carrier shall file with the commissioner the following information related to health benefit plans issued or marketed by that carrier to small employers in this state:

(a) The number of small employers that were issued health benefit plans in the previous calendar year, indicating the number of newly issued plans and the number of renewals;

(b) The number of small employers that were issued basic health benefit plans and the number of small employers that were issued standard health benefit plans in the previous calendar year, arranged separately, showing the number of newly issued plans and the number of renewals as to each class of business;

(c) The number of small employer health benefit plans in

force in each county of the state as of December 31 of the previous calendar year;

(d) The number of small employer health benefit plans that were voluntarily not renewed by small employers in the previous calendar year;

(e) The number of small employer health benefit plans that were terminated or nonrenewed, for reasons other than nonpayment of premium, by the carrier in the previous calendar year;

(f) The number of small employer health benefit plans that were issued to small employers that were uninsured for at least 3 months prior to issue; and

(g) A list of all health benefit plans being actively marketed by the carrier in the small employer market, together with a list of all form numbers used in connection with those plans and the date of approval for each such form. In the case that a health benefit plan is not being actively marketed, the list must specify the date on which the carrier notified the commissioner that the carrier ceased actively marketing the plan.

AUTH: Sec. 33-1-313, 33-22-143, and 33-22-1822, MCA
IMP: Sec. 33-22-1802, 33-22-1810, 33-22-1811, 33-22-1812, and 33-22-1814, MCA

6.6.5058 REQUIREMENT TO INSURE ENTIRE GROUPS (1) ~~Small employer carriers that offer coverage to small employers shall offer to provide coverage to each eligible employee and to each dependent.~~ A carrier providing health insurance coverage to a small employer shall offer coverage to all eligible employees and their dependents and shall issue coverage to all eligible employees and their dependents who make timely application and who do not waive coverage under (6). Except as provided in (2), such small employer carriers shall provide the same health benefit plan to each such eligible employee and dependent.

(2) Small employer carriers may offer the employees of a small employer the option of choosing among any health plans which have been chosen by the employer. ~~Except as provided in 33-22-1811(3), MCA, with respect to exclusions for pre-existing conditions, t~~The choice among benefit plans may not be limited, restricted, or conditioned based upon the risk characteristics of the employees or their dependents or upon any factors set forth in 33-22-526, MCA.

(3) ~~Small employer carriers may not issue health benefit plans to small employers unless the health benefit plans cover all eligible employees and all eligible dependents as defined in 33-22-1803, MCA, and ARM 6.6.5001. The~~A small employer has the sole discretion, within the parameters of 33-22-1803(13),

MCA and ARM 6.6.5001(8), to define the hourly workweek eligibility criteria as a normal workweek between 20 and 40 hours, ~~so long as~~ provided the criteria is applied uniformly among all employees. If the employer has chosen to define the hourly eligibility as other than 30 hours a week, the employer must sign a contract endorsement stating the following:

(a) the specific hourly employee eligibility requirement with a normal workweek between 20 and 40 hours ~~an average workweek~~;

(b) that all employees have been, and new employees will be, informed of the eligibility requirement;

(c) that the hourly eligibility requirement was not established for the purposes of excluding an employee or dependent of an employee because of the individual's health status, claims experience ~~or~~, risk characteristics, or any factor set forth in 33-22-526, MCA; and

(d) ~~and~~ that the eligibility requirement applies uniformly among all employees.

(4) Part-time and temporary employees may be offered coverage in a small employer group health plan at the discretion of the employer, provided all part-time and temporary employees are treated uniformly and eligibility for coverage is not related to risk characteristics or factors listed in 33-22-526, MCA.

(4) will remain the same but is renumbered (5).

~~(5)~~(6) Small employer carriers shall secure waivers with respect to each eligible employee and each eligible dependent who declines an offer of coverage under a health benefit plan provided to a small employer. Such waivers must be signed by the eligible employees on behalf of such employee or the dependent of such employee and must certify that the individual who declined coverage was informed of the availability of coverage under the health benefit plan. The waiver form may request but must not require that the reason for declining coverage be stated on the form, and must include a written warning of the penalties imposed on late enrollees. Waivers must be maintained by the small employer carrier for a period of 6 years.

~~(6)~~(7) Small employer carriers may not issue coverage to any small employer if the carrier is unable to obtain the list required under ~~(4)~~(5), and the waivers required under ~~(5)~~(6).

(6)(a) and (b) will remain the same but are renumbered (8) and (9).

~~(7) New entrants to a small employer group must be offered an opportunity to enroll in the health benefit plan currently held by such group by the end of 12 months of employment. Any new entrant that does not exercise the opportunity to enroll in the health benefit plan within the~~

~~period provided by the small employer carrier may be treated as a late enrollee by the carrier, provided that the time within which to enroll in the health benefit plan extends at least 30 days after the date the new entrant is notified of his or her opportunity to enroll. If a small employer carrier has offered more than one health benefit plan to a small employer group pursuant to (2), the new entrant must be offered the same choice of health benefit plans as the other members of the group.~~

~~(a) New entrants to a group must be accepted for coverage by the small employer carrier without any restrictions or limitations on coverage related to the risk characteristics of the employees or their dependents, except that a carrier may exclude coverage for pre-existing medical conditions, consistent with the provisions of 33-22-1811(3), MCA.~~

~~(b) Small employer carriers may assess a risk load to the new entrants' premium rate consistent with the requirements of 33-22-1809, MCA. The risk loads must be the same risk load charged to the small employer group immediately prior to acceptance of the new entrant into the group.~~

~~(8) In the case of an eligible employee, or eligible dependent, who, prior to the effective date of 33-22-1811, MCA, or the date a small group carrier receives approved status pursuant to ARM 6.6.5050 and 6.6.5054, was excluded from coverage or denied coverage by a small employer carrier in the process of providing a health benefit plan to an eligible small employer, the small employer carrier shall provide an opportunity for the eligible employee or eligible dependent, to enroll in the health benefit plan currently held by the small employer.~~

~~(a) Small employer carriers may require any individual who requests enrollment under this subsection to sign a statement indicating that such individual sought coverage under the group contract, other than as a late enrollee, and that the coverage was not offered to the individual.~~

~~(b) The opportunity to enroll must meet the following requirements:~~

~~(i) The opportunity to enroll must begin on the effective date of 33-22-1811, MCA, or the date a small group carrier receives approved status pursuant to ARM 6.6.5050 and 6.6.5054 and continue for a period of at least 6 months.~~

~~(ii) Eligible employees and eligible dependents who are provided an opportunity to enroll pursuant to this subsection must be treated as new entrants. Premium rates related to such individuals must be set in accordance with (7).~~

~~(iii) The terms of coverage offered to an individual described in (8) may exclude coverage for pre-existing medical conditions for a period not to exceed 12 months, if the health~~

~~benefit plan currently held by the small employer contains such an exclusion, provided that the exclusion period must be reduced by the number of days between the date the individual was excluded or denied coverage and the date coverage is provided to the individual pursuant to this provision. Exclusion of coverage for a pre-existing medical condition must be waived for the time period that the new enrollee had previous qualifying coverage.~~

~~(iv) Small employer carriers shall provide written notice prior to the opportunity to enroll provided in (8) to each small employer insured under a health benefit plan offered by such carrier. The notice must clearly describe the rights granted under this subsection to employees and dependents who were previously excluded from or denied coverage and the process for enrollment of such individuals in the employer's health benefit plan.~~

AUTH: Sec. 33-1-313, 33-22-143, and 33-22-1822, MCA
IMP: Sec. 33-22-526, 33-22-1802, 33-22-1803, 33-22-1811, and 33-22-1812, MCA

6.6.5060 COVERAGE THROUGH ASSOCIATIONS ~~(1) Associations providing health insurance to small groups must comply with this act and its regulations. Associations are exempt from this act only if they do not deny coverage to any small employer member of the association or any employee of its small employer members who apply for coverage as part of a group.~~

~~(2) Associations must apply to the department for this exemption and submit evidence that their policies are guaranteed issue.~~

~~(3) Associations that have received exemption must provide guaranteed issue policies after January 1, 1995.~~

~~(4) Associations must provide an open enrollment period of 60 days to all employees of member groups currently enrolled with the association's health care plan except those employees previously denied coverage as late enrollees. A notice regarding the open enrollment period must be sent to all member organizations currently enrolled in the association's health care plan, instructing employers to notify employees of the open enrollment period.~~

(1) A bona fide association must:

(a) Meet all the requirements listed in 33-22-1803(8), MCA; for purposes of meeting the requirement of being actively in existence for at least 5 years, activities for that duration must include legitimate trade or association business; and

(b) Make health insurance coverage offered through the association available to all members of the association.

(2) A "non-bona fide association" means an association

which meets the requirements listed in 33-22-1803(8), MCA, except:

(a) The association must have been actively in existence for at least 2 years; and

(b) The association is not required to make health insurance coverage available to all members of the association, except to small employer members.

(3) A health insurance carrier that provides a group health plan to a non-bona fide association must comply with the Small Employer Health Insurance Availability Act with respect to the small employer members of the association. For purposes of the guaranteed issue requirement for small employers in a non-bona fide association, a health insurance carrier must actively market all the carrier's small employer health benefit plans to small employers within a non-bona fide association, and actively market any plan provided to a non-bona fide association's small employers to other small employers not in the association. Small employers may be rated together with other members of a non-bona fide association provided that the rates for the whole group meet the requirements of 33-22-1809, MCA.

(4) Members leaving a bona fide or non-bona fide association are considered to be voluntarily leaving a group, in which case a health insurance carrier insuring the group is not required to guarantee renewal of such members' coverage, unless the policy for the coverage provides for guaranteed renewal.

(5) A health insurance carrier may not issue a group health plan to an association if the association does not meet the requirements of either a bona fide or non-bona fide association.

(6) Bona fide associations and non-bona fide associations may impose a waiting period of up to 12 months before members can enroll in health insurance provided through the association. This initial waiting period may not be counted as a break in creditable coverage.

(7) Bona fide associations and non-bona fide associations may impose a waiting period before members that cancel their membership in an association, or in an association's health insurance coverage, may reenroll in the association's health insurance coverage.

AUTH: Sec. 33-1-313, 33-1-501, and 33-22-1822, MCA
IMP: Sec. 33-22-501, 33-22-1802, and 33-22-1803, MCA

6.6.5078 FAIR MARKETING STANDARDS (1) Small employer carriers shall actively market each of their basic and standard health benefit plans to small employers in this state~~.~~ and

shall comply with the guaranteed availability of coverage and disclosure requirements set forth in [Rule II and Rule III]. Examples of active marketing include, but are not limited to, promotional materials for agents and consumers, marketing classes for agents, direct mail to small businesses, and paid media advertising. Small employer carriers may not suspend the marketing or issuance of the basic and standard health benefit plans except for good cause and with the prior approval of the commissioner. A small employer carrier suspending the marketing and issuance of any small employer plan shall notify the commissioner of such suspension by the suspension date.

(2) will remain the same.

~~(3) Every small employer carrier shall offer at least its basic and standard health benefit plans to any small employer that applies for or makes an inquiry regarding health insurance coverage from the small employer carrier. Such offers may be provided directly to the small employers or delivered through a producer. The offers must be in writing and must include at least the following information:~~

~~(a) A general description of the benefits contained in the basic and standard health benefit plans and any other health benefit plan being offered to the small employer; and~~

~~(b) A description how the small employer may enroll in the plans~~.

(4) and (5) will remain the same but are renumbered (3) and (4).

~~(6) If a small employer carrier denies coverage under a plan that is not a basic or standard health benefit plan, the denial must be in writing and must state with specificity the reasons for the denial, subject to any restrictions related to confidentiality of medical information.~~

~~(a) The written denial must be accompanied by a written explanation of the availability of the basic and standard health benefit plans from the small employer carrier. The explanation must include at least the following:~~

~~(i) A general description of the benefits contained in each such plan;~~

~~(ii) A price quote for each such plan; and~~

~~(iii) Written advice as to how the small employer may enroll in such plans.~~

~~(b) The written information must be provided within the time periods provided in (4) directly to the small employer and can be delivered through an authorized producer.~~

~~(c) Price quotes required under this subsection must be for the lowest priced basic and standard health benefit plan for which the small employer is eligible. Availability of other basic and standard plans must be described in the price quotes.~~

(7) will remain the same but is renumbered (5).

~~(8) Carriers offering individual and group health benefit plans in this state must be responsible for determining whether the plans are subject to the requirements of the act and these rules.~~

~~(9) No later than March 1 of each year, all small employer carriers shall file with the commissioner, the following information related to health benefit plans issued by them to small employers in this state:~~

~~(a) The number of small employers that were issued health benefit plans in the previous calendar year, indicating the number of newly issued plans and the number of renewals;~~

~~(b) The number of small employers that were issued basic health benefit plans and the number of small employers that were issued standard health benefit plans in the previous calendar year, arranged separately, showing the number of newly issued plans and the number of renewals as to each class of business;~~

~~(c) The number of small employer health benefit plans in force in each county of the state as of December 31 f the previous calendar year;~~

~~(d) The number of small employer health benefit plans that were voluntarily not renewed by small employers in the previous calendar year;~~

~~(e) The number of small employer health benefit plans that were terminated or nonrenewed, for reasons other than nonpayment of premium, by the carrier in the previous calendar year; and~~

~~(f) The number of small employer health benefit plans that were issued to small employers that were uninsured for at least 3 months prior to issue.~~

AUTH: Sec. 33-1-313 and 33-22-1822, MCA
IMP: Sec. 33-22-1802, 33-22-1809, 33-22-1812, and 33-22-1813, MCA

6.6.5090 RATE MANUAL AND RATE RESTRICTION GUIDELINES

(1) will remain the same.

~~(2) Small employer carriers may not modify the rating method or any characteristics used in the rate manual for a class of business, until the change has been approved by the commissioner.~~

~~(a) The commissioner may approve a change to a rating method if the commissioner finds that the change is reasonable, actuarially supported, and consistent with the purposes of the act.~~

~~(b) A carrier requesting to change the rating method for a class of business shall file a request with the commissioner~~

~~for authority to modify the rating method at least 30 days prior to the proposed date of the change. The filing must contain at least the following information:~~

~~(i) The reasons the change in rating method is being requested;~~

~~(ii) A complete description of each of the proposed modifications to the rating method;~~

~~(iii) A description how the proposed change in rating method would affect the premium rates currently charged to small employers in the class of business, including an estimate from premium rates may change by more than 10% due to the proposed change in rating method. This estimate must include a narrative description of the types of groups and individuals whose premium rates may change by more than 10%;~~

~~(iv) A certification from a qualified actuary that the proposed rating method is based on objective and credible data and would be actuarially sound and appropriate; and~~

~~(v) A certification from a qualified actuary that the proposed change in rating method would not produce premium rates for small employers that would be in violation of 33-22-1809, MCA.~~

~~(3) For the purpose of this rule, a change in rating method includes the following:~~

~~(a) A change in the number of case characteristics used by a small employer carrier to determine premium rates for health benefit plans in a class of business;~~

~~(b) A change in the manner or procedures by which insured are assigned into categories for the purpose of applying a case characteristic to determine premium rates for health benefit plans in a class of business;~~

~~(c) A change in the method of allocating expenses among health benefit plans in a class of business; or~~

~~(d) A change in a rating factor with respect to any case characteristic if the change would produce a change in premium for any small employer that exceeds 10%.~~

~~(i) For the purpose of this subsection, a change in a rating factor involves the cumulative change with respect to such factor over a 12 month period.~~

~~(ii) If a small employer carrier changes rating factors with respect to more than one case characteristic in a 12 month period, the carrier shall consider the cumulative effect of all such changes in applying the 10% test under this subsection.~~

(4) through (14)(b) will remain the same but are renumbered (2) through (12)(b).

AUTH: Sec. 33-1-313 and 33-22-1822, MCA
IMP: Sec. 33-22-1802, 33-22-1809, and 33-22-1812, MCA

3. The rules proposed for repeal provide as follows:

6.6.5020 DEDUCTIBLE CHARGES, COINSURANCE, MAXIMUM ALLOWABLE OUT-OF-POCKET CHARGES, AND LIFETIME MAXIMUM BENEFIT LEVEL UNDER THE STANDARD PLAN found at page 6-1113 of the Administrative Rules of Montana (ARM).

AUTH: Sec. 33-1-313 and 33-22-1822, MCA; IMP: Sec. 33-22-1802, 33-22-1812, and 33-22-1828, MCA

6.6.5028 CONTRACT LANGUAGE found at page 6-1115 of the ARM.

AUTH: Sec. 33-1-313 and 33-22-1822, MCA; IMP: 33-22-1802 and 33-22-1812, MCA

6.6.5044 FILING AND APPROVAL OF BASIC AND STANDARD PLANS found at page 6-1121 of the ARM.

AUTH: Sec. 33-1-313, 33-1-501, and 33-22-1822, MCA; IMP: Sec. 33-22-1802, 33-22-1811, and 33-22-1812, MCA

6.6.5054 APPLICATION TO REENTER STATE found at page 6-1127 of the ARM.

AUTH: Sec. 33-1-313 and 33-22-1822, MCA; IMP: Sec. 33-22-1802, 33-22-1810, and 33-22-1812, MCA

6.6.5062 RESTORATION OF COVERAGE found at page 6-1133 of the ARM.

AUTH: Sec. 33-1-313 and 33-22-1822, MCA; IMP: Sec. 33-22-1802, 33-22-1809, 33-22-1812, and 33-22-1814, MCA

6.6.5066 QUALIFYING PREVIOUS AND QUALIFYING EXISTING COVERAGES found at page 6-1134 of the ARM.

AUTH: Sec. 33-1-313 and 33-22-1822, MCA; IMP: Sec. 33-22-1802, 33-22-1810, 33-22-1811, and 33-22-1812, MCA

6.6.5070 CONSIDERATION OF TRADE, OCCUPATION, OR INDUSTRY IN DECIDING WHETHER TO OFFER COVERAGE found at page 6-1137 of the ARM.

AUTH: Sec. 33-1-313 and 33-22-1822, MCA; IMP: Sec. 33-22-1802, 33-22-1809, 33-22-1811, and 33-22-1812, MCA

6.6.5074 RESTRICTIVE RIDERS found at page 6-1137 of the ARM.

AUTH: Sec. 33-1-313 and 33-22-1822, MCA; IMP: Sec. 33-22-1802, 33-22-1811, and 33-22-1812, MCA

4. The new rules proposed for adoption provide as follows:

RULE I OPPORTUNITIES FOR INDIVIDUALS TO ENROLL IN SMALL GROUP PLANS (1) Upon the inception of a small group health plan all eligible employees and their dependents, and thereafter all new eligible employees and their dependents, must be offered an opportunity to enroll in the plan. Any waiting period prior to enrollment may not exceed twelve months. If a small employer carrier issues more than one health benefit plan to a small employer group pursuant to ARM 6.6.5058(2), all eligible employees must be offered the same choice of health benefit plans as the other members of the group.

(2) Except as provided in (3), eligible employees who do not enroll during an initial enrollment opportunity as described in (1), provided that the opportunity lasted at least 30 days, may be considered late enrollees. A carrier may not exclude a late enrollee from coverage for more than 18 months from the date of the late enrollee's application. Any exclusion from coverage must be coordinated with any preexisting condition exclusion as set forth in 33-22-1811(3)(c), MCA.

(3) Eligible individuals who meet the requirements set forth in 33-22-140(17)(a), (b) or (c) which provides exceptions to late enrollee status, or who qualify for a special enrollment period under 33-22-523, MCA, are not considered late enrollees. Individuals qualifying for special enrollment must be given an opportunity to enroll according to the terms of 33-22-523, MCA. Eligible individuals who are not late enrollees under the terms of 33-22-140(17)(a), (b) or (c), MCA, must be given opportunities to enroll as set forth in (1), and the enrollment period must extend at least 30 days.

(4) On or before the time an employee is offered an initial opportunity to enroll in a group health plan, the plan is required to provide the employee with a description, as set forth in [Rule X(3)] of the plan's special enrollment rules. Additionally, the plan shall provide at the same time a description of opportunities to enroll under 33-22-140(17)(a), (b) or (c), MCA, and as a late enrollee.

AUTH: Sec. 33-22-143 and 33-22-1822, MCA
IMP: Sec. 33-22-140, 33-22-523, 33-22-526, and 33-22-1811, MCA

RULE II GUARANTEED AVAILABILITY OF COVERAGE IN THE SMALL GROUP MARKET - GUARANTEED ISSUE REQUIREMENTS - EXCEPTIONS (1) Except for coverage offered only through a bona fide

association, and subject to (2), (3), and (4), each small group carrier that offers health insurance coverage in the small group market must offer, to any small employer in the state, all products that are approved for sale in the small group market and that the issuer is actively marketing, and must accept any small employer that applies for any of those products.

(2) A small employer carrier is not required to issue coverage to a small group employer that does not meet the minimum participation and contribution requirements of the carrier, as permitted by 33-22-1811(3)(d), MCA. However, solely for the purpose of meeting participation requirements, carriers may not consider as part of the group of eligible employees those otherwise eligible employees who waive coverage under the plan because they are covered under other health insurance. If a carrier refuses to issue any plan to a small employer on the basis that the small employer does not meet participation or contribution requirements, the carrier may not issue any other plan to the small group employer.

(3) A small employer carrier is not required to issue coverage in circumstances set forth in 33-22-1811(4), MCA. In the event that a small employer carrier denies coverage to a small employer under that section and is prevented from offering coverage for 180 days, the responsibilities of the small employer carrier to renew existing coverage pursuant to 33-22-524 and 33-22-1810, MCA, continue.

(4) A small employer carrier may not issue coverage to a small employer under circumstances described in 33-22-1811(3)(e)(iv), MCA.

(5) For purposes of this rule, "product" refers to a health benefit plan, and includes all contract provisions included in the contract language for a health benefit plan issued to a small group employer.

AUTH: Sec. 33-22-1822, MCA
IMP: Sec. 33-22-1811, MCA

RULE III DISCLOSURE OF INFORMATION (1) In connection with the offering of any health insurance coverage to a small employer, a small employer carrier is required to:

(a) Make a reasonable disclosure to the employer, as part of its solicitation and sales materials, of the availability of the information described in (2) of this rule for all plans marketed by the carrier; and

(b) Upon request of the employer, provide that information to the employer.

(2) Information that must be provided under (1)(b) of this rule is:

(a) Information required in 33-22-1810(4), MCA;
(b) A description of benefits in summary form;
(c) The rate or rating schedule that applies to the plan. If the plan has options with respect to the length or existence of preexisting condition waiting periods or affiliation periods, information regarding rates under those options must be provided;
(d) The minimum employer contribution and group participation rules that apply; and
(e) In the case of a network plan, a map or listing of counties served and a list of providers in the network.

AUTH: Sec. 33-22-1822, MCA
IMP: Sec. 33-22-1802, 33-22-1809(4), and 33-22-1811, MCA

RULE IV PREEXISTING CONDITIONS - PERMISSIBLE RESTRICTIONS IN SMALL GROUPS (1) Eligible employees and their dependents making timely application must be accepted for coverage in a small employer's group health plan without any restrictions or limitations on coverage related to risk characteristics of the eligible individuals, except as provided in 33-22-1811(3), MCA, and this rule.
(2) A preexisting condition exclusion must relate to a condition based on presence of a condition for which medical advice, diagnosis, care or treatment was recommended or received by the participant or beneficiary within the 6-month period ending on the enrollment date as defined in 33-22-140, MCA. Medical advice, diagnosis, care, or treatment may be taken into account only if it is recommended by, or received from, an individual licensed or similarly authorized to provide such services under the laws of this state and operating within the scope of practice authorized by this state. A negative diagnosis does not constitute medical advice, diagnosis, care, or treatment for purposes of determining whether there is a preexisting condition.
(3) A preexisting exclusion period may not extend for more than 12 months, or 18 months in the case of a late enrollee, after the effective date of the individual's coverage.
(4) Exclusionary riders are not permitted.
(5) A small group plan must not impose a preexisting exclusion more restrictive than those allowed in 33-22-514, MCA.
(6) The following may not be excluded as a preexisting condition:
(a) Genetic information in the absence of diagnosis of the condition related to the genetic information;
(b) Pregnancy;

(c) Adopted children as set forth in 33-22-130, MCA; and
(d) Newborns as set forth in 33-22-504, MCA.
(7) A health benefit plan must waive any time period permitted for a preexisting exclusion under this rule by applicable periods of creditable coverage as set forth in 33-22-1811(3)(b) and 33-22-141, MCA.
(8) Small group carriers are required to give prior notice of the imposition of a preexisting exclusion period as set forth in [Rule IX (6)].

AUTH: Sec. 33-22-1822, MCA
IMP: Sec. 33-22-1811, MCA

RULE V SMALL EMPLOYER HEALTH INSURANCE SUBJECT TO GENERAL HEALTH INSURANCE AND GROUP RULES (1) Unless otherwise specified in Title 33, chapter 22, part 18, MCA, or this subchapter, small employer carriers and small employer health plans are subject to applicable statutes in Title 33, chapter 22, MCA. Those sections include, but are not limited to, provision regarding:
(a) Definitions in 33-22-140, MCA;
(b) Crediting previous coverage and issuing certificates of creditable coverage in 33-22-141 and 33-22-142, MCA;
(c) Special enrollment periods in 33-22-523, MCA;
(d) Guaranteed renewability in the group market at 33-22-524, MCA; and
(e) Prohibiting discrimination in the group market at 33-22-526, MCA.

AUTH: Sec. 33-22-143 and 33-22-1822, MCA
IMP: Sec. 33-22-140, 33-22-141, 33-22-142, 33-22-523, 33-22-524, 33-22-526, and 33-22-1802, MCA

RULE VI TRANSITION IN LARGE AND SMALL GROUP HEALTH PLANS TO CHANGES UNDER HEALTH INSURANCE PORTABILITY ACCOUNTABILITY ACT (HIPAA) IN MONTANA LAW (1) Group health insurance plans and health insurance coverage offered in connection with group health plans for group health plan and health insurance coverage contracts issued or renewed after June 30, 1997, are subject to the following sections of the Montana Code Annotated (MCA) regarding:
(a) Representations in applications at 33-15-402, MCA;
(b) Prohibiting against preexisting condition exclusions for adopted children at 33-22-130, MCA;
(c) Definitions at 33-22-140, MCA;
(d) Creditable coverage at 33-22-141, MCA;
(e) Issuing certificates of coverage at 33-22-142, MCA;
(f) Preexisting condition exclusions in the group market

at 33-22-514, MCA;

(g) Special enrollment periods at 33-22-523, MCA;

(h) Guaranteed renewability requirements at 33-22-524, MCA;

(i) Guaranteed renewability in multiple employer welfare arrangements at 33-22-525, MCA;

(j) Discrimination in group health insurance at 33-22-526, MCA;

(k) Prohibitions against preexisting condition exclusions for newborns at 33-22-504(1), MCA;

(l) Definitions under the Small Employer Health Insurance Availability Act at 33-22-1803, MCA;

(m) The applicability and scope of the Small Employer Health Insurance Availability Act at 33-22-1804(1)(d) and (3), MCA;

(n) Guaranteed issue of all small group plans at 33-22-1811(1), MCA. These requirements are further defined in [Rule II];

(o) Rules for preexisting condition exclusions in small group plans at 33-22-1811(3)(a)(i) and (b), MCA;

(p) Regarding the requirements for small employer carriers to offer or provide coverage under certain circumstances at 33-22-1811(4), MCA;

(q) Prohibiting preexisting condition exclusions in plans issued by health service corporations at 33-30-1001, MCA;

(r) The definition of an "affiliation period" for health maintenance organizations at 33-31-102(1), MCA;

(s) Health maintenance organizations being subject to 33-22-141, 33-22-142, 33-22-514, 33-22-523, 33-22-524 and 33-22-526, MCA, at 33-31-111(6), MCA; and

(t) Affiliations periods in health maintenance organizations at 33-31-307, MCA.

(2) A group health plan issued or renewed after June 30, 1997 must provide an open enrollment period for the purpose of providing an opportunity to enroll in the plan to those persons who previously may have been excluded from coverage, or discouraged from participating, for reasons now prohibited under any statute listed in (1). The period shall commence at the time the plan is issued or renewed and last not less than 30 days after eligible employees and their dependents are notified of the enrollment opportunity as set forth in (3).

(3) Small employer carriers must provide written notice prior to the opportunity to enroll set forth in (2) to each small employer insured under a health benefit plan offered by such carrier. The notice must clearly describe the enrollment rights required by this rule to all eligible employees and dependents not currently covered under the plan. Carriers are not required to send this notice to each eligible employee or

dependent, but must obtain written proof from the employer that each eligible individual has been notified.

(4) A group health plan renewing after June 30, 1997 must remove any remaining preexisting exclusion periods for any covered individual to the extent that those preexisting conditions conflict with 33-22-130, 33-22-504, 33-22-514 or 33-22-1811(3), MCA, as applicable. Additionally, any preexisitng exclusion periods permitted under 33-22-514 or 33-22-1811(3), MCA, must be reduced by any creditable coverage periods, assuming the application of creditable coverage held by an individual as of the individual's enrollment date, regardless of whether the enrollment date occurred before or after a plan's renewal date.

(5) A small employer carrier that has not previously complied with the guaranteed issue requirements set forth in [Rule II] must comply with those provisions with respect to any small employers for whom the carrier is providing health insurance coverage as of July 1, 1997 by following the disclosure requirements set forth in [Rule III] with respect to those small employers.

(6) In order to continue operating as a small employer carrier, each health insurance carrier that was approved as a small employer carrier prior to [the effective date of these rules] must make a submission in accord with ARM 6.6.5050(1)(b) by April 1, 1998.

AUTH: Sec. 33-1-313, 33-22-143, and 33-22-1822
IMP: Sec. 33-22-141, 33-22-514, 33-22-526, and 33-22-1811, MCA

RULE VII CREDITABLE COVERAGE AND METHODS OF COUNTING

(1) Periods of creditable coverage must be counted for individuals previously covered under any health coverage set forth in 33-22-140(4)(a), MCA, and for coverage under the association plan or the association portability plan as set forth in Title 33, chapter 22, part 15, MCA.

(2) For purposes of reducing any preexisting condition exclusion period, as provided under 33-22-514 and 33-22-1811, MCA, a group health plan, and a health insurance issuer offering group health coverage, must determine the amount of an individual's creditable coverage by using the standard method described in (3), except that the plan, or issuer, may use the alternative method under (4) with respect to any or all of the categories of benefits described under (4)(b).

(3) Under the standard method, a group health plan, and a health insurance issuer offering group health insurance coverage, shall determine the amount of creditable coverage without regard to the specific benefits included in the

coverage.

(a) Subject to (4)(d), for purposes of reducing the preexisting condition exclusion period, a group health plan, and a health insurance issuer offering group health insurance coverage, shall determine the amount of creditable coverage by counting all the days that the individual has under one or more types of creditable coverage. Accordingly, if on a particular day, an individual has creditable coverage from more than one source, all the creditable coverage on that day is counted as one day. Further, any days in a waiting period for a plan or policy are not creditable coverage under the plan or policy.

(i) Days of creditable coverage that occur before a significant break in coverage are not required to be counted.

(ii) A significant break in coverage means a period of 63 consecutive days during all of which the individual does not have any creditable coverage, except that neither a waiting period nor an affiliation period is taken into account in determining a significant break in coverage.

(iii) Notwithstanding any other provisions of (3), for purposes of reducing a preexisting condition exclusion period using the standard method, but not for purposes of issuing a certificate under [Rule VIII], a group health plan, and a health insurance issuer offering group health insurance coverage, may determine the amount of creditable coverage in any other manner that is at least as favorable to the individual as the method set forth in (3), subject to the requirements of other applicable law.

(4) Under the alternative method, a group health plan, or a health insurance issuer offering group health insurance coverage, shall determine the amount of creditable coverage based on coverage within any category of benefits described in (4)(b) and not based on coverage for any other benefits. The plan or issuer may use the alternative method for any or all of the categories. The plan may apply a different preexisting condition exclusion period with respect to each category, and may apply a different preexisting condition exclusion period for benefits that are not within any category. The creditable coverage determined for a category of benefits applies only for purposes of reducing the preexisting condition exclusion period with respect to that category. An individual's creditable coverage for benefits that are not within any category for which the alternative method is being used is determined under the standard method of (3).

(a) A plan or issuer using the alternative method is required to apply it uniformly to all participants and beneficiaries under the plan or policy. The use of the alternative method must be set forth in the plan.

(b) The alternative method for counting creditable coverage

may be used for coverage for any of the following categories of benefits:

(i) Mental health;

(ii) Substance abuse treatment;

(iii) Prescription drugs;

(iv) Dental care;

(v) Vision care;

(c) If the alternative method is used, the plan is required to:

(i) State prominently that the plan is using the alternative method of counting creditable coverage in disclosure statements concerning the plan, and state this to each enrollee at the time of enrollment under the plan; and

(ii) Include in these statements a description of the effect of using the alternative method, including an identification of the categories used.

(d) With respect to health insurance coverage offered by an issuer in the small or large group market, if the insurance coverage uses the alternative method, the issuer shall state prominently in any disclosure statement concerning the coverage, and to each employer at the time of the offer or sale of the coverage, that the issuer is using the alternative method, and include in such statements a description of the effect of using the alternative method. This applies separately to each type of coverage offered by the health insurance issuer.

(e) Statements under (4)(c) and (d) must be in writing.

(f) Under the alternative method, the group health plan or issuer must count creditable coverage within a category if any level of benefits is provided within the category. Coverage under a reimbursement account or arrangement, such as a flexible spending arrangement (as defined in section 106(c)(2) of the Internal Revenue Code), does not constitute coverage within any category. In counting an individual's creditable coverage under the alternative method, the group health plan, or issuer, shall first determine the amount of the individual's creditable coverage that may be counted under (3), up to a total of 365 days of the most recent creditable coverage (546 days for a late enrollee in the case of an individual in a small group plan). The period over which this creditable coverage is determined is referred to as the "determination period". Then, for the category specified under the alternative method, the plan or issuer must count within the category all days of coverage that occurred during the determination period (whether or not a significant break in coverage for that category occurs), and must reduce the individual's preexisting condition exclusion period for that category by that number of days. The plan or issuer may

determine the amount of creditable coverage in any other reasonable manner, uniformly applied, that is at least as favorable to the individual.

AUTH: Sec. 33-22-143 and 33-22-1822, MCA
IMP: Sec. 33-22-141, MCA

RULE VIII CERTIFICATION OF CREDITABLE COVERAGE - GROUPS AND INDIVIDUALS (1) A group health plan, and each health insurance issuer offering group health insurance coverage under a group health plan, is required to issue certificates of creditable coverage in accordance with 33-22-142, MCA, and this rule. A health insurance issuer offering health insurance coverage in the individual market is required to issue certificates of creditable coverage in accordance with this rule, notwithstanding references in this rule to "group health plan" and "plan".

(2) Certificates required under 33-22-142(1)(a) and (b), MCA, must be mailed or hand-delivered to the individual within a reasonable time. Certificates provided under 33-22-142(1)(c), MCA, must be mailed or hand-delivered within 7 days of the receipt of the request by the plan or the health insurance issuer or a designee of either.

(3) No automatic written certificate of creditable coverage is required to be provided to an individual if:

(a) An individual is entitled to receive a certificate;

(b) The individual requests that the certificate be sent to another plan or issuer instead of to the individual; and

(c) The plan or issuer that would otherwise receive the certificate agrees to accept the information through means other than a written certificate (for example, by telephone or electronic mail).

(4) The certification must contain:

(a) The date the certificate is issued;

(b) The name of the group health plan that provided the coverage described in the certificate;

(c) The name of the participant or dependent with respect to whom the certificate applies, and any other information necessary for the plan providing the coverage specified in the certificate to identify the individual, such as the individual's identification number under the plan and the name of the participant if the certificate is for, or includes, a dependent;

(d) The name, address, and telephone number of the plan administrator or issuer required to provide the certificate, and the telephone number to call for further information regarding the certificate; and

(e) Either:

(i) A statement that an individual has at least 18 months (for this purpose, 546 days is deemed to be 18 months) of creditable coverage, disregarding days of creditable coverage before a significant break in coverage; or

(ii) The date any waiting period (and affiliation period, if applicable) began and the date creditable coverage began;

(iii) The date creditable coverage ended, unless the certificate indicates that creditable coverage is continuing as of the date of the certificate; and

(iv) Information required under 33-22-142, MCA.

(5) If an individual requests a certificate under 33-22-142(1)(c), MCA, a certificate must be provided for each period of continuous coverage ending within the 24-month period ending on the date of the request, or continuing on the date of the request. A separate certificate may be provided for each such period of continuous coverage.

(6) A certificate may provide information with respect to both a participant and the participant's dependents if the information is identical for each individual or, if the information is not identical, certificates may be provided on one form if the form provides all the required information for each individual and separately states the information that is not identical.

(7) The certificate must be provided to each covered individual or to an entity requesting the certificate on behalf of an individual. The certificate may be provided by first-class mail. If the certificate or certificates are provided to the participant and the participant's spouse at the participant's last known address, then the requirement is satisfied with respect to all individuals residing at that address. If a dependent's last known address is different than the participant's last known address, a separate certificate must be provided to the dependent at the dependent's last known address. If separate certificates are being provided by mail to individuals who reside at the same address, separate mailings of each certificate are not required.

(8) A plan or issuer must establish a procedure for individuals to request and receive certificates under 33-22-142(1)(c), MCA.

(9) If an automatic certificate is required to be provided, and the individual entitled to receive the certificate designates another individual or entity to receive the certificate, the plan or issuer responsible for providing the certificate is permitted to provide the certificate to the designated party. If a certificate is required to be provided upon request and the individual entitled to receive the certificate designates another individual or entity to receive the certificate, the plan or issuer responsible for providing

the certificate is required to provide the certificate to the designated party.

(10) A plan or issuer is required to use reasonable efforts to determine any information needed for a certificate relating to the dependent coverage. In any case in which an automatic certificate is required to be furnished, no individual certificate is required to be furnished until the plan or issuer knows, or making reasonable efforts should know, of the dependent's cessation of coverage under the plan.

(11) Issuers of group and individual health insurance are required to provide certificates of any creditable coverage they provide in the group or individual health insurance market, even if the coverage is provided in connection with an entity or program that is not itself required to provide a certificate because it is not subject to the group market provisions of the Health Insurance Portability and Accessability Act, PL 104-191 and Title 33, chapter 22, MCA. However, a certificate is not required to be provided with respect to short-term limited duration insurance that is not provided in connection with a group health plan.

(12) If the accuracy of a certificate is contested or a certificate is unavailable when needed by an individual, the individual has the right to demonstrate creditable coverage (and waiting or affiliation periods) through the presentation of documents or other means. For example, the individual may make such a demonstration when:

(a) An entity has failed to provide a certificate within a reasonable or required time period;

(b) The individual has creditable coverage but an entity may not be required to provide a certificate of the coverage;

(c) The coverage is for a period before July 1, 1996;

(d) The individual has an urgent medical condition that necessitates a determination before the individual can deliver a certificate to the plan; or

(e) The individual lost a certificate that the individual had previously received and is unable to obtain another certificate.

(13) In case of an individual attempting to demonstrate creditable coverage under (12), a plan or issuer is required to take into account all information that it obtains or that is presented on behalf of an individual to make a determination, based on the relevant facts and circumstances, whether an individual has creditable coverage and is entitled to offset all or a portion of any preexisting condition exclusion period. A plan or issuer shall treat the individual as having furnished a certificate if the individual attests to the period of creditable coverage, the individual also presents relevant corroborating evidence of some creditable coverage during the

period, and the individual cooperates with the plan's or issuer's efforts to verify the individual's coverage. For this purpose, cooperation includes providing, upon the plan's or issuer's request, a written authorization for the plan or issuer to request a certificate on behalf of the individual, and cooperating in efforts to determine the validity of the corroborating evidence and the dates of creditable coverage. While a plan or issuer may refuse to credit coverage where the individual fails to cooperate with the plan's or issuer's efforts to verify coverage, the plan or issuer may not consider an individual's inability to obtain a certificate to be evidence of the absence of creditable coverage.

(14) In the absence of a certificate, documents which may establish creditable coverage under (12), including categories of creditable coverage and waiting or affiliation periods, include explanations of benefit claims (EOB) or other correspondence from a plan or issuer indicating coverage, pay stubs showing a payroll deduction for health coverage, a health insurance identification card, a certificate of coverage under a group health policy, records from medical care providers indicating health coverage, third party statements verifying periods of coverage, and any other relevant documents that evidence periods of health coverage. The information may also be established through means other than documentation, such as by a telephone call from the plan or provider to a third party verifying creditable coverage.

(15) If, in the course of providing evidence, including a certificate, of creditable coverage, an individual is required to demonstrate dependent status, the group health plan or issuer must treat the individual as having furnished a certificate showing the dependent status if the individual attests to such dependency and the period of such status and the individual cooperates with the plan's or issuer's efforts to verify the dependent status.

(16) In the event that a group health plan or health insurance issuer offering group health insurance coverage receives a certification of creditable coverage, information regarding categories of coverage, or through the alternative method set forth in (12), the entity must, within a reasonable time period following receipt of the information, make a determination regarding the individual's period of creditable coverage and notify the individual in writing of the determination. Whether a determination and notification regarding an individual's creditable coverage is made within a reasonable time period is determined based on the relevant facts and circumstances. Relevant facts and circumstances include whether a plan's application of a preexisting condition exclusion would prevent an individual from having access to

urgent medical services.

(17) A plan or issuer seeking to impose a preexisting condition exclusion is required to disclose to the individual, in writing, its determination of any preexisting condition exclusion period that applies to the individual, and the basis for such determination, including the source and substance of any information on which the plan or issuer relied. In addition, the plan or issuer is required to provide the individual with a written explanation of any appeal procedures established by the plan or issuer, and with a reasonable opportunity to submit additional evidence of creditable coverage. However, nothing in this rule prevents a plan or issuer from modifying an initial determination of creditable coverage if it determines that the individual did not have the claimed creditable coverage, provided that:

(a) A notice of the reconsideration is provided to the individual; and

(b) Until the final determination is made, the plan or issuer, for purposes of approving access to medical services (such as a pre-surgery authorization), acts in a manner consistent with the initial determination.

(18) If an individual's coverage under an issuer's policy ceases before the individual's coverage under the plan ceases, the issuer is required to provide sufficient information to the plan, or to another party designated by the plan, to enable a certificate to be provided by the plan (or other party), after cessation of the individual's coverage under the plan, that reflects the period of coverage under the policy. The provision of that information to the plan will satisfy the issuer's obligation to provide certification under 33-22-142(1)(a) and (b), MCA. In addition, an issuer providing that information is required to cooperate with the plan in responding to any request relating to the alternative method of counting creditable coverage, and to any request made by an individual pursuant to 33-22-142(1)(c), MCA.

(19) This section of this rule applies to establishing creditable coverage for dependents only through June 30, 1998. A group health plan or health insurance issuer that cannot provide the names of dependents, or related coverage information, for purposes of providing a certificate of coverage for a dependent may satisfy the requirements to do so by providing the name of the participant covered by the group health plan or health insurance issuer and specifying that the type of coverage described in the certificate is for dependent coverage, such as family coverage or employee-plus-spouse coverage. For purposes of certificates provided on the request of, or on behalf of, an individual under 33-22-142(1)(c), MCA, a plan or issuer must make reasonable efforts to obtain and

provide the names of any dependent covered by the certificate where such information is requested to be provided. If it does not include the name of any dependent of an individual covered by the certificate, the individual may, if necessary, use the procedures described in (12) for submitting documentation to establish that the creditable coverage in the certificate applies to the dependent.

AUTH: Sec. 33-22-142(3)(v) and 33-22-143, MCA
IMP: Sec. 33-22-142, MCA

RULE IX PREEXISTING CONDITIONS - PERMISSIBLE RESTRICTIONS IN GROUP PLANS OTHER THAN SMALL EMPLOYER PLANS (1) A group health plan or a health insurance issuer offering group health insurance coverage may not exclude coverage for a preexisting condition except as set forth in 33-22-514, MCA, and this rule.

(2) For purposes of a preexisting condition exclusion, medical advice, diagnosis, care, or treatment may be taken into account only if it is recommended by, or received from, an individual licensed or similarly authorized to provide such services under the laws of this state and operating within the scope of practice authorized by this state. A negative diagnosis does not constitute medical advice, diagnosis, care, or treatment for purposes of determining whether there is a preexisting condition.

(3) A preexisting condition exclusionary period may not exceed more than 12 months after the enrollment date, including exclusionary periods for late enrollees.

(4) Exclusionary riders are not permitted.

(5) The following may not be excluded as a preexisting condition:

(a) Genetic information in the absence of diagnosis of the condition related to the genetic information;

(b) Pregnancy;

(c) Adopted children as set forth in 33-22-130, MCA; and

(d) Newborns as set forth in 33-22-504, MCA.

(6) A group health plan, and health insurance issuer offering group health insurance under the plan, may not impose a preexisting condition exclusion with respect to a participant or dependent of the participant before notifying the participant, in writing, of the existence and terms of any preexisting condition exclusion under the plan and of the rights of individuals to demonstrate creditable coverage (and any applicable waiting periods). The description of the rights of individuals to demonstrate creditable coverage includes a description of the right of the individual to request a certificate from a prior plan or issuer, if necessary, and a statement that the current plan or issuer will assist in

obtaining a certificate from any prior plan or issuer, if necessary.

AUTH: Sec. 33-22-143, MCA
IMP: Sec. 33-22-514, MCA

RULE X SPECIAL ENROLLMENT PERIODS (1) If an employee or dependent makes a timely request for enrollment under 33-22-523(1), MCA, enrollment must be effective not later than the first day of the first calendar month beginning after the date the completed request for enrollment is received.

(2) Special enrollment opportunities must be provided for the following individuals under 33-22-523(2), MCA:

(a) An employee, if the individual is an employee who is eligible, but not enrolled in the plan, and the individual would be a participant but for a prior election by the individual not to enroll in the plan during a previous enrollment period, and a person becomes a dependent of the individual through marriage, birth, or adoption or placement for adoption;

(b) A spouse of an employee, if the individual becomes the spouse of a participant, or if the individual is a spouse of the participant and a child becomes a dependent of the participant through birth, adoption, or placement for adoption;

(c) An employee who is eligible, but not enrolled, in the plan, and a spouse of such employee, if the employee would be a participant but for a prior election by the employee not to enroll in the plan during a previous enrollment period, and either:

(i) The employee and the individual become married; or

(ii) The employee and individual are married and a child becomes a dependent of the employee through birth, adoption or placement for adoption;

(d) An individual who becomes a dependent of a participant through marriage, birth, or adoption or placement for adoption; and

(e) An employee who is eligible, but not enrolled, in the plan, and an individual who is a dependent of the employee, if the employee would be a participant but for a prior election by the employee not to enroll in the plan during a previous enrollment period, and the dependent becomes a dependent of the employee through marriage, birth, or adoption or placement for adoption.

(3) On or before the time an employee is offered the opportunity to enroll in a group health plan, the plan is required to provide the employee with a description of the plan's special enrollment rules under 33-22-523, MCA, and this rule. For this purpose, the plan may use the following model

description of the special enrollment rules:

(a) "If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption."

(4) A special enrollment date for an individual means any date on which the individual has a right to have enrollment in a group health plan become effective under 33-22-523, MCA.

AUTH: Sec. 33-22-143, MCA
IMP: Sec. 33-22-523, MCA

RULE XI OPPORTUNITIES FOR INDIVIDUALS TO ENROLL IN GROUP PLANS OTHER THAN SMALL EMPLOYER PLANS (1) Upon issuance of a group health plan all eligible employees and their dependents, and thereafter all new eligible employees and their dependents, must be offered an opportunity to enroll in the plan. Any waiting period prior to enrollment may not exceed 12 months.

(2) Except as provided in (3), eligible employees who do not enroll during an initial enrollment opportunity as described in (1), provided that the opportunity lasted at least 30 days, may be considered late enrollees. A health insurance carrier or group health plan must afford late enrollees and opportunity to enroll at least annually.

(3) Eligible individuals who meet the requirements set forth in 33-22-140(17)(a), (b) or (c), MCA, which provides exceptions to late enrollee status, or who qualify for a special enrollment period under 33-22-523, MCA, are not considered late enrollees. Opportunities to enroll individuals qualifying for special enrollment must be given according to the terms of 33-22-523, MCA. Eligible individuals who meet the criteria set forth in 33-22-140(17)(a), (b) or (c), MCA, must be given opportunities to enroll as set forth in that section.

(4) On or before the time an employee is offered an initial opportunity to enroll in a group health plan, the plan is required to provide the employee with a description, as set forth in [Rule X(3)] of the plan's special enrollment rules. Additionally, the plan shall provide at the same time a description of opportunities to enroll under 33-22-140(17)(a), (b) or (c), MCA, and as a late enrollee.

AUTH: Sec. 33-1-313 and 33-22-143, MCA

IMP: Sec. 33-22-140, 33-22-523, and 33-22-526, MCA

RULE XII TRANSITION IN INDIVIDUAL MARKET TO CHANGES UNDER HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) UNDER MONTANA LAW (1) An individual health insurance policy issued or renewed after June 30, 1997 must remove any remaining preexisting exclusion periods for any covered individual to the extent that those preexisting exclusions conflict with 33-22-246, MCA.

AUTH: Sec. 33-22-143, MCA
IMP: Sec. 33-22-246, MCA

RULE XIII PREEXISTING CONDITIONS IN THE INDIVIDUAL MARKET - DISCLOSURE (1) A health insurer offering individual health insurance coverage may not limit coverage for a preexisting condition except as set forth in 33-22-246, MCA, and this rule. Additionally, the following provisions prohibit or limit preexisting condition exclusions for:

(a) Newborns (33-22-301, MCA);
(b) Adopted children (33-22-130, MCA); and
(c) Genetic conditions (33-18-206(4), MCA).

(2) For purposes of a preexisting condition exclusion, medical advice, diagnosis, care or treatment may be taken into account only if it is recommended by, or received from, an individual licensed or similarly authorized to provide such services under the laws of this state and operating within the scope of practice authorized by this state. A negative diagnosis does not constitute medical advice, diagnosis, care, or treatment for purposes of determining whether there is a preexisting condition.

(3) A health insurance carrier may not impose a preexisting condition exclusion on a covered individual before notifying the individual, in writing, of the existence and terms of any preexisting condition exclusion and of the individual's right to demonstrate any qualifying previous coverage as provided for in 33-22-242, MCA.

AUTH: Sec. 33-1-313 and 33-22-143, MCA
IMP: Sec. 33-18-206(4), 33-22-130, 33-22-246, and 33-22-301, MCA

RULE XIV CERTIFICATION OF CREDITABLE COVERAGE ISSUED BY INSURERS IN THE INDIVIDUAL MARKET (1) Insurers providing health insurance coverage in the individual market must issue certificates of creditable coverage as set forth in 33-22-142(6), MCA and [Rule VIII].

AUTH: Sec. 33-22-143, MCA
IMP: Sec. 33-22-142(6), MCA

5. REASON: In 1996 Congress passed Public Law 104-191, the Health Insurance Portability and Accountability Act [HIPAA]. That Act contained requirements for health insurance carriers and group health plans regarding health insurance accessability and portability. The act allowed states a choice of whether to implement the requirements for insurers and health plans and enforce those requirements through state insurance departments, or to allow the federal government to enforce the act directly. Montana elected to adopt most of the provisions of HIPAA and to enforce those provisions through the Insurance Commissioner's office, a department of the state auditor. Montana's version of HIPAA was Senate Bill 378, enacted into law in 1997.

These proposed amendments and new rules implement provisions of SB378 by amending existing sections of current rules to conform with the new statutory amendments and by creating new rules to clarify and provide necessary details regarding the new statutes. In many cases language from federal rules implementing HIPAA are proposed where the new Montana statutes closely parallel the federal statutory language. Those federal rules are found at 45 CFR Subtitle A (regarding group health insurance) and 45 CFR Part 148 (regarding individual health insurance). With respect to changes in the individual health insurance market, states had the option of imposing HIPAA requirements on all health insurance carriers, or of implementing any one of several "alternative mechanisms." Montana chose to implement an alternative mechanism which entailed creation of an insuring mechanism attached to the current "Comprehensive Health Association Plan," commonly known as the "high risk pool." This mechanism, the "portability plan," is not addressed in these proposed amendments and rules, but may be the subject of proposed rules at a later date. Only those few provisions of the new statutes which relate to all insurance carriers operating in the individual market are the subject of amendments and rules in this notice. The majority of these proposals relate to the large and small group health insurance markets.

In addition to the rule changes described above, this notice includes a number of housekeeping amendments which involve corrections and style changes. Further, a few changes to rules previously passed pursuant to the Small Employer Health Insurance Availability Act are amended in cases where the rules unnecessarily repeat statutory language.

The principal reasons for each proposed amendment follows.

6.6.2503 and 6.6.2504 contain housekeeping amendments to health maintenance organization [HMO] rules deleting references to statutory subsections that have been renumbered.

6.6.2506 adds to existing requirements the new requirement to disclose any affiliation period in an HMO contract or evidence of coverage. This is necessary to conform with new provisions for affiliation periods created in 33-31-307, MCA.

6.6.2507 clarifies that HMO contracts and evidences of coverage may no longer contain "reasonable" preexisting condition exclusions, but must conform to the preexisting exclusion limitations as set forth in 33-22-246, MCA, (regarding the individual market), 33-22-514, MCA, (regarding the group market) and 33-22-1811, MCA, (regarding the small group market).

6.6.5001 amends the existing definition rule by deleting references to obsolete subsections of statutes, and substantively as follows:

In order to meet guaranteed issue and other small group insurance requirements under SB378, an insurance carrier must determine whether an employer to which it is marketing a group health plan is a "small employer" as set forth in the definition of "small employer" at 33-22-1803(24), MCA. In order to do this, the carrier must determine the number of the employer's "eligible employees". Hence, the term "eligible employee" must be clarified, which is done in (8). These proposed amendments to that subsection delete reference to "substitute" as a type of employee because it is redundant with "temporary" employee. Reference to "seasonal employees" in (8)(a) is deleted for the same reason. "Temporary" is further defined as anyone who works less than nine months per year. New (8)(b) is added to clarify that officers are subject to the same eligibility requirements as regular employees.

Subsection (11) referring to "new entrants" is proposed for deletion. The existing rules created a new type of eligible employee called a "new entrant." This entity is not necessary to implement the statutes and creates confusion. Hence, the term is deleted here in the definition section and in later rules addressing it substantively.

New (12) defines "renewal date" consistently with federal regulation. This definition is necessary because Section 52 of SB378 makes many of the statutory changes in that act applicable to health insurance plans upon the plan's "renewal date" that occurs after July 1, 1997. Additionally, other substantive rules in this part refer to "renewal date."

New (14) clarifies the reference to "this subchapter".

6.6.5004 modifies the existing rule clarifying when the Small Employer Health Insurance Availability Act is applicable to conform with new 33-22-1804(3), MCA. That new subsection

makes certain individual health insurance policies subject to small group law. Existing (2) of the rule is deleted because it conflicts with the new statutory section. New (2) contains housekeeping changes and deletes language about carriers responsibilities to determine whether an employer makes certain contributions. The carrier's responsibilities in this regard are addressed in more detail in new (12) and (13). Old (3) deletes repetitive statutory language, and adds a reference to a new proposed rule amendment (6.6.5060) clarifying applicability of the act to coverage under associations. Old (6) changes certain words to conform with statutory language. Sections (6) through (9) clarify a carrier's responsibilities when the number of employees in a group changes during a coverage period resulting in the group moving in or out of the small group market. Subsections (10) and (11) contain language clarifications.

6.6.5008 deletes language in (2)(a) which is no longer meaningful, and in (3) which is redundant of language in (1) and (2).

6.6.5024(2) is modified to refer to the relevant statute and to delete reference to a rule which is proposed for deletion.

6.6.5032(3) is proposed for deletion because it repeats statutory language. Existing (4) is modified to refer to relevant statutes and not to (3) which is proposed for deletion.

6.6.5036(1) changes a word error. The balance of the modifications to (1) are designed to provide that the actuarial methods used by a carrier are optional to the carrier, as opposed to being mandated by the rule. Subsection (2) currently refers to 6.6.5044 which is proposed for repeal, so the amendment substitutes language which still requires carriers to file their calculations without reference to the repealed rule.

6.6.5050 proposes deletion of obsolete language and clarifies what a carrier must do in order to market and issue health insurance plans in the small group market, including how to move out of the small group market. The changes in (1) through (5) are intended to clarify how insurers can comply with requirements to have certain plans approved (33-22-1811, MCA), how to move in and out of the small group market (33-22-1810, 1811, MCA), and to provide a mechanism for the commissioner to know which carriers are operating in the small group market and which products they have available for guaranteed issue (in compliance with 33-22-1811, MCA). New (6) contains existing language moved from ARM 6.6.7078, as well as a new (g) requiring carriers to report annually their forms and actively marketed plans in the small group market. This latter new section will enable the commissioner to determine whether carriers are complying with guaranteed issue and other small

group requirements.

6.6.5058 is amended in order to clarify, in one rule, the requirements of insurers with respect to insuring all members of a small group as required by existing language in 33-22-1811, MCA, and new language in 33-22-526, MCA. Some changes simply reword existing language. Sections (7) and (8) are proposed for deletion because they use the concept of "new entrant," which is not a statutory concept and does not serve to clarify or better implement the statutes. Rather, (1) and (3)(b) are modified to make it clear that the requirements to insure entire groups extend to individuals who join the group, or become new employees, after a group insurance plan is issued. New (4) is added to clarify the option of coverage for part-time or temporary employees. Similar language is currently in the definitions at 6.6.5001(8)(a), but is being proposed for deletion there because it is substantive and not definitional. The new subsection also clarifies that any coverage opportunities afforded such employees must comply with the new non-discrimination requirements of 33-22-526, MCA. Existing (5) is modified to be consistent with language in 33-22-1811(3)(e)(iii), MCA, which allows a carrier to enquire as to an individual's reasons for rejecting coverage.

6.6.5060 proposes changing the way health insurance coverage is provided through associations in order to comply with the new definition of "bona fide association" at 33-22-1803, MCA, and with guaranteed issue and other new statutory requirements under SB378. Under the existing rule, associations had to apply to the commissioner for exemptions from small group requirements. The exemption is no longer required, as the statutes and this proposed rule amendment will be self-executing. Additionally, the new definition of "bona fide association" creates one type of association which is generally exempt from small group requirements. However, existing language in 33-22-501(2), MCA, still refers to an "association," and deems health insurance coverage through associations to be "group" insurance. This reference is thought to include non-bona fide associations, although there is no statutory definition of such associations. The amendments to this rule seek to clarify the differences between bona fide and non-bona fide associations and to set forth how they and carriers providing health coverage through them must comply with various relevant sections of existing law and new law under SB378.

6.6.5078 currently conforms with previous law under which small employer carriers were only required to guarantee issue of a basic and standard plan. Proposed amendments would generally bring the rule into conformance with the new all products guarantee issue requirements in 33-22-1811(1)(b), MCA.

Additionally, (8) and (9) are proposed for deletion and placement more appropriately elsewhere in the rules at 6.6.5004(12) and 6.6.5050(6).

6.6.5090(2) is deleted because 33-22-1809(6) no longer allows the commissioner to approve rates. Subsection (3) is deleted because it clarifies language in (2) which is proposed for deletion.

The principal reasons for each proposed repeal follows.

6.6.5020 is proposed for repeal because it unnecessarily repeats statutory language.

6.6.5028 is proposed for repeal because it is unnecessary.

6.6.5044 is proposed for repeal because it is outdated in part and redundant with statute in part. The outdated language refers to a transitional time when the Small Employers' Health Insurance Availability Act had just passed.

6.6.5054 is proposed for repeal because it unnecessarily repeats statutory language.

6.6.5062 generally concerns health insurance coverage for small employers during the transition period after the Small Employers Health Insurance Availability Act was passed in 1993. The transition period has passed, so the rule is deemed obsolete and is thus proposed for repeal.

6.6.5066 dealt with "qualifying coverage" which is a term that has been replaced in the new statutes by "creditable coverage." Hence, this rule is obsolete and is being replaced by new proposed rule VII regarding crediting coverage.

6.6.5070 is being repealed because it adds nothing beyond the statutory language and it contemplates a small employer carrier's option to deny coverage to a small employer, which is not optional under new language in 33-22-1811, MCA.

6.6.5074 is proposed for repeal because it refers to a transition period after the initial adoption of the small employer rules, a period which is now passed. A similar but updated transition rule regarding restrictive riders is proposed in new rule XI regarding transition to the statutes in SB378.

The principal reasons for the proposed new rules follows.

Rule I is designed to bring together in one rule various code references pertaining to eligible individuals enrolling in small group health plans in order to facilitate carrier compliance. Some of these provisions are in the small group law at 33-22-1811, MCA, but others appear in the general insurance disability definitions at 33-22-140(17), MCA, and in the provisions for large groups at 33-22-523, MCA. Additionally, this section contains language that appears in current rules scheduled for repeal regarding the twelve month limitation on waiting periods. Subsection (4) requires carriers to notify eligible plan participants of later

enrollment opportunities so that those persons who deny coverage initially will be aware of their opportunities to enroll at a later date.

Rule II clarifies that small employer carriers must offer coverage on a guaranteed issue basis in the small group market. New language in 33-22-1811(1)(b), MCA, allowed carriers to do issue underwriting on all but standard and basic plans provided "Public Law 104-191, an agency of the United States, or a court does not prohibit a small employer carrier from doing so...." Federal regulations clarifying Public Law 104-191 indicate that that act requires an "all products guarantee" in the small group market, so the rule is necessary to clarify that PL104-191 does not permit underwriting in the issuance of any plan in that market. (See 45 CFR 146.150.) In addition, the proposed rule sets forth circumstances under Montana law in which small employer carriers are not required, or are prohibited from, issuing coverage to small employers, and clarifies the meaning of the term "product" so that carriers will know what must be guaranteed issue.

Rule III sets forth disclosure requirements necessary to enforce the guaranteed issue requirements described in Rule II. The language is largely drawn from federal regulation 25 CFR 146.160.

Rule IV describes permissible preexisting restrictions in the small group market. Statutory restrictions appear in many code sections in Title 33, including some sections that are not in the Small Employer Health Insurance Availability Act. Those sections are all noted here in order to facilitate small employer carrier compliance with all relevant provisions. Additionally, language in (2) clarifies, consistent with the federal regulations implementing the same statutory language in PL 104-191 language (see 25 CFR 146.111), that medical attention must be given by an individual properly authorized under state law in order for it to be considered for preexisting condition purposes. Other language in that section clarifies that a negative diagnosis shall not operate as a preexisting condition trigger.

Rule V is proposed to clarify that small employer carriers are subject to other general provisions of Title 33, and to highlight those new sections outside of the Small Employer Health Insurance Availability Act with which carriers must come into compliance.

Rule VI provides for the transition in the group health market between law in existence prior to the passage of SB378 and afterward. All merely transitional features are brought together in one rule for ease of repeal once the transition time has passed. Generally, carriers that were in the small employer market before the new laws will have to take certain

actions with respect to their forms, plans, and those employers and individuals they are currently covering to come into compliance. This rule sets forth those actions. Transitional requirements in both large and small group markets with respect to nondiscrimination and preexisting condition limitations are also set forth.

Rule VII sets forth the details of how creditable coverage must be taken into consideration and counted so that carriers will know how to comply with the statutory requirements. 33-22-141, MCA, pertaining to creditable coverage, refers twice to regulations under PL104-191. The language largely parallels federal regulation pursuant to PL104-191 at 25 CFR 146.113.

Rule VIII sets forth necessary details of how carriers must provide certificates of creditable coverage and how individuals may obtain certificates and prove creditable coverage in the absence of certificates. The rule largely parallels the related federal regulation at 25 CFR 146.115, which is itself a lengthy rule. Insurance carriers often operate in several states and other states' rules on this subject are likely to parallel the federal rule. Hence the length is thought to be justified by the consistency of rules in various states.

Rule IX describes permissible preexisting restrictions in the large group market. Statutory restrictions appear in many code sections in Title 33, including sections not in parts relating solely to group health coverage. Those sections are all noted here in order to facilitate carrier compliance with all relevant provisions. Additionally, language in (2) clarifies, consistent with the federal regulations implementing the same statutory language in PL 104-191 language (see 25 CFR 146.111), that medical attention must be given by an individual properly authorized under state law in order for it to be considered for preexisting condition purposes. Other language in that section clarifies that a negative diagnosis shall not operate as a preexisting condition trigger.

Rule X provides necessary detail to enable carriers to determine how to comply with special enrollment period requirements under 33-22-523, MCA. The rules contain language from 25 CFR 146.117.

Rule XI is designed to bring together in one rule various code references pertaining to opportunities for eligible individuals enrolling in non-small group health plans in order to facilitate carrier compliance. Additionally, this section contains language that appears in current rules scheduled for repeal regarding the twelve month limitation on waiting periods. Subsection (4) requires carriers to notify eligible plan participants of later enrollment opportunities so that those persons who decline coverage initially will be aware of

their opportunities to enroll at a later date.

Rule XII provides for the transition in the individual market between law in existence prior to the passage of SB378 and afterward. Generally, carriers covering individuals at the time the new laws affect them will have to take certain actions with respect to preexisting condition exclusions and this rule sets forth those actions.

Rule XIII describes permissible preexisting restrictions in the individual market. Statutory restrictions appear in many code sections in Title 33, including sections not in parts relating solely to individual health coverage. Those sections are all noted here in order to facilitate carrier compliance with all relevant provisions. Additionally, language in (2) clarifies, consistent with the federal regulations implementing the same statutory language in PL 104-191 language (see 25 CFR 146.111), that medical attention must be given by an individual properly authorized under state law in order for it to be considered for preexisting condition purposes. Other language in that section clarifies that a negative diagnosis shall not operate as a preexisting condition trigger.

XIV clarifies that carriers in the individual market must issue certificates of creditable coverage in the same manner as carriers in the group market. A rule clarifying this is necessary because the statutory provision mandating the issuance of such certificates in the individual market only appears in a code section, 33-22-142, MCA, which is not in provisions directly relating to the individual market.

6. 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 Russell B. Hill and must be received no later than February 20, 1998.

7. The State Auditor's Office will make reasonable accommodations for persons with disabilities who wish to participate in this public hearing. If you require an accommodation, contact the office no later than 5:00 p.m., February 6, 1998, to advise us as to the nature of the accommodation needed. Please contact Sandi Binstock at 126 North Sanders, Mitchell Building, Room 270, Helena, Montana, 59620; telephone (406) 444-1744; Montana Relay 1-800-332-6148; TDD (406) 444-3246; facsimile (406) 444-3497. Persons with disabilities who need an alternative accessible format of this document in order to participate in this rule-making process should contact Sandi Binstock.

8. Claudia Clifford has been designated to preside over

and conduct the hearing.

9. The State Auditor's Office maintains a list of interested persons who wish to receive notices of rulemaking actions proposed by this agency. Persons who wish to have their name added to the list shall make a written request which includes the name and mailing address of the person to receive notices and specifies whether the person wishes to receive notices regarding insurance rules, securities rules, or both. Such written request may be mailed or delivered to the State Auditor's Office, P.O. Box 4009, Helena, MT 59604, faxed to the office at 406-444-3497, or may be made by completing a request form at any rules hearing held by the State Auditor's Office.

10. The both bill sponsor notice requirements of section 2-4-302, MCA, apply and have been complied with.

MARK O'KEEFE, State Auditor
and Commissioner of Insurance

By: _____
Frank Coté
Deputy Insurance Commissioner

By: _____
Russell B. Hill
Rules Reviewer

Certified to the Secretary of State December 30, 1997.

BEFORE THE STATE AUDITOR AND COMMISSIONER OF INSURANCE
OF THE STATE OF MONTANA

In the matter of the amendment of Rule 6.6.4001 pertaining to the valuation of securities other than those specifically referred to in statutes.	)))))	NOTICE OF PROPOSED AMENDMENT NO PUBLIC HEARING CONTEMPLATED

TO: All Interested Persons:

1. On February 17, 1998, the State Auditor and Commissioner of Insurance proposes to amend Rule 6.6.4001 pertaining to the valuation of securities other than those specifically referred to in statutes.

2. The proposed rule amendments are as follows (new material is underlined; material to be deleted is interlined):

6.6.4001 VALUATION OF SECURITIES OTHER THAN THOSE SPECIFICALLY REFERRED TO IN STATUTES (1) Securities and assets must be valued in accordance with valuation standards of the NAIC published in its 1997 ~~1996~~ Accounting Practices and Procedures manual and its December 31, 1997 ~~1996~~ Valuation of Securities manual.

(2) The department hereby adopts and incorporates herein by reference the standards adopted by the NAIC for valuation of securities and other investments appearing in its 1997 ~~1996~~ Accounting Practices and Procedures manual and its December 31, 1997 ~~1996~~ Valuation of Securities manual. These are nationally-recognized models for such standards. Copies of the manuals are available for inspection at the office of the Commissioner of Insurance, Room 270, Sam W. Mitchell Building, Helena, Montana. Copies of the Accounting Practices and Procedures manual and the Valuation of Securities manual may be obtained by writing to the National Association of Insurance Commissioners, 120 West 12th Street, Suite 1100, Kansas City, MO 64105-1925. Persons obtaining copies of such manuals may be required to pay the NAIC's costs of providing such copies.

AUTH: 33-1-313, 33-2-533, and 33-2-1517, MCA
IMP: 33-2-533 and 33-2-1517, MCA

3. Rule 6.6.4001 is being amended because the manuals referenced are updated on an annual basis and are being changed to incorporate the most current manual.

4. Interested parties may submit their data, views or arguments concerning the proposed amendment in writing to Russell B. Hill, Montana Insurance Department, P.O. Box 4009, Helena, Montana 59604, and must be received no later than February 17, 1998.

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 a written request for a hearing and submit this request along with any written comments he has to Russell B. Hill, Montana Insurance Department, P.O. Box 4009, Helena, Montana 59604. A written request for hearing must be received no later than February 17, 1998.

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 action; 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 30 persons based on the 300 persons who have indicated interest in the rules of this agency and who the agency has determined could be directly affected by these rules.

7. The State Auditor's Office maintains a list of interested persons who wish to receive notices of rulemaking actions proposed by this agency. Persons who wish to have their name added to the list shall make a written request which includes the name and mailing address of the person to receive notices and specifies whether the person wishes to receive notices regarding insurance rules, securities rules, or both. Such written requests may be mailed or delivered to the State Auditor's Office, P.O. Box 4009, Helena, MT 59604, faxed to the office at 406-444-3497, or may be made by completing a request form at any rules hearing held by the State Auditor's Office.

MARK O'KEEFE, State Auditor
and Commissioner of Insurance

By _____
Frank Coté
Deputy Insurance Commissioner

_____
Russell B. Hill
Rules Reviewer

Certified to the Secretary of State on January 2, 1998.

BEFORE THE BOARD OF CHIROPRACTORS
DEPARTMENT OF COMMERCE
STATE OF MONTANA

In the matter of the proposed amendment of rules pertaining to applications, examination requirements, temporary permit, renewals, unprofessional conduct and the adoption of a new rule pertaining to endorsement	NOTICE OF PUBLIC HEARING ON THE PROPOSED AMENDMENT AND ADOPTION OF RULES PERTAINING TO THE PRACTICE OF CHIROPRACTIC

TO: All Interested Persons:

1. On February 17, 1998, at 9:00 a.m., a public hearing will be held in the Division of Professional and Occupational Licensing conference room, Lower Level, Arcade Building, 111 North Jackson, Helena, Montana, to consider the proposed amendment and adoption of rules pertaining to the practice of chiropractic.

2. The proposed amendment of ARM 8.12.601, 8.12.603, 8.12.604, 8.12.606 and 8.12.607 will read as follows: (new matter underlined, deleted matter interlined)

"8.12.601 APPLICATIONS (1) through (7) will remain the same.

~~(8) An application must be received in the board office 21 days in advance of the board's next regularly scheduled meeting. Applications received after this deadline will be held for consideration at the next regularly scheduled board meeting.~~

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

(a) will remain the same.

(b) a certified copy of examination results sent directly from the national board of chiropractic examiners (NBCE), parts I and II, including physiotherapy, ~~and~~ part III and part IV; and

(c) will remain the same.

~~(10) Effective January 1, 1997, all applicants shall be required to submit evidence of having passed part IV of the NBCE.~~"

Auth: Sec. 37-1-131, 37-12-201, MCA; IMP, Sec. 37-1-131, 37-12-302, 37-12-304, 37-12-305, MCA

REASON: The amendment of (9)(b) is being proposed to add Part IV of the examination as required by statute. The deletion of (8) is being proposed because the state no longer offers a board examination so the application deadline has become obsolete. Subsection (10) is being proposed for deletion because the time frame in the rule has elapsed and the subsection is obsolete.

"8.12.603 EXAMINATION REQUIREMENTS (1) The board accepts as its approved method of examination, parts I and II, including physiotherapy, ~~and~~ part III and part IV of the national board of chiropractic examiners (NBCE) examination. In addition, the applicant must pass the state ~~clinical proficiency examination and the state~~ jurisprudence examination. ~~The applicant will not be required to take the state clinical proficiency examination if part IV (clinical proficiency), of the NBCE, has been taken and passed.~~ Effective January 1997, the board will require passage of part IV of the NBCE, and will no longer administer the state clinical proficiency examination.

~~(2) An applicant scoring less than 60% on any branch of the state examination will be required to retake only that section(s).~~"

Auth: Sec. 37-1-131, 37-12-201, MCA; IMP, Sec. 37-12-304, MCA

REASON: The amendment of (1) is being proposed to add Part IV to comply with current licensing requirements. The deleted material relates to the state clinical proficiency examination, which the board no longer administers. Subsection (2) is being proposed for deletion because the national examination pass rate is determined by the testing agency and, therefore, the rule is obsolete.

"8.12.604 TEMPORARY PERMIT (1) Temporary permit applicants ~~must show evidence of having completed parts I through III of the NBCE and~~ may be issued a permit under 37-1-305(2), MCA, while waiting to take either part IV ~~or the state practical examination~~ of the NBCE or the special purposes examination for chiropractors (SPEC). The permit shall requires the permit holder to practice under the on-premises supervision of a chiropractor licensed in the state of Montana.

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

Auth: Sec. 37-1-319, 37-12-201, MCA; IMP, Sec. 37-12-305, MCA

REASON: This amendment is being proposed because the Board determined that the rule needed substantially more clarity for purposes of alerting applicants to the necessary requirements and also to alert applicants to the examination requirements which must be satisfied to obtain licensure within the state.

"8.12.606 RENEWALS - CONTINUING EDUCATION REQUIREMENTS

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

(3) For the period beginning September 1, 1997 through September 1, 2000, inclusive, the board is requiring each licensee to demonstrate successful completion of a professional boundary continuing education course. The course shall be a minimum of four hours in length and will be in addition to the 12-hour annual requirement. Each licensee will be required to complete the course once during that time period.

(3) through (7) will remain the same, but will be renumbered (4) through (8)."

Auth: Sec. 37-1-134, 37-1-141, 37-1-319, 37-12-201, 37-12-307, MCA; IMP, Sec. 37-1-134, 37-1-306, 37-1-319, 37-12-307, MCA

REASON: This amendment is being proposed because the Board recognizes an increasing number of complaints and inquiries regarding the issue of professional boundaries between doctors and patients. Accordingly, the Board will require this one-time course and then will review the necessity of continuing with further instruction based on the complaints received.

"8.12.607 UNPROFESSIONAL CONDUCT For the purpose of implementing the provisions of ~~37-12-321(14)~~ 37-1-316, MCA, the board further defines ~~"conduct unbecoming a person licensed to practice chiropractic or detrimental to the best interests of the public"~~ unprofessional conduct as follows:

(1) ~~Using or causing to be used advertising matter which contains misstatements, falsehoods, misrepresentations, distorted and fabulous statements relative to cures, or in the wording of such advertisement any matter which may in any way reflect against a fellow licensee. Personal advertising in any media which deals with the particular abilities, features or accomplishments of the individual licensees or which either directly or by implication makes promise of a cure, offers free examination or consultations, claims special techniques or methods, or implies superiority, in any manner over other licensees or other licensed health sciences shall be prima facie evidence of unethical conduct. Documentation showing sufficient training by the licensee in the specialty area, shall be presented to the board before advertising the specialty. Business type announcements should be limited to who, what and where.~~ using or causing to be used advertising matter which contains:

(a) misstatements, falsehoods, misrepresentations or distorted and fabulous statements relative to cures or treatments;

(b) statements which may in any way reflect against a fellow licensee including statements which imply superiority over another licensee or health care professional; or

(c) personal advertising claiming particular abilities, features or accomplishments regarding the licensee or areas of specialty practice unless documentation of such abilities, features, accomplishments or specialties are documented with the board prior to placing the advertisement.

(2) through (5) will remain the same, but the ending periods will be changed to semi-colons.

~~(6) Submitting to any third party payer a claim for a service or treatment that contains a fee or charge greater than the customary or usual fee or outside the range of fees, the licensee customarily or usually charges for that type of service or treatment when rendered without third party reimbursement.~~

(7) and (8) will remain the same, but will be renumbered (6) and (7), and the ending periods will be changed to semi-colons.

~~(9) Directly referring a patient to a person located in Montana who is not licensed or not regulated by the state of Montana.~~

~~(10) Defaming another chiropractor by falsely imputing dishonorable conduct or by falsely disparaging his or her business or practice methods.~~

(11) will remain the same, but will be renumbered (8), and the ending period will be changed to a semi-colon.

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

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

~~(13) Having had a license to practice chiropractic or any related health care discipline in another state or foreign country disciplined or voluntarily surrendered for any of the above specified conduct.~~

(10) falsifying, altering or making incorrect essential entries or failing to make essential entries of patient records;

(11) violating any state, federal, provincial, or tribal statute or administrative rule governing or affecting the professional conduct of any licensee;

(12) providing professional services while impaired by dangerous drugs or controlled substances;

(13) failing to obtain an appropriate consultation or make an appropriate referral when the problem of the patient is beyond the licensee's training, experience or competence;

(14) failing to render adequate supervision, management, training, or control of auxiliary staff or other persons, including preceptors, temporary permit holders and/or licensees practicing under the licensee's supervision or control according to generally accepted standards of practice;

(15) failing to cooperate with a board inspection or investigation in any material respect."

Auth: Sec. ~~37-12-201~~, 37-1-319, 37-1-131, MCA; IMP, Sec. ~~37-12-321, 37-12-322~~, 37-1-307, 37-1-308, 37-1-309, 37-1-311, 37-1-312, MCA

REASON: These amendments are being proposed because the Board has determined that further clarity is required for some subsections. The deletion of subsections is proposed because the statute adequately describes the proscribed conduct and need not be repeated in the rule.

3. The proposed new rule will read as follows:

"I ENDORSEMENT (1) In order to receive a license by endorsement, license applicants shall provide proof of equal credentials from the current licensing state. In instances where applicant cannot demonstrate equal credentials, the applicant may obtain a license upon successful passage of the SPEC examination administered by the NBCE."

Auth: Sec. 37-12-201, MCA; IMP, Sec. 37-12-305, MCA

REASON: The Board is proposing this rule to clarify the analytical process utilized by the board in evaluating applications for licensure by out-of-state applicants and provide guidance so that applicants are adequately informed regarding the expectations required of them.

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 the Board of Chiropractors, 111 North Jackson, P.O. Box 200513, Helena, Montana 59620-0513, or by facsimile, number (406) 444-1667, to be received no later than the close of hearing on February 17, 1998.

5. R. Perry Eskridge, attorney, has been designated to preside over and conduct this hearing.

6. The Department of Commerce will make reasonable accommodations for persons with disabilities who wish to participate in this public hearing. If you wish to request an accommodation, contact the Department no later than 5:00 p.m., February 10, 1998, to advise us of the nature of the accommodation that you need. Please contact Cheryl Smith, Board of Chiropractors, 111 N. Jackson, P.O. Box 200513, Helena, Montana 59620-0513; telephone (406) 444-5433; Montana Relay 1-800-253-4091; TDD (406) 444-2978; facsimile (406) 444-1667. Persons with disabilities who need an alternative accessible format of this document in order to participate in this rule-making process should contact Cheryl Smith.

7. Persons who wish to be informed of all Board of Chiropractors administrative rulemaking proceedings or other administrative proceedings may be placed on a list of interested persons by advising the Board at the hearing or in writing to the Board of Chiropractors, 111 North Jackson, P.O. Box 200513, Helena, Montana 59620-0513 or by phone at (406) 444-5433.

BOARD OF CHIROPRACTORS
KARLENE BERISH, D.C., CHAIRMAN

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

Anne M. Bartos
ANNIE M. BARTOS, RULE REVIEWER

Certified to the Secretary of State, January 5, 1998.

BEFORE THE BOARD OF CLINICAL
LABORATORY SCIENCE PRACTITIONERS
DEPARTMENT OF COMMERCE
STATE OF MONTANA

In the matter of the proposed amendment of rules pertaining to fees and renewal and the adoption of new rules pertaining to inactive status and reactivation of license	)))))	NOTICE OF PUBLIC HEARING ON THE PROPOSED AMENDMENT OF ARM 8.13.303 FEES AND 8.13.304 RENEWAL AND THE ADOPTION OF NEW RULES I INACTIVE STATUS AND II REACTIVATION OF LICENSE

TO: All Interested Persons:

1. On February 18, 1998, at 9:00 a.m., a public hearing will be held in the upstairs conference room, Department of Commerce building, 1424 - 9th Avenue, Helena, Montana, to consider the proposed amendment and adoption of the above-stated rules.

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

"8.13.303 FEES (1) through (2)(f) will remain the same.
(g) reactivation of license fee 30"
Auth: Sec. 37-34-201, MCA; IMP, Sec. 37-34-201, MCA

REASON: Section 37-1-134, MCA, mandates that fees must be commensurate with program area costs. The Board is amending this rule to add a fee for reactivation of inactive status licenses to cover administrative costs.

"8.13.304 RENEWAL (1) will remain the same.
(2) Licenses will be renewed on a biennial basis every even-numbered year beginning with the May 1, 1998 renewal."
Auth: Sec. 37-34-201, MCA; IMP, Sec. 37-34-201, MCA

REASON: This amendment is being proposed to implement Senate Bill 598 which allows the staggered renewal dates in an effort to alleviate work loads.

3. The proposed new rules will read as follows:

"I INACTIVE STATUS (1) A licensee may place the licensee's license on inactive status by:
(a) submitting a written request for inactive status; and
(b) paying the required fee in accordance with 37-34-201, MCA, and ARM 8.13.303.
(2) A licensee on inactive status has sole responsibility for providing the board information regarding changes in residency or mailing address.

(3) A licensee may remain on inactive status for a period not to exceed three years. After three years, the licensee shall submit a request for further inactive status or reactivate the license. Failure to renew an inactive status license or reactivate will result in termination of the license. The holder of a terminated license will be required to re-apply for licensure."

Auth: Sec. 37-1-131, 37-34-201, MCA; IMP, Sec. 37-1-131, 37-34-201, MCA

REASON: This rule is being proposed to allow licensees the option of placing their license on inactive status rather than allowing their license to lapse and require licensee to reapply.

"II REACTIVATION OF LICENSE (1) For a licensee to reactivate a license, the licensee must:

(a) file an updated application form and pay the required fee in accordance with ARM 8.13.303;

(b) submit proof of obtaining the required continuing education in accordance with ARM 8.13.306, for the two-year period immediately preceding the submission of a reactivation application."

Auth: Sec. 37-1-131, 37-34-201, MCA; IMP, Sec. 37-1-131, 37-34-201, MCA

REASON: This rule is being proposed to provide licensees with the procedures, and the requirements for, reactivation of a license after having been on inactive status.

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 the Board of Clinical Laboratory Science Practitioners, 111 North Jackson, P.O. Box 200513, Helena, Montana 59620-0513, to be received no later than the close of hearing on February 18, 1998.

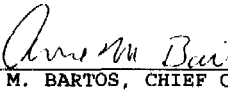
5. R. Perry Eskridge, attorney, has been designated to preside over and conduct this hearing.

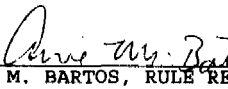
6. The Department of Commerce will make reasonable accommodations for persons with disabilities who wish to participate in this public hearing. If you wish to request an accommodation, contact the Department no later than 5:00 p.m., February 11, 1998, to advise us of the nature of the accommodation that you need. Please contact Pam Bragg, Board of Clinical Laboratory Science Practitioners, 111 N. Jackson, P.O. Box 200513, Helena, Montana 59620-0513; telephone (406) 444-3561; Montana Relay 1-800-253-4091; TDD (406) 444-2978; facsimile (406) 444-1667. Persons with disabilities who need an alternative accessible format of this document in order to participate in this rulemaking process should contact Pam Bragg.

7. Persons who wish to be informed of all Board of Clinical Laboratory Science Practitioners administrative rulemaking proceedings or other administrative proceedings may

be placed on a list of interested persons by advising the Board at the hearing or in writing to the Board of Clinical Laboratory Science Practitioners, 111 North Jackson, P.O. Box 200513, Helena, Montana 59620-0513 or by phone at (406) 444-3561.

BOARD OF CLINICAL LABORATORY
SCIENCE PRACTITIONERS
JOANNE SCHNEIDER, CHAIRMAN

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


ANNIE M. BARTOS, RULE REVIEWER

Certified to the Secretary of State, January 5, 1998.

BEFORE THE BOARD OF PSYCHOLOGISTS
DEPARTMENT OF COMMERCE
STATE OF MONTANA

In the matter of the proposed amendment of rules pertaining to application procedures and continuing education, the repeal of rules pertaining to unprofessional conduct and ethical practice of psychology and the adoption of new rules pertaining to unprofessional conduct	))))))))	NOTICE OF PROPOSED AMENDMENT, ADOPTION AND REPEAL OF RULES PERTAINING TO THE PRACTICE OF PSYCHOLOGY NO PUBLIC HEARING CONTEMPLATED

TO: All Interested Persons:

1. On February 14, 1998, the Board of Psychologists proposes to amend rules pertaining to application procedures and continuing education, repeal rules pertaining to unprofessional conduct and ethical practice of psychology and adopt new rules pertaining to unprofessional conduct.

2. The proposed amendment of ARM 8.52.604 and 8.52.702 will read as follows: (new matter underlined, deleted matter interlined)

"8.52.604 APPLICATION PROCEDURES (1) through (2) will remain the same.

(a) Work samples shall be written examples of recent work (within two years of application date), at least two of which must be psychological evaluations. The evaluations must demonstrate competence in history taking, administration and interpretation of formal tests of intelligence, and administration and interpretation of objective and projective tests of personality. Tests utilized must include, but are not limited to, those widely recognized and respected in the practice of psychology. Examples must also demonstrate competence in formulating appropriate diagnoses and recommendations. Work samples do not include newspaper or other similar articles or publications. Questions regarding the work samples may be included in the oral examination and candidates may be requested to present the raw data upon which their work samples were based.

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

Auth: Sec. 37-1-131, 37-17-202, MCA; IMP, Sec. 37-17-302, MCA

REASON: The proposed amendment will clarify the word "recent" to a definite date of within two years of the application date, as the Board had been receiving work samples which were older than this time frame, and therefore of little use. The

proposed amendment will also further define work sample to exclude newspaper articles, as these have been submitted by applicants in the past, but are inappropriate to demonstrate an applicant's competency. The use of diagnoses is so candidate can demonstrate competency.

8.52.702 CONTINUING EDUCATION PROGRAM OPTIONS

(1) through (1)(b)(iv) will remain the same.

(A) Initial presentation of a meeting paper, ~~or~~ poster presentation or workshop in the field of psychology based on thorough review of the literature, and including theoretical ideas, with application to clinical work. One hour of continuing education will be credited for each hour of presentation. In addition, one hour of continuing education will be credited for preparation for each hour of presentation;

~~(B) Initial presentation of a workshop in the field of psychology;~~

(C) through (F) will remain the same, but will be renumbered (B) through (E).

(c) through (iii)(D) will remain the same."

Auth: Sec. 37-1-319, 37-17-202, MCA; IMP, Sec. 37-1-306, MCA

REASON: The proposed amendment will clarify the amount of continuing education credit to be given for preparation time of presentations, as licensees have been confused about the issue in the past.

3. The Board is proposing to repeal ARM 8.52.617 and 8.52.618 because they are being replaced by the proposed new rules, which contain updated language and standards on unprofessional conduct and ethical practice of psychology. The authority sections for ARM 8.52.617 are 37-1-131, 37-1-319, 37-17-202, MCA and the implementing section is 37-1-319, MCA. The authority sections for ARM 8.52.618 are 37-1-131, 37-17-202, MCA and the implementing section is 37-1-131, MCA. The rules are located at pages 8-1427 through 1435, Administrative Rules of Montana.

4. The proposed new rules will read as follows:

"I REPRESENTATION OF SELF AND SERVICES (1) In representation of self or services, a licensee:

(a) shall display the psychologist's current license to practice psychology on the premises of the professional office;

(b) shall not represent him/herself as a psychologist while unlicensed or while the practitioner's license is currently suspended, revoked or not renewed;

(c) shall not use fraud, misrepresentation or deception in obtaining a psychology license, in passing a psychology licensing examination, in assisting another to obtain a psychology license or to pass a psychology licensing examination;

(d) shall not aid or abet an unlicensed person in misrepresenting the person's professional credentials or in practicing when a license is required, or otherwise illegally engaging in the practice of psychology;

(e) shall not promote the use of psychological assessment techniques by unqualified persons;

(f) shall not use fraud, misrepresentation or deception in billing clients or third party payors, in providing psychological services, in reporting the results of psychological evaluations or services, or in conducting any other activity related to the practice of psychology.

(2) In regard to advertising, a licensee or license applicant:

(a) shall not engage in advertising that is false, fraudulent or misleading;

(b) shall identify paid advertisements as such, unless it is already apparent from the context;

(c) shall not solicit testimonials from current psychotherapy clients or patients or other persons who, because of their particular circumstances, are vulnerable to undue influence;

(d) shall not induce a client to solicit business on behalf of the psychologist;

(e) shall take professional responsibility when engaging others to create or place public statements that promote their professional practice, products or activities.

(3) In regard to representation in the public arena, a licensee or license applicant:

(a) shall make reasonable efforts to prevent others whom they do not control (such as employers, publishers, sponsors, organizational clients, and representatives of the print or broadcast media) from making deceptive statements concerning psychologists' practice or professional or scientific activities;

(b) shall make reasonable efforts to correct deceptive statements about their work or misuse of their work made by others;

(c) shall not compensate the press (radio, television, or other communication media), or their employees, in return for publicity or a news item;

(d) shall not make public statements that are false, deceptive, misleading or fraudulent (either by omission or commission) concerning licensee's research, practice or concerning other work activities or those of persons or organizations with which they are affiliated;

(i) As examples (and not in limitation) of this rule, psychologists shall not make false or deceptive statements concerning their:

(A) training, experience or competence;

(B) academic degrees;

(C) credentials;

(D) institutional or association affiliations;

(E) services;

(F) the scientific or clinical basis for, or results or degree of, success of their services;

(G) fees; or

(H) publications or research findings;

(e) shall, when providing advice or comment by means of public lectures, demonstrations, radio or television programs, prerecorded tapes, printed articles, mailed material, computer or other electronically transmitted media, or other media, take reasonable precautions to ensure that the statements are based on appropriate psychological literature and practice. Furthermore, the psychologist shall take reasonable precautions to ensure that the recipient of the information does not infer that a relationship has been established with the psychologist personally;

(f) shall not engage, directly or through agents, in uninvited in-person solicitation of business from actual or potential psychotherapy patients or clients or other persons who, because of their particular circumstances, are vulnerable to undue influence. However, this does not preclude attempting to implement appropriate collateral contacts with significant others for the purpose of benefiting an already engaged therapy patient;

(g) shall not associate with, or permit the psychologist's name to be used in connection with, any services or products in such a way as to misrepresent the services or products, the degree of the psychologist's responsibility for the services or products, or the nature of the psychologist's association with the services or products."

Auth: Sec. 37-1-131, 37-1-319, 37-17-202, MCA; IMP, Sec. 37-1-316, 37-1-319, MCA

"II PRACTICE OF PSYCHOLOGY (1) In regard to conduct in the integrity of the profession, a licensee:

(a) shall not create an unreasonable risk of physical or mental harm or serious financial loss to the client, such as malpractice or an act or acts below the standard of care for psychologists, whether actual physical or mental injury or harm was suffered by the client;

(b) shall not provide diagnostic, therapeutic, teaching, research, supervisory, consultative, or other psychological services, except in the context of a defined professional or scientific relationship or role based on their education, training, supervised experience, or appropriate professional experience;

(c) shall not participate in activities in which it appears likely that the psychologist's skills or data will be misused by others, unless corrective mechanisms are available.

(2) In regard to disclosure and obligation to report, a licensee:

(a) shall disclose fees and confidentiality prior to initiating the professional relationship with clients, except in the case of a clinical emergency. Upon initiating the professional relationship there will be a discussion of the nature and anticipated course of contracted services,

limitations of confidentiality and mandated reporting situations. When services rendered involve more than one interested party, the psychologist shall clarify the dimensions of confidentiality and professional responsibility to all participating parties;

(b) who has substantial reason to believe that there has been a violation of the statutes or rules of the board, shall so inform the board in writing. However, when the information regarding such violation is obtained in a professional relationship with a client, the psychologist shall report it only with the written permission of the client;

(c) shall, when initiating conjoint services to several persons who have a relationship (e.g. familial, communal or business), attempt to clarify which of the individuals are clients and the relationship the psychologist will have with each person. This clarification includes the role of the psychologist and the probable uses of the services provided or the information obtained;

(d) shall keep the client fully informed as to the purpose and nature of any evaluation, treatment, or other procedures, and of the client's right to freedom of choice regarding services provided;

(e) shall not undertake research on human subjects without a study of the potential effects of the research on the subjects, and shall not undertake research on human subjects without full disclosure of risks to the subjects.

(3) In regard to judicial or disciplinary situations, a licensee or license applicant:

(a) shall cooperate with an investigation by:

(i) furnishing any papers or documents in the possession and under the control of the licensee, as per the appropriate health care records act;

(ii) furnishing in writing a full and complete explanation covering the matter contained in the complaint; and

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

(b) a psychologist shall not offer, undertake or agree to cure or treat disease or affliction by a secret method, procedure or treatment; nor shall the psychologist treat, operate or prescribe for any health condition by a method, means or procedure which the licensee refuses to divulge upon demand from the board."

Auth: Sec. 37-1-131, 37-1-319, 37-17-202, MCA; IMP, Sec. 37-1-316, 37-1-319, MCA

"III PROFESSIONAL RESPONSIBILITY (1) In regard to client welfare, a licensee:

(a) shall attempt to terminate a clinical or consulting relationship when it is reasonably clear to the psychologist that the client is not benefiting from it or is being harmed by continued service;

(b) shall not use relationships with clients to promote commercial enterprises of any kind for personal gain or the profit of an agency;

(c) shall not bill for services not directly performed for a client, unless there is an explicit agreement that permits this type of billing;

(d) shall take reasonable steps to avoid harming the psychologist's clients, research participants, students and others with whom there is a professional relationship, and to minimize harm where it is foreseeable and unavoidable;

(e) shall make reasonable efforts to plan for facilitating care in the event that psychological services are interrupted by factors such as the psychologist's illness, death, unavailability or relocation or by the client's relocation or financial limitations;

(f) shall, when entering into employment or contractual relationships, provide for orderly and appropriate resolution of responsibility for client care in the event the employment or contractual relationship ends, with paramount consideration given to the welfare of the client;

(g) shall make an appropriate referral of the client to another professional when requested to do so by the client;

(h) shall continue the professional relationship with the client until a relationship is established with the professional person to whom the client is referred or until the relationship has been terminated by mutual agreement. In situations where referral, consultation or other changes in the conditions of the treatment are indicated, and the client refuses referral, the psychologist shall carefully weigh the possible harm to the client, the psychologist and the psychologist's profession that might ensue from continuing the relationship.

(2) In regard to respect for others, a licensee:

(a) shall not exploit persons over whom they have supervisory, evaluative or other authority such as students, supervisees, employees, research participants or clients;

(b) who performs interventions or administers, scores, interprets or uses assessment techniques shall be familiar with the reliability, validation and related standardization or outcome studies of, and proper applications and uses of, the techniques they use; and

(i) shall recognize limits to the certainty with which diagnoses, judgements or predictions can be made about individuals;

(ii) shall attempt to identify situations in which particular interventions or assessment techniques or norms may not be applicable or may require adjustment in administration or interpretation because of factors such as individuals' gender, age, race, ethnicity, national origin, religion, sexual orientation, disability, language or socioeconomic status;

(iii) shall, when offering assessment or scoring procedures to other professionals, accurately describe the purpose, norms, validity, reliability and applications of the

procedures and any special qualifications applicable to their use;

(iv) shall ensure, unless the nature of the relationship is clearly explained to the person being assessed in advance and precludes provision of an explanation of results, that an explanation of the results is provided using language that is reasonably understandable to the person assessed or to another legally authorized person on behalf of the client;

(v) shall, regardless of whether the scoring and interpretation are done by the psychologist, by assistants or by automated or other outside services, take reasonable steps to ensure that appropriate explanations of results are given and adequate provisions are made for referring and counseling individuals when needed;

(c) when interpreting assessment results, including automated interpretations, shall take into account the various test factors and characteristics of the person being assessed that might affect psychologists' judgments or reduce the accuracy of their interpretations and indicate any significant reservations they have about the accuracy or limitations of their interpretations.

(3) In regard to conflict of interest, a licensee shall be concerned primarily with the welfare of any client involved and only secondarily with the interest of the psychologist's own professional group, when there is a conflict among professional workers.

(4) In regard to the therapeutic relationship, a licensee:

(a) shall provide psychological services for the purpose of diagnosis, treatment or personalized advice only in the context of a professional relationship, and shall not be given by means of public lectures or demonstrations, newspaper or magazine articles, radio or television programs, mail or similar media. Psychologists shall perform evaluations, diagnostic services or interventions only within the context of a defined professional relationship;

(b) shall not prepare personnel reports and recommendations based on test data secured solely by mail unless such appraisals are an integral part of a continuing client relationship with a company;

(i) The reports shall not be embellished with detailed analyses of the subject's personality traits as would be appropriate only after intensive interviews with the subject;

(ii) The reports shall not make specific recommendations as to the employment or placement of the subject which go beyond the psychologist's knowledge of the job requirements of the company;

(iii) The reports shall not purport to eliminate the company's need to carry on other regular employment or personnel practices such as appraisal of the work history, checking of references, or past performance in the company.

(c) shall not undertake or continue a professional relationship with a client when the psychologist is, or could reasonably be expected to be impaired due to mental, emotional,

physiologic, pharmacologic or substance abuse conditions. If such a condition develops after a professional relationship has been initiated, the psychologist shall terminate the relationship in an appropriate manner, shall notify the client in writing of the termination, and shall assist the client in obtaining services from another professional;

(d) shall give a truthful, understandable and appropriate account of the client's condition to the client or to those responsible for the care of the client;

(e) shall make assessments, recommendations, reports and psychological diagnostic or evaluative statements based on information and techniques (including personal interviews of the individual when appropriate) sufficient to provide appropriate substantiation for their findings;

(f) shall refrain from releasing raw test results or raw data to persons, other than to clients as appropriate, who are not qualified to use such information.

(5) In regard to education, a licensee:

(a) shall present psychological information accurately and with a reasonable degree of objectivity, when engaged in teaching or training;

(b) shall not teach the use of techniques or procedures that require specialized training, licensure or expertise, including but not limited to hypnosis, biofeedback and projective techniques, to individuals who lack the prerequisite training, legal scope of practice or expertise;

(c) shall establish an appropriate process for providing feedback to students and supervisees in academic and supervisory relationships;

(d) shall evaluate students and supervisees on the basis of their actual performance on relevant and established program requirements.

(6) In regard to supervision, a licensee:

(a) shall adequately supervise auxiliary staff to ensure that the client's mental or physical health or safety is not at risk;

(b) shall delegate to their employees, supervisees and research assistants only those responsibilities that such persons can reasonably be expected to perform competently, on the basis of their education, training or experience, either independently or with the level of supervision being provided.

(7) In regard to forensic activities, a licensee:

(a) shall not render a formal professional opinion about the psychological and emotional characteristics of an individual without direct and substantial professional contact with or a formal assessment of that person, for example, about the fitness of a parent in a custody hearing."

Auth: Sec. 37-1-131, 37-1-319, 37-17-202, MCA; IMP, Sec. 37-1-316, 37-1-319, MCA

"IV RELATIONSHIPS (1) In regard to multiple relationships, a licensee:

(a) shall not undertake or continue a professional relationship with a client when the objectivity of the licensee is, or could reasonably be construed to be, impaired because of present or previous familial, social, sexual, emotional, financial, supervisory, political, administrative or legal relationship with the client or a relevant person directly associated with or related to the client.

(2) In regard to sexual relationships, a licensee:

(a) shall not accept as clients persons with whom they have engaged in sexual intimacies;

(b) shall not engage in sexual intimacies with current clients;

(c) shall not engage in sexual intimacies with a former client for at least two years after termination of professional services. The licensee who engages in such activity after the two years following termination of professional services bears the burden of demonstrating that there has been no exploitation, in light of all relevant factors, including:

(i) the amount of time that has passed since professional services terminated;

(ii) the nature and duration of the professional services;

(iii) the circumstances of termination;

(iv) the client's personal history;

(v) the client's current mental status;

(vi) the likelihood of adverse impact on the client; and

(vii) any statements or actions made by the licensee during the professional relationship suggesting or inviting the possibility of post termination sexual or romantic relationship with the client.

(3) In regard to bartering, the licensee:

(a) shall not participate in bartering if the relationship is clinically contraindicated or exploitative;

(b) shall not engage in bartering unless fair market value is used for goods or services bartered."

Auth: Sec. 37-1-131, 37-1-319, 37-17-202, MCA; IMP, Sec. 37-1-316, 37-1-319, MCA

"V PRIVILEGED INFORMATION AND RECORDS (1) In regard to privileged information and records, the licensee:

(a) shall not reproduce or describe psychological tests or assessment procedures in popular publications, lectures or public presentations in ways that might invalidate them;

(b) shall, in rendering professional services to an individual client, or services billed to a third party payer, maintain professional records that include:

(i) the presenting problem(s) or purpose of diagnosis;

(ii) the fee arrangement;

(iii) the date and substance of each billed contact or service;

(iv) any test results or other evaluative results obtained and any basic test data from which they were derived;

(v) notation and results of formal consults with other providers; and

(vi) a copy of all test or other evaluative reports prepared as part of the professional relationship.

(c) shall administer, store and dispose of written, electronic and other records in such a manner as to insure their confidentiality;

(d) shall not withhold records under their control that are requested and imminently needed for a client's treatment solely because payment has not been received, except as otherwise provided by law;

(e) shall continue to treat as confidential information regarding a client after the professional relationship between the psychologist and the client has ceased."

Auth: Sec. 37-1-131, 37-1-319, 37-17-202, MCA; IMP, Sec. 37-1-316, 37-1-319, MCA

REASON: The proposed new rules will replace the former rules regarding unprofessional conduct and ethical practice of psychology, as the previous rules were out-dated, and did not include new standards created by 1995 Montana legislation and more current versions of APA and ASPPB ethical standards. The new rules are a combination of various sources and will, therefore, serve to guide licensees in professional and unprofessional conduct in the practice of psychology.

5. Interested persons may submit their data, views or arguments concerning the proposed amendments, repeals and adoptions in writing to the Board of Psychologists, 111 N. Jackson, P.O. Box 200513, Helena, Montana 59620-0513, or by facsimile to (406) 444-1667, to be received no later than 5:00 p.m., February 12, 1998.

6. If a person who is directly affected by the proposed amendments, repeals and adoptions wishes to present his data, views or arguments orally or in writing at a public hearing, he must make written request for a hearing and submit the request along with any comments he has to the Board of Psychologists, 111 N. Jackson, P.O. Box 200513, Helena, Montana 59620-0513, or by facsimile to (406) 444-1667, to be received no later than 5:00 p.m., February 12, 1998.

7. If the Board receives requests for a public hearing on the proposed amendments, repeals and adoptions from either 10 percent or 25, whichever is less, of those persons who are directly affected by the proposed amendments, repeals and adoptions, from the Administrative Code Committee of the legislature, from a governmental agency or subdivision or from an association having no less than 25 members who will be directly affected, a hearing will be held at a later date. Notice of the hearing will be published in the Montana Administrative Register. Ten percent of those persons directly affected has been determined to be 20 based on the 198 licensees in Montana.

8. Persons who wish to be informed of all Board of Psychologists administrative rulemaking proceedings or other administrative proceedings may be placed on a list of interested persons by advising the Board at the hearing or in

writing to the Board of Psychologists, 111 North Jackson, P.O. Box 200513, Helena, Montana 59620-0513 or by phone at (406) 444-5436.

BOARD OF PSYCHOLOGISTS
JAMES MURPHEY, Ph.D., CHAIRMAN

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

Anne M. Bartos
ANNIE M. BARTOS, RULE REVIEWER

Certified to the Secretary of State, January 5, 1998.

BEFORE THE CONSUMER AFFAIRS DIVISION
DEPARTMENT OF COMMERCE
STATE OF MONTANA

In the matter of the proposed adoption of rules pertaining to the New Motor Vehicle Warranty Act	))))	NOTICE OF PUBLIC HEARING ON THE ADOPTION OF NEW RULES PERTAINING TO THE NEW MOTOR VEHICLE WARRANTY ACT

TO: All Interested Persons:

1. On February 17, 1998, at 1:00 p.m., a public hearing will be held in the Upstairs Conference Room at the Department of Commerce, 1424 9th Avenue, Helena, Montana 59620, to consider the adoption of rules pertaining to the New Motor Vehicle Warranty Act.

2. The proposed new rules will read as follows:

"I DEFINITIONS (1) "Department" means the Montana department of commerce.

(2) "Panel" means a three-member arbitration panel.

(3) Reference to "days" as a time for the performance of any act under this chapter shall mean calendar days, unless otherwise specified.

(4) "Manufacturer" includes a designee of the manufacturer."

Auth: Sec. 61-4-532, MCA; IMP, Sec. 61-4-515, 61-4-516, MCA

REASON: Section 61-4-532, MCA, authorizes the Department of Commerce (Department) to adopt rules to implement the provisions of the New Motor Vehicle Warranty Act. Section 61-4-515, MCA, provides that the Department "shall provide an independent forum and arbitration procedure for the settlement of disputes between consumers and manufacturers of motor vehicles that do not conform to all applicable warranties under the provisions of this part." The Department proposes to adopt rules to implement the arbitration forum as required by statute.

In rule I, the Department sets forth the definitions necessary for consumers, manufacturers, arbitrators, and other interested persons to be fully informed of the requirements for utilizing the Department's arbitration program. These definitions, which supplement the definitions contained in section 61-4-501, MCA, clarify the rules.

The word "Department" has been defined to advise that, throughout the rules, "Department" refers to the Montana Department of Commerce. Use of the word Department rather that Department of Commerce reduces redundancy, enhances readability, and avoids confusion with a reference to the Montana Department of Justice in rule XVII.

The word "Panel" has been defined to advise that,

throughout the rules, the word panel refers to a three-member arbitration panel. Defining the phrase "panel" at the outset of the rule reduces redundancy, enhances readability, and notifies consumers, manufacturers, arbitrators, and other interested persons that the arbitration panel must conform to section 61-4-517, MCA. Section 61-4-517, MCA, provides that the arbitration panel must consist of three members.

The word "Manufacturer" is defined in this rule to encompass a designee of the manufacturer. This definition allows the manufacturer to designate another party, such as an attorney, to act in its stead in meeting the requirements of an arbitration proceeding.

"II CORRESPONDENCE (1) All communications, applications, filings, complaints or other matters shall be directed to the Administrator, New Vehicle Warranties, Consumer Affairs Division, Department of Commerce, 1424 9th Avenue, Helena, Montana 59620."

Auth: Sec. 61-4-532, MCA; IMP, Sec. 61-4-515, 61-4-517, 61-4-518, MCA

REASON: Section 61-4-515, MCA, requires the Department of Commerce to operate an arbitration procedure to be used by consumers who have purchased an alleged defective vehicle. Rule II provides a mailing address for all communications relative to a claim under the New Motor Vehicle Warranty Act to consumers, manufacturers, arbitrators, and other interested parties. The rule identifies the party within the Department of Commerce who is responsible for operating the arbitration program, the "Administrator."

The Department is charged pursuant to section 61-4-518, MCA, to "investigate, gather, and organize all information necessary for a fair and timely decision in each dispute." Much of the information required for a fair and timely decision is provided to the arbitration panel through the mail. Section 61-4-517, MCA, provides that a consumer initiates a request for arbitration by filing notice with the Department. The rule provides the consumer with the name and address of the party within the Department who must be contacted to request an arbitration. By providing the proper address for the "Administrator" in the rules, the Department seeks to avoid mishandled communications during the initiation and conduct of arbitration proceedings.

"III PROCEDURES ADOPTED (1) The procedural rules adopted by the department shall be in effect, except as may be inconsistent with the statutory provisions for procedure applying herein."

Auth: Sec. 61-4-532, MCA; IMP, Sec. 61-4-515, MCA

REASON: Rule III clarifies that the rule is subservient to all applicable statutes. In the event that a rule requires action

in conflict with a statutory requirement of the New Motor Vehicle Warranty Act, or other applicable procedural law, the rule must yield to the statute.

The New Motor Vehicle Warranty Act requires that the arbitration program operated by the Department must "conform to Title 27, chapter 5." Section 61-4-515, MCA. Title 27, chapter 5 is the Uniform Arbitration Act, and, with the provisions of the New Motor Vehicle Warranty Act, provides guidelines for arbitration in Montana. Inclusion of this rule advises those utilizing the law that if a question arises concerning the procedural aspects of an arbitration, the issue will be resolved in a manner consistent with statutory requirements found in Title 27, chapter 5, MCA, the New Motor Vehicle Warranty Act, or other applicable law.

"IV MANUFACTURER'S INFORMAL DISPUTE SETTLEMENT PROCEDURE - CERTIFICATION (1) Manufacturers may apply for certification of an informal dispute settlement procedure or any amendment to a certified procedure.

(2) The application shall be made to the department and be accompanied by a fee of $500, which shall be used to cover the cost of review and investigation.

(3) Expenditures of the fee shall be accounted for by the department and the balance not expended shall be refunded to the manufacturer within a reasonable time following final order by the department.

(4) The department shall have 90 days to complete the review and grant or deny the certification of any procedure submitted.

(5) Certification shall be issued after investigation and review if the procedure is in compliance with the applicable statutes and administrative rules.

(6) A certified procedure shall remain certified unless the certification is revoked."

Auth: Sec. 61-4-532, MCA; IMP, Sec. 61-4-511, MCA

REASON: Section 61-4-507, MCA, provides that a consumer may not receive the remedy provided in section 61-4-503, MCA, against a manufacturer who has "established an informal dispute settlement procedure certified by the Department of Commerce", unless the consumer first utilizes the manufacturer's arbitration procedure. The statute effectively shifts the cost of arbitrating Lemon Law claims to the manufacturer. At the same time the statute provides that the manufacturer's arbitration procedure must meet standards necessary to achieve a just, impartial determination of lemon law claims.

Section 61-4-511, MCA, requires that the Department provide certification for manufacturers who have implemented arbitration programs in compliance with federal and state standards for arbitration. The statute expressly provides that the manufacturer's program must be in substantial compliance with the provisions of Title 16, Code of Federal Regulations,

part 703, as those provisions read on October 1, 1983 (hereinafter 16 CFR, part 703). Rule IV sets forth the process by which a manufacturer may apply to the Department for certification of an arbitration program.

The rule provides that a $500 fee must be paid at the time the application for certification is received by the Department. The fee will defray the cost to the Department of investigating whether a manufacturer's program is in compliance with sections 61-4-511 and 61-4-512, MCA. The statutes require the Department to investigate manufacturer's arbitration procedures to ensure they both remain in compliance with the provisions of 16 CFR, part 703, and are not "used to create hardship to consumers." The rule provides a time limit for the Department to respond to a request for certification. If the manufacturer program is in compliance, a certificate is issued to the manufacturer which remains valid until suspended by the Department.

The Department is required to certify manufacturer's arbitration programs. Section 61-4-511, MCA. Rule IV sets forth the procedure followed by the Department in the certification process.

"V MANUFACTURER'S INFORMAL DISPUTE SETTLEMENT PROCEDURE - AUDIT (1) Manufacturers shall file an annual audit with the department.

(2) The audit shall be based on the calendar year and shall be filed by January 20th following the year for which the audit applies.

(3) Manufacturers shall include in the annual audit, the following information:

(a) all information otherwise required by statute or rule;

(b) the names, addresses and phone numbers of all persons who have notified the manufacturer that a new vehicle does not conform to all applicable warranties, including:

(i) the date such notification was made;

(ii) the identity by year, make and model of the vehicle to which the nonconformity was asserted;

(iii) the nature of the nonconformity asserted; and

(iv) the date and nature of the final action taken by the manufacturer.

(c) a summary of the yearly activities of the manufacturer pertaining to its informal dispute resolution, including:

(i) the number of notices of nonconformity received;

(ii) the number of notices denied; and

(iii) the number of refunds, replacements and other corrective actions taken."

Auth: Sec. 61-4-532, MCA; IMP, Sec. 61-4-512, MCA

REASON: Pursuant to 16 CFR, part 703, manufacturer's arbitration programs are annually audited. Section 61-4-512,

MCA, requires manufacturers to supply the annual audits to the Department, along with additional information deemed necessary by the Department. The information is used by the Department to determine whether a manufacturer's arbitration program should remain certified.

Rule V states that the manufacturers shall file an annual audit with the Department. The rule then lists information which must be included with the annual audit. The information gathered is necessary for the Department to accurately evaluate whether the manufacturer's arbitration program complies with 16 CFR, part 703, and whether the procedure is being used to create hardship to consumers.

The Department is required to suspend or revoke the certification of a manufacturer whose procedure is found, after notice and hearing as provided in Title 2, chapter 4, to be used to "create hardship to the consumer." Section 61-4-512, MCA. Rule V provides a list of the information the Department considers in evaluating a manufacturer's arbitration program. The rule provides notice to the manufacturer of the information required for continuing certification with the Department.

"VI DEPARTMENT'S DISPUTE RESOLUTION PROCEDURE - WHEN AVAILABLE TO CONSUMER (1) The department's dispute resolution procedure shall be available to the consumer in the following cases:

(a) in the event that a manufacturer has not established an informal dispute resolution procedure which has been certified by the department; and

(b) de novo, by appeal from a decision following the manufacturer's dispute settlement procedure when such procedure does not conform to procedures established by a manufacturer pursuant to 61-4-511, MCA, and the consumer has been injured thereby."

Auth: Sec. 61-4-532, MCA; IMP, Sec. 61-4-507, 61-4-515, 61-4-520, MCA

REASON: Section 61-4-507, MCA, provides that a consumer may not avail himself of the remedies in section 61-4-503, MCA, against a manufacturer who has established an arbitration procedure certified by the Department. Section 61-4-515, MCA, provides that a consumer may bring a case before the Department's arbitration panel "only if the manufacturer...has not established [a]...procedure...certified by the Department of Commerce." Finally, section 61-4-520, MCA, provides that if a consumer is damaged by the operation of any procedure not in compliance with 16 CFR, part 703, the consumer is entitled to an arbitration de novo before a Department arbitration panel.

Based on the provisions in sections 61-4-507, 61-4-515, and 61-4-520, MCA, Rule VI clearly states the two circumstances when a consumer is entitled to file a claim for arbitration by the Department panel. A consumer may only use the Department's arbitration procedure if the manufacturer does not have a

certified arbitration procedure, or if the consumer, after utilizing the manufacturer's procedure, claims that the manufacturers procedure did not conform to the standards set forth in section 61-4-511, MCA.

The jurisdiction of the Department's arbitration panel is established by statute in sections 61-4-507, 61-4-515, 61-4-520, MCA. Because the jurisdictional requirements are scattered between three statutes, it is necessary to clearly define the jurisdictional reach of the Department's panel in one rule. Rule VI succinctly sets out for the consumer, manufacturer, arbitrator, and other interested person, those circumstances when the Department's arbitration is available. The rule clarifies that, if the manufacturer has a certified arbitration procedure, the consumer must first resort to that procedure.

"VII ARBITRATION PANELS (1) An arbitration panel shall consist of three volunteer members. The consumer shall choose one member, the manufacturer shall choose one member and both parties shall choose one member by mutual agreement, from a list maintained by the department of persons willing to serve on arbitration panels.

(2) Prior to an arbitration hearing, the arbitration panel shall designate one of its members to serve as chairperson for the duration of the case to which that arbitration panel has been assigned.

(3) A list of persons willing to serve on arbitration panels shall be maintained by the department and shall include the following information:

(a) the name of the person;

(b) the address and phone number of the person;

(c) the relevant background, training and education of the person; and

(d) any other information that the department may determine is necessary.

(4) The list of persons willing to serve on arbitration panels shall be made available to the consumer and the manufacturer upon request.

(5) Arbitration volunteers shall undergo arbitration training as established by the department. Training shall include procedural techniques, the duties and responsibilities of arbitrators and the principles, specific provisions and implementation of Title 61, chapter 4, part 5, MCA."

Auth: Sec. 61-4-532, MCA; IMP, Sec. 61-4-515, 61-4-517, MCA

REASON: The Department is required to provide an independent forum and arbitration procedure for the settlement of disputes arising under the New Motor Vehicle Warranty Act. Section 61-4-515, MCA. Section 61-4-532, MCA, provides that the Department may adopt rules to implement the New Motor Vehicle Warranty Act. Section 61-4-517, MCA, sets forth criteria for

the composition of the Department's arbitration panel.

In Rule VII, the Department sets forth the same criteria as that provided in section 61-4-517, MCA, and provides for one panel member to be appointed chairman of the panel. The rule then sets forth information which will be included in the list of arbitrators available to consumers and manufacturers seeking an arbitrator for a Lemon Law claim. The rule further provides that each arbitrator must undergo Department sponsored training.

The rule ensures that both the consumer and the manufacturer will have sufficient information to make an informed choice of arbitrators when utilizing the Department's program. The rule further ensures that those who serve as arbitrators receive adequate training in both the substantive content of the New Motor Vehicle Warranty Act and arbitration techniques.

"VIII POWERS AND DUTIES OF ARBITRATORS (1) Arbitrators shall have the duty to appoint a time and place of hearing at a convenient location in the state of Montana, to conduct fair and impartial hearings, to take all necessary actions to avoid delay in the disposition of proceedings, to maintain order and to render a final decision no later than 60 days after the department has accepted a request for arbitration. The decision must comply with Title 61, chapter 4, part 5 and Title 27, chapter 15, MCA. The arbitrators shall have all powers necessary to meet these ends including, but not limited to, the following:

(a) to consider any and all evidence offered by the parties which the panel deems necessary to an understanding and determination of the dispute;

(b) to request the department to issue subpoenas to compel the attendance of witnesses and the production of documents, papers and records relevant to the dispute;

(c) to request the department to forward a copy of all written testimony and documentary evidence to an independent technical expert certified by the national institute of automotive excellence, to consult with the technical expert as necessary and to request the technical expert to sit as a nonvoting member of the arbitration panel during presentation of oral testimony;

(d) to regulate the course of the hearings and the conduct of the parties and their counsel therein;

(e) to hold conferences for simplification of the issues or for other purposes;

(f) to schedule vehicle inspections, if deemed necessary, at such facility as the arbitrators determine;

(g) to continue the arbitration hearing to a subsequent date if a party requests a continuance before hearing, or at the initial hearing or if the panel determines that additional information is necessary in order for the panel to render a fair and accurate decision. A continuance shall be held within

five days of the initial hearing;

(h) to reopen the hearing at will or upon motion of either party for good cause shown at any time before the decision is rendered; and

(i) to permit a deposition to be taken of a witness who cannot be subpoenaed or is unable to attend the hearing upon the application of a party and for use as evidence, in the manner and upon the terms designated by the arbitrators.

(2) Arbitrators shall maintain their impartiality throughout the course of the arbitration proceedings.

(3) An arbitrator shall not be assigned to an arbitration panel if he or she has any relationship to either party to the dispute to be decided by that panel.

(4) There shall be no direct communication between the parties and the arbitrators other than at the oral hearing. Any other oral or written communications between the parties and the arbitrators shall be channeled through the department for transmittal to the appropriate individual(s). Any such prohibited contact shall be reported by the arbitrators to the department and noted in the case record."

Auth: Sec. 61-4-532, MCA; IMP, Sec. 61-4-515, 61-4-518, 61-4-519, MCA

REASON: The Department is required to provide an independent forum and arbitration procedure for the settlement of disputes arising under the New Motor Vehicle Warranty Act. Section 61-4-515, MCA. Section 61-4-532, MCA, provides that the Department may adopt rules to implement the New Motor Vehicle Warranty Act. The Department's arbitration panel is composed of three arbitrators. Section 61-4-517, MCA. The arbitrators are charged with "render[ing] a fair decision based on the information gathered and disclose its findings and its reasoning to the parties." Section 61-4-519, MCA.

Rule VIII defines the duties of an arbitrator and lists generally those powers an arbitrator may exercise in conducting a Lemon Law arbitration. The arbitrator is given the duty of setting a time and place for hearing, avoiding delay in the resolution of complaint, and, in accordance with section 61-4-519, MCA, rendering a final decision within 60 days after the Department accepts a request for arbitration. These procedural aspects of an arbitration are relayed to consumers, manufacturers, arbitrators, and other interested parties by inclusion in the administrative rules.

Rule VIII provides the arbitrators with the authority to collect all information necessary for a just and timely decision in Lemon Law cases. The arbitrators are provided authority to consider all relevant evidence, to gain information through subpoenas and depositions, to request expert opinions, to conduct hearings in an orderly manner, to schedule hearings and conferences between the parties, and to order inspections of vehicles. These powers are necessary to allow the arbitrator to consider all evidence relevant to a

decision in the case.

Rule VIII also lists limitations for arbitrators. The arbitrator must act in an impartial manner. The arbitrator cannot be assigned to an arbitration panel if any relationship exists between the arbitrator and a party to the dispute. The arbitrator may not engage in ex parte communications. The limitations placed upon the arbitrators ensures that the Department is providing a "independent forum and arbitration procedure," as required in section 61-4-515, MCA.

"IX CONSUMER'S REQUEST FOR ARBITRATION (1) The consumer shall file a request for arbitration on a form prescribed by the department along with a filing fee of $50. The fee shall be refunded if the department determines the request for arbitration does not allege a warranty violation. The date of the receipt by the department of the completed form and fee shall be considered the filing date of the request.

(2) The consumer shall be required to provide the information relevant to the resolution of the dispute on the request for arbitration form. The information shall include, but not be limited to, the following:

(a) the name, address and telephone number of the consumer;

(b) the name, address and telephone number of the consumer's legal counsel, if applicable and known;

(c) vehicle information, including the date of purchase and date of delivery of the vehicle, the make, model and manufacturer of the vehicle, the vehicle identification number, present mileage and whether the vehicle was new or used at the time of purchase;

(d) all financial information related to the purchase and/or defect;

(e) the name and address of the selling dealership;

(f) the name and address of the servicing dealership(s) or facility(ies);

(g) information regarding the defect, including:

(i) the nature of the defect(s);

(ii) the date and mileage when the defect(s) first occurred;

(iii) the date the defect(s) was first reported to the dealer or manufacturer;

(iv) the dealer or manufacturer;

(v) the mileage when the defect(s) was so reported;

(vi) the dates on which the car was at the dealership for repair;

(vii) the total number of days the vehicle was at the dealership by reason of repair since the purchase date; and

(viii) the circumstances concerning any refusal of service by the dealer, if applicable.

(h) name(s), date(s) and the nature of any and all oral or written communication with the manufacturer, selling or servicing dealership(s) or facility regarding the dispute;

(i) a statement regarding the consumer's assessment of what actions would constitute a fair resolution of the dispute;

(j) a statement regarding the consumer's chosen form of arbitration hearing, whether oral or documentary;

(k) a copy of any and all warranties, including extended warranties, sales contracts and other relevant documents;

(l) copies of any and all correspondence between the consumer and the manufacturer or its representative(s), if available; and

(m) copies of any and all service orders.

(3) The consumer's request for arbitration shall further include an agreement to arbitrate, which shall be signed by the consumer."

Auth: Sec. 61-4-532, MCA; IMP, Sec. 61-4-515 & 61-4-517, MCA

REASON: The Department is required to provide an independent forum and arbitration procedure for the settlement of disputes arising under the New Motor Vehicle Warranty Act. Section 61-4-515, MCA. Section 61-4-532, MCA, provides that the Department may adopt rules to implement the New Motor Vehicle Warranty Act. Section 61-4-517, MCA, allows that a consumer may initiate an arbitration by filing notice with the Department of Commerce. The request for arbitration must be made on a form produced by the Department and accompanied with a $50 filing fee. Section 61-4-517, MCA.

Rule IX sets forth the information which must be included on the request for arbitration form. The rule also establishes the filing date of a request for arbitration. The rule establishes that the filing date of an arbitration request is when the completed form is returned along with the filing fee. The date of filing is relevant to whether the arbitration decision is reached within 60 days as required under section 62-4-511, MCA.

The rule advises the consumer that a $50 fee is required to file a request for arbitration. The rule also specifies the information that must be included in a request. The rule identifies for the consumer, manufacturer, arbitrator, and other interested persons, the information generally most relevant to a Lemon Law claim. The rule provides the means to implement sections 61-4-515 and 61-5-517, MCA, which requires the Department to facilitate a consumer's request for arbitration.

"X MANUFACTURER'S STATEMENT (1) The department shall require a manufacturer, on a form prescribed by the department, to provide information relevant to the resolution of the dispute along with a filing fee of $250 within 15 days from the date of the manufacturer's receipt of the certified notice of the dispute. The information shall include, but not be limited to, the following:

(a) the name of the selling dealership;

(b) the name of the servicing dealership(s) or

facility(ies);

(c) the purchase date and delivery date of the vehicle;

(d) the vehicle identification number;

(e) dates and nature of service provided by the servicing dealership(s) or facility(ies) and the total number of days the vehicle was at the dealership or facility for service since the date of delivery;

(f) a statement regarding all repair attempts including the name, title and business address of any person(s) performing such repairs and dates thereof;

(g) a statement regarding the manufacturer's assessment of what action(s) would constitute a fair resolution of the dispute;

(h) copies of any and all service orders for the vehicle;

(i) copies of any and all correspondence between the consumer and the manufacturer or its representative(s);

(j) a copy of any and all warranties including extended warranties, sales contracts and other relevant documents; and

(k) all affirmative defenses asserted by the manufacturer."

Auth: Sec. 61-4-532, MCA; IMP, Sec. 61-4-517, MCA

REASON: The Department is required to provide an independent forum and arbitration procedure for the settlement of disputes arising under the New Motor Vehicle Warranty Act. Section 61-4-515, MCA. Section 61-4-532, MCA, provides that the Department may adopt rules to implement the New Motor Vehicle Warranty Act. Section 61-4-517, MCA, requires that the Department, upon accepting a consumers request for arbitration, "notify the manufacturer of the filing of a request for arbitration and shall obtain from the manufacturer, on a form prescribed by Department of Commerce, any information considered relevant to the resolution of the dispute. The manufacturer must return the form within 15 days of receipt, with a filing fee of $250." Rule X provides information to the manufacturer about its obligations when a consumer files a request for arbitration.

Rule X provides to the manufacturer a list of information that must be included in its response to the request for arbitration. The information required from the manufacturer is intended to advise the arbitrator of the facts relevant to a determination of the claim. The rule further reflects that the manufacturer must submit a filing fee of $250 along with the requested information.

In fulfilling its obligation to provide an arbitration procedure, the Department has proposed Rule X to set forth the information required of the manufacturer when responding to a request for arbitration.

"XI CONSUMER APPEALS PROCESS (1) If a consumer has proceeded through a manufacturer's certified dispute settlement program and contends that he or she was injured by the

operation of any procedure that does not conform to procedures established pursuant to 61-4-511, MCA, and the provisions of Title 16, Code of Federal Regulations, part 703, as in effect as of October 1, 1983, he or she may request arbitration de novo by a department arbitration panel.

(2) When filing a request for arbitration de novo with the department, the consumer shall include a copy of the decision rendered by a manufacturer's dispute settlement procedure and all other relevant documentation.

(3) The form for arbitration de novo shall be identical to that used for an original request for arbitration."

Auth: Sec. 61-4-532, MCA; IMP, Sec. 61-4-520, MCA

REASON: The Department is required to provide an independent forum and arbitration procedure for the settlement of disputes arising under the New Motor Vehicle Warranty Act. Section 61-4-515, MCA. Section 61-4-532, MCA, provides that the Department may adopt rules to implement the New Motor Vehicle Warranty Act. Section 61-4-520, MCA, provides that a consumer may initiate a Department arbitration if the manufacturers arbitration does not conform to section 61-1-511, MCA, and 16 CFR, part 703.

Rule XI requires that the consumer include a copy of the manufacturer's arbitration decision with the request for an arbitration de novo by the Department. A consumer requesting a de novo arbitration by the Department must establish that he or she has been "injured by the operation of any procedure that does not conform" to state requirements. Thus, the Department must first analyze whether the procedure used in the manufacturer's arbitration, rather than the decision itself, injured the consumer. It is essential that the Department arbitration board have access to all documentary records of the manufacturer's arbitration to determine if the prior proceeding was in compliance with the law.

Section 61-4-520, MCA, provides that the findings of the manufacturer's arbitration are admissible as evidence at a de novo arbitration by the Department. Rule XI necessarily requires the consumer to produce documentation from the manufacturer's arbitration. Requiring submission of these materials aids the Department's arbitration board in reaching a decision, and avoids duplicating the earlier efforts of the manufacturer's arbitration.

Finally, the rule advises the consumer, manufacturer, arbitrator, and other interested persons that the process for filing a request for a de novo arbitration is the same as used when filing a request for arbitration under section 61-4-517, MCA.

"XII NOTIFICATION OF PARTIES AND ARBITRATORS (1) The department shall notify the consumer of the department's acceptance or rejection of his or her request for arbitration.

(2) If the department accepts a request for arbitration,

the department shall notify the manufacturer, by certified mail, of the filing of the request for arbitration.

(3) The department shall enclose with the notification a manufacturer's statement form and require the manufacturer to return the form within 15 days of receipt, with a filing fee of $250."

Auth: Sec. 61-4-532, MCA; IMP, Sec. 61-4-517, MCA

REASON: The Department is required to provide an independent forum and arbitration procedure for the settlement of disputes arising under the New Motor Vehicle Warranty Act. Section 61-4-515, MCA. Section 61-4-532, MCA, provides that the Department may adopt rules to implement the New Motor Vehicle Warranty Act. Section 61-4-517, MCA, requires that the Department, upon receipt of a request for arbitration, "determine whether the complaint alleges the violation of any applicable warranty under this part." The section further provides that, in the event the Department determines that consumer has not alleged a violation of the New Motor Vehicle Warranty Act, the filing fee must be returned. Section 61-4-517, MCA. Finally, if the Department determines that the consumer has stated a claim sufficient to warrant an arbitration, the Department must notify the manufacturer. The manufacturer has 15 days to reply. Section 61-4-517, MCA.

Rule XII provides that the Department shall perform all the statutory requirements contained in section 61-4-517, MCA. The rule provides the manufacturer, consumer, arbitrator, and other interested persons with notice that the Department reviews the request for arbitration initially to determine whether the consumer has stated a claim under the New Motor Warranty Vehicle Act.

"XIII REPRESENTATION BY AN ATTORNEY (1) Any party to an oral arbitration hearing has the right to be represented by an attorney."

Auth: Sec. 61-4-532, MCA; IMP, Sec. 27-5-214, MCA

REASON: The Department is required to provide an independent forum and arbitration procedure for the settlement of disputes arising under the New Motor Vehicle Warranty Act. Section 61-4-515, MCA. Section 61-4-532, MCA, provides that the Department may adopt rules to implement the New Motor Vehicle Warranty Act. Section 61-5-515, MCA, provides that the Department's arbitration procedure must conform to Title 27, chapter 5, "Uniform Arbitration Act."

Section 27-5-214, MCA, provides that a party to a proceeding subject to the Uniform Arbitration Act has a right to an attorney at any proceeding or hearing. Rule XIII provides that any party to an arbitration pursuant to the New Motor Vehicle Warranty Act is entitled to representation by counsel.

"XIV CONDUCT OF ORAL ARBITRATION HEARINGS (1) Upon receipt of the manufacturer's statement and filing fee, the department shall forward copies of the consumer's request for arbitration and the manufacturer's statement to the appointed arbitrators at least five days prior to the scheduled hearing date.

(2) Each party at an oral arbitration hearing shall have the right to present evidence, cross-examine witnesses, enter objections and assert all other rights essential to a fair hearing.

(3) The chairperson of the arbitration panel shall preside at the arbitration hearing and shall require all witnesses to testify under oath or affirm that their statements are true to the best of their knowledge.

(4) The hearing shall be opened by the recording of the place, time and date, the identities of the arbitrators and parties and counsel, if any.

(5) The consumer shall then present his or her testimony and witnesses, who shall submit to questions by the opposing party and/or the arbitrators.

(6) The manufacturer shall then present its testimony and witnesses, who shall submit to questions by the opposing party and/or the arbitrators.

(7) If good cause is shown, the arbitrators may, at their discretion, vary these procedures. Any variance shall afford full and equal opportunity to all for the presentation of any material or relevant proofs and for the ensurance of all essential rights to a fair hearing.

(8) Exhibits offered by either party may be received in evidence. The names and addresses of all witnesses and exhibits in the order received shall be made a part of the record. The parties may offer such evidence as they desire and shall produce whatever additional evidence the arbitrators may deem necessary to an understanding and determination of the dispute. The arbitrators shall evaluate the relevancy and materiality of the evidence offered by both parties. The arbitration panel shall not be bound by the rules of evidence.

(9) The arbitrators may receive and consider evidence of witnesses not present at the hearing by affidavit, and give it such weight as the arbitrators deem appropriate, after considering any objections made to its submission.

(10) All documents requested by either party, if deemed relevant by the arbitrators, and all documents not filed at the time of the hearing but requested by arbitrators shall be submitted to the department by a specified date and transmitted to the arbitrators in a timely fashion and in no event later than five days prior to the date set for a decision. All parties shall be given an opportunity to examine or request copies of such documents.

(11) The arbitrators may schedule vehicle inspections, if deemed necessary.

(12) The hearing generally shall be completed within one

session unless the arbitrators, for good cause and time permitting, schedule any additional hearing(s). After the arbitrators are satisfied that the presentations are complete, the chairperson of the panel shall declare the hearings closed.

(13) The hearings may be reopened by the arbitrators at will or upon motion of either party for good cause shown at any time before the decision or award is made.

(14) The arbitrators shall, after any necessary consultations among themselves or with a technical expert, render a decision not later than 60 days after the date the department has accepted the consumer's request for arbitration.

(15) Oral arbitration hearings shall be recorded.

(16) At the close of the arbitration hearing, either party may file a request for a written transcript of the proceedings. The party making the request shall be responsible for transcription costs. Any party requesting a copy of the transcript shall be charged for the cost of reproduction. If no request is filed, the department may order that a written transcript be prepared."

Auth: Sec. 61-4-532, MCA; IMP, Sec. 61-4-515, 61-4-519, 27-5-213, MCA

REASON: The Department is required to provide an independent forum and arbitration procedure for the settlement of disputes arising under the New Motor Vehicle Warranty Act. Section 61-4-515, MCA. Section 61-4-532, MCA, provides that the Department may adopt rules to implement the New Motor Vehicle Warranty Act. The Department's arbitration procedure is conducted by arbitrators who render a decision "based on the information gathered and disclose its findings and its reasoning to the parties." Section 61-4-519, MCA.

Rule XIV sets forth the procedure to be followed during an arbitration held pursuant to the New Motor Vehicle Warranty Act. The rule specifies a procedure intended to aid the arbitrators in gathering all information relevant to a determination in an arbitration. The rule states each party to the hearing "shall have the right to present evidence, cross-examine witnesses, enter objections, and assert all rights essential to a fair hearing."

Rule XIV provides a time table for providing pre-hearing information to the arbitrators, allows that the arbitrators shall require all witnesses to testify under oath, and provides a structure for conducting an arbitration. The rule provides that parties may produce exhibits which are made part of the record. The rule provides that the arbitrator has discretion in determining the weight given to the evidence presented at the arbitration.

The arbitrators are given authority to schedule vehicle inspections to determine the nature of the vehicle's alleged defect. The rule provides that the hearing should be completed in one session, that the hearing may be reopened for good cause prior to a determination, and that a decision shall be rendered

within 60 days after the consumers request for arbitration is accepted. Finally, the rule provides that either party can, at their own cost, request a transcript of the arbitration proceeding.

Rule XIV sets forth procedural requirements which ensure that each party to an arbitration has an opportunity to present all relevant evidence. The rule establishes that the arbitrators must receive the consumers request for arbitration and the manufacturer's statement within five days of the Department's receipt of the manufacturer's statement and filing fee. Additionally, the rule establishes a deadline for reaching a decision in an arbitration. The rule provides guidelines to efficiently gather relevant evidence for an arbitration, deadlines for initiating an arbitration and reaching a decision, and provides that a permanent record be maintained of each arbitration. The rule promotes a "fair and timely decision" in each dispute brought to the attention of the Department. Section 61-4-519, MCA.

"XV CONDUCT OF DOCUMENTARY ARBITRATION HEARINGS (1) If the consumer elects a documentary arbitration procedure, the department shall gather and disseminate all documentary information and evidence in accordance with the following procedures:

(a) the department shall notify the consumer by certified mail that he or she must submit a sworn or affirmed statement as to the facts of the dispute and any evidence which he or she wishes the panel to consider. The consumer shall forward the documentation to the department within 15 days from the date of his or her receipt of the certified notice;

(b) the department shall notify the manufacturer of the dispute by certified mail. The department shall enclose, with a notice, a copy of the consumer's request for arbitration and a manufacturer's statement form. The manufacturer shall submit a sworn or affirmed statement as to the facts of the dispute, any evidence the manufacturer wishes the panel to consider and a $250 filing fee to the department within 15 days from the date of the manufacturer's receipt of the certified notice; and

(c) upon receipt of both the consumer's and manufacturer's sworn or affirmed statements and documentary evidence, the department shall, by certified mail, forward copies of the consumer's submissions to the manufacturer and forward copies of the manufacturer's submissions to the consumer.

(2) Each party shall have the opportunity to respond to the opposing party's submissions. Each party shall submit a response in writing to the department within 10 days from the date of the responding party's receipt of the opposing party's submissions.

(3) The department shall forward copies of all submitted documents and responses thereto to the arbitrators at least five days prior to the scheduled hearing date.

(4) At the documentary hearing, the arbitration panel

shall:

(a) review all documents and statements;

(b) consult with a technical expert, as necessary;

(c) seek further information or documents of either or both parties through the department and request that, upon receipt, the department forward all copies of said information to the opposing party, arbitration panel and technical expert assigned to the case; and

(d) schedule vehicle inspections, if deemed necessary.

(5) All evidence and statements received by the department panel shall be considered part of the record."

Auth: Sec. 61-4-532, MCA; IMP, Sec. 61-4-517, MCA

REASON: The Department is required to provide an independent forum and arbitration procedure for the settlement of disputes arising under the New Motor Vehicle Warranty Act. Section 61-4-515, MCA. Section 61-4-532, MCA, provides that the Department may adopt rules to implement the New Motor Vehicle Warranty Act.

The Department proposes rule XV to provide an arbitration to consumers based on submitted documentary evidence. The rule reasonably provides the consumer an alternative to appearing before the arbitration panel. Section 61-4-517, MCA, provides that the Department must offer to the consumer a choice of submitting testimony either orally, or in writing. If the consumer chooses to proceed with a written, or documentary hearing, rule XV provides notice to the consumer, manufacturer, arbitrator, and other interested persons of the procedure that will be followed in reaching a decision.

The rule requires both the consumer and the manufacturer to submit to the Department a sworn or affirmed statement of the facts of the dispute and any documentary evidence. The Department provides copies of the statements and documentary evidence of each party to the opposing party. Each party is then given an opportunity to respond to the statement and documentary evidence produced by the other party. All statements, evidence and responses are forwarded to the arbitration panel.

The rule provides that the arbitration panel review the material at a documentary hearing. The panel may request further information, consult with technical experts, or schedule a vehicle inspection in furtherance of reaching a determination of the dispute. All evidence received by the arbitration panel is considered part of the record.

Rule XV requires both parties to submit evidence necessary to a fair determination of the dispute. Each party is given an opportunity to respond to the evidence produced by the other party. Rule XV ensures that the decision reached in a documentary hearing is based on relevant information fully disclosed to both parties. Further, the rule imposes a time limitation for each party's submissions to ensure a prompt result. Rule XV aids the Department in investigating,

gathering, and organizing all information necessary for a fair and timely decision.

"XVI PRE-DECISION SETTLEMENT OF DISPUTE (1) One or both of the parties shall notify the department if, through outside mediation efforts, the dispute is settled at any time after the filing date and before the decision is rendered. The department shall thereupon verify the terms of the settlement and the date for performance to which the parties have agreed, if applicable. The consumer shall notify the department if compliance has not occurred by the agreed date, and the arbitration process shall recommence at the point within the 60-day time frame at which it had been interrupted by the notification to the department of the pre-decision settlement."

Auth: Sec. 61-4-532, MCA; IMP, Sec. 61-4-519, 61-4-526, MCA

REASON: The Department is required to provide an independent forum and arbitration procedure for the settlement of disputes arising under the New Motor Vehicle Warranty Act. Section 61-4-515, MCA. Section 61-4-532, MCA, provides that the Department may adopt rules to implement the New Motor Vehicle Warranty Act. Section 61-4-519, MCA, provides that the arbitration panel shall act "as expeditiously as possible", including providing a decision within 60 days, and setting a date for performance and completion of awarded remedies. Rule XVI establishes the Department's role in cases in which the parties reach a settlement after filing for hearing and prior to receiving a decision from the arbitration panel.

The rule provides that, if a dispute is settled, the parties must notify the Department of the terms of the settlement, and the date of performance of the agreed upon remedy. The consumer may resume the Department's arbitration process in the event that compliance with the remedy has not occurred by the agreed upon date.

Rule XVI implements the Departments mandate to provide an arbitration procedure under the New Motor Vehicle Warranty Act. Section 61-4-515, MCA. Settlement of some disputes prior to arbitration is inevitable; it is likely that some of these settlements will fail and require a full arbitration proceeding. Rule XVI provides a means to complete the arbitration process without unnecessary delay and duplication of effort.

Finally, the Department of Commerce is required to file with the Department of Justice records and statistics compiled from all New Motor Vehicle Warranty Act disputes. Section 61-4-526, MCA. The Department of Justice must consider the information in issuance of any manufacturer's license required under Title 61, chapter 4, part 2, MCA. Id. The number of cases settled between consumers and manufacturers is relevant to the Department of Justice's determination. Rule XVI ensures consistency of record keeping.

"XVII RECORD KEEPING (1) The department shall maintain records of each dispute, which shall include:

(a) the name, address and telephone number of the consumer;

(b) the name, address, telephone number and contact person of the manufacturer;

(c) brand name and model of the vehicle;

(d) the filing date of the dispute, the date on which the arbitration decision was rendered and the date of the official notification to all parties of the decision;

(e) all correspondence or other written documents submitted by both parties;

(f) all other evidence collected by the department relating to the dispute;

(g) a transcript or tape recording of all oral arbitration hearings;

(h) the decision of the department panel including information as to the time, date and place of the arbitration hearing and the identities of the voting arbitrators;

(i) a copy of the official written notice to the parties of the decision;

(j) a record of the follow-up contact to the consumer and the response thereto; and

(k) copies of any and all other documents, notated telephone conversations or other communications relevant to the dispute.

(2) The department shall maintain an index of each manufacturer's disputes grouped under brand name and subgrouped under model.

(3) The department shall maintain an index for each manufacturer which shall indicate:

(a) all disputes in which the arbitration decision was in favor of the manufacturer;

(b) all disputes in which the manufacturer has complied with the arbitration decision by the date set for performance, if applicable;

(c) all disputes in which the manufacturer did not comply with the arbitration decision, if applicable;

(d) all disputes resolved by pre-decision settlement, time for compliance has occurred and manufacturer has complied; and

(e) all disputes resolved by pre-decision settlement, time for compliance has occurred and manufacturer has not complied.

(4) The department shall maintain an index of all disputes delayed beyond 60 days, noting specific causes for any such delay.

(5) The department shall compile semi-annually and maintain statistics which show the number and percentage of disputes in each of the following categories:

(a) telephone and written complaints received from consumers;

(b) complaints referred to arbitration;
(c) complaints adjudged to be ineligible for arbitration by failing to meet the criteria established by law;
(d) cases decided by arbitration panels and the manufacturer has complied;
(e) cases decided by arbitration panels in which time for compliance has occurred and manufacturer has not complied;
(f) cases decided by arbitration panels in which time for compliance has not occurred;
(g) cases adversely decided for the consumer;
(h) cases decided by arbitration panels in which partial recovery was awarded to the consumer;
(i) cases in which a full refund was awarded to the consumer;
(j) cases in which a replacement vehicle satisfactory to the consumer was awarded;
(k) cases resolved by pre-decision settlement, time for compliance has occurred and manufacturer has complied;
(l) cases resolved by pre-decision settlement, time for compliance has occurred and manufacturer has not complied;
(m) cases resolved by pre-decision settlement and time for compliance has not occurred;
(n) cases in which the decision is pending;
(o) cases in which the consumer accepted the decision; and
(p) cases in which the consumer rejected the decision;
(q) cases in which requests were made for copies of records for submission to court.
(6) The department shall file a copy of the semi-annual statistical summary with the Montana department of justice for consideration in determining the issuance of any manufacturer license required under Title 61, chapter 4, part 2, MCA."
Auth: Sec. 61-4-532, MCA; IMP, Sec. 61-4-518, 61-4-526, MCA

REASON: The Department is required to provide an independent forum and arbitration procedure for the settlement of disputes arising under the New Motor Vehicle Warranty Act. Section 61-4-515, MCA. Section 61-4-532, MCA, provides that the Department may adopt rules to implement the New Motor Vehicle Warranty Act. Section 61-4-526, MCA, requires the Department of Commerce to file with the Department of Justice records and statistics compiled from all New Motor Vehicle Warranty Act disputes. Section 61-4-518, MCA, requires the Department to "investigate, gather, and organize all information necessary for a fair and timely decision." Rule XVII requires the Department to gather an extensive record of each arbitration, as well as compile on a semi-annual basis statistics necessary to track the effectiveness of the arbitration program.

Rule XVII requires the Department to maintain an extensive record of each arbitration performed. The Department is required to index the material in several formats - by

manufacturer, brand name, and model; by type of dispute; and by manner of resolution. The Department is required to semi-annually compile and maintain statistical data relative to the success of the arbitration process for submission to the Department of Justice for consideration in issuing manufacturer licenses pursuant to Title 61, chapter 4, part 2, MCA.

The Department is obligated by statute to gather and provide information relative to requests for arbitration. Rule XVII advises consumers, manufacturers, arbitrators, and other interested persons of the information which must be provided in conjunction with a request for arbitration. In addition, the rule ensures that sufficient information is gathered to complete the statistical compilations which are prepared for the Department of Justice.

"XVIII NOTICE OF ARBITRATION DECISION (1) The arbitration panel shall render its decision within 60 days following the initial filing date of the consumer's request for arbitration. The decision shall be rendered by an agreement of the majority of the arbitrators.

(2) The department shall send the consumer and manufacturer official written notice of the arbitration decision by certified mail.

(3) The panel chairperson shall draft the decision and shall obtain the signatures of the majority of arbitrators. In the event that the chairperson dissents from the majority decision, he or she shall designate one of the agreeing arbitrators to write the decision. The department shall forward copies of the decision to all parties and arbitrators.

(4) The effective date of the decision shall be the date the written decision is signed by the panel chairperson or his or her designated representative.

(5) The arbitration decision shall contain the following:

(a) the panel's findings of fact and the reasons for its decision;

(b) appropriate remedies, if applicable, including but not limited to:

(i) repair of vehicle;

(ii) replacement of the vehicle with an identical vehicle or a comparable vehicle acceptable to the consumer;

(iii) refund as provided in 61-4-503(2), MCA;

(iv) any other remedy available under the applicable warranties or 15 U.S.C. 2301 through 2313 in effect on October 1, 1983; and

(v) reimbursement of expenses and costs to the prevailing party.

(6) Included with the copy of the arbitration decision sent to the consumer shall be a form to be completed by the consumer, indicating his or her acceptance or rejection of the decision. The consumer shall return the form to the department within 10 days from the date of the consumer's receipt of the notice. If the decision is not accepted, the parties shall

follow the provisions of Title 27, chapter 5, MCA."
Auth: Sec. 61-4-532, MCA; IMP, Sec. 61-4-519, MCA

REASON: The Department is required to provide an independent forum and arbitration procedure for the settlement of disputes arising under the New Motor Vehicle Warranty Act. Section 61-4-515, MCA. Section 61-4-532, MCA, provides that the Department may adopt rules to implement the New Motor Vehicle Warranty Act. Section 61-4-519, MCA, requires that the arbitration panel render a decision no later than 60 days after the Department has received a complaint.

The arbitration panel consists of three members. Section 61-4-516, MCA. Rule XVIII provides that a decision shall be rendered by an agreement of the majority of the arbitrators. The rule further provides that the effective date of a decision is when the written copy is signed by the panel chairperson or his or her representative. The rule provides for a determination in the event that the arbitrators are not unanimous in their decision. Additionally, the effective date of a decision is relevant to a determination of whether a party has in good faith timely completed performance of a remedy ordered by the panel.

Rule XVIII provides that a decision of the arbitration panel shall contain findings of fact and the reasons for the determination, and lists the remedies which may be awarded by the panel. The rule requires the Department to provide to the consumer a form to be completed and returned indicating if the decision of the panel is acceptable. If the decision is not acceptable, then the rule provides that the parties follow the provisions of Title 27, chapter 5, MCA.

Rule XVIII provides that a decision will be rendered in all cases, even when the arbitrators are not in agreement. The rule provides for a written decision, lists the available remedies, and advises the subsequent action in the event a panel decision is rejected by the consumer. The rule aids the Department in implementing section 61-5-519, MCA.

"XIX POST-PERFORMANCE DATE CONTACT (1) If the arbitration decision is in the favor of the consumer and requires some performance by the manufacturer, the department shall contact the consumer within 10 days following the date scheduled for performance of the arbitration award either by telephone or by mail to determine whether performance has occurred.

(2) If the consumer anticipates that the department either will be unable to contact or will encounter difficulties in contacting him or her at this time, he or she shall so notify the department at the time of the arbitration hearing. An alternative means or date for confirming performance shall then be determined by the department and the consumer."
Auth: Sec. 61-4-532, MCA; IMP, Sec. 61-4-519, MCA

REASON: The Department is required to provide an independent forum and arbitration procedure for the settlement of disputes arising under the New Motor Vehicle Warranty Act. Section 61-4-515, MCA. Section 61-4-532, MCA, provides that the Department may adopt rules to implement the New Motor Vehicle Warranty Act. Section 61-4-519, MCA, requires that, following an arbitration, the Department "contact the prevailing party within 10 working days of the date for performance" of the awarded remedy to determine whether performance has occurred.

Rule XIX requires that, if the arbitration decision requires performance on the part of the manufacturer, the Department shall contact the consumer within 10 days of the date the performance is to have occurred. The rule states that the contact may be either by telephone or mail. The rule also provides that, if the consumer anticipates the Department will have difficulty contacting him or her to verify the performance of the remedy, an alternative method of contact shall be determined by the Department and the consumer.

The Department is obligated to provide extensive reporting and statistical analysis of the New Motor Vehicle Warranty Act. Section 61-4-526, MCA. Rule XIX clearly provides that the Department is to gather information from the consumer regarding the performance of remedies afforded by the arbitration panel. The Department must be able to collect the post-arbitration information to fulfill its statutory reporting requirements.

"XX NOTICE OF RESALE OF RETURNED VEHICLE (1) If a motor vehicle is returned to the manufacturer and requires replacement or refund, that vehicle may not be sold in the state unless the seller provides the ultimate consumer a conspicuous written disclosure of the fact that the vehicle was returned. The seller shall give the ultimate consumer opportunity to review the disclosure form in its entirety and shall obtain on the form the ultimate consumer's signature."

Auth: Sec. 61-4-532, MCA; IMP, Sec. 61-4-525, MCA

REASON: The Department is required to provide an independent forum and arbitration procedure for the settlement of disputes arising under the New Motor Vehicle Warranty Act. Section 61-4-515, MCA. Section 61-4-532, MCA, provides that the Department may adopt rules to implement the New Motor Vehicle Warranty Act. Section 61-4-525, MCA, provides that a motor vehicle which is returned to the manufacturer and which requires replacement or refund may not be sold in this state without disclosure of the fact that the vehicle was returned.

Rule XX provides that the seller of a returned vehicle must provide to a buyer of the vehicle a conspicuous, written, disclosure of the returned status of the vehicle. In addition, the seller must give the purchaser an opportunity to review the

disclosure form in its entirety and obtain on the form the signature of the ultimate consumer of the vehicle.

The Department proposes rule XX to ensure that the disclosure required by section 61-4-525, MCA, is seen by the ultimate purchaser of the vehicle. By requiring that the seller of the vehicle obtain the signature of the ultimate purchaser on the disclosure form, the Department ensures that the ultimate purchaser is advised of the status of the vehicle. Section 61-4-525, MCA, is effectively implemented by requiring the signature of the ultimate purchaser on the disclosure statement.

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 Consumer Affairs Division, Department of Commerce, 1424 9th Avenue, P.O. Box 200501, Helena, Montana 59620-0546, no later than February 17, 1998.

4. Persons who wish to be informed of all Consumer Affairs rulemaking proceedings or other administrative proceeding, may be placed on a list of interested persons by advising the Department of Commerce at the rulemaking hearing or in writing to the Consumer Affairs Division, Department of Commerce, 1424 9th Avenue, P.O. Box 200501, Helena, Montana 59620-0546.

5. 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., February 10, 1998, to advise us of the nature of the accommodation that you need. Please contact Greg Overturf, Consumer Affairs Division, Department of Commerce, 1424 9th Avenue, P.O. Box 200501, Helena, Montana 59620-0546; telephone (406) 444-3553; 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 Greg Overturf.

6. Greg Overturf, Legal Counsel, has been designated to preside over and conduct the hearing.

CONSUMER AFFAIRS DIVISION

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, January 5, 1998.

BEFORE THE BOARD OF HOUSING
DEPARTMENT OF COMMERCE
STATE OF MONTANA

In the matter of the proposed amendment of rules pertaining to the Reverse Annuity Mortgage (RAM) Loan	))))	NOTICE OF PUBLIC HEARING ON THE PROPOSED AMENDMENT OF RULES PERTAINING TO THE REVERSE ANNUITY MORTGAGE (RAM) LOAN

TO: All Interested Persons:

1. On February 17, 1998, at 9:00 a.m., a public hearing will be held at the Board of Housing, 836 Front Street, Helena, Montana, to consider the proposed amendment of rules pertaining to the Reverse Annuity Mortgage (RAM) Loan.

2. The proposed amendments to ARM 8.111.402, 8.111.404 and 8.111.409 will read as follows: (new matter underlined, deleted matter interlined)

"8.111.402 DEFINITIONS As used in these rules the following words and phrases have the following meanings:

(1) will remain the same.

(2) "Family income" means the income of all adult members of the household, other than full-time students. The income is the amount of ~~the~~ anticipated total income ~~(adjusted gross income) shown on the prior year's federal income tax return(s) plus the prior year's~~ from all sources for the subsequent 12 month period from application. This includes non-taxable income such as social security and municipal bond interest. Any investment or business losses ~~which were~~ can not be subtracted in determining gross income ~~must be included~~. An exclusion will be allowed for certain defined, non-reimbursed, on-going, medical and independent living expenses.

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

Auth: Sec. 90-6-507, MCA; IMP, Sec. 90-6-503, 90-6-505, 90-6-506, MCA

REASON: The Definitions changes relate to the definition of "Family income". The first change to the definition is allowing income to be calculated based on anticipated gross income for the subsequent 12 month period from application. Many times the need for a RAM loan is because of changes in the applicants situation. They may have lost their ability to work because of medical problems that would not be reflected accurately based on the prior years tax return. The second change in the definition is to allow exclusions for certain medical and independent living expenses. We are finding there are more and more people who are above the set income levels but are truly in need of a RAM loan because of large medical bills. The exclusions will be similar to our existing Disabled Accessible Homeownership Program.

"8.111.404 ELIGIBILITY REQUIREMENTS (1) through (1)(b) will remain the same.

(c) ~~obtain an~~ agree to allow the board to obtain a current FHA appraisal and title insurance policy for the property;

(d) agree to pay for all closing costs including, but not limited to, the appraisal, title insurance policy, document recording and other closing costs;

~~(d)~~(e) ~~own the subject residence free and clear of any liens or encumbrances~~ assure that the reverse annuity loan is in first lien position at loan closing;

~~(e)~~(f) be at least 68 years of age or older, except as provided on a case-by-case basis by the board of housing;

(f) through (h) will remain the same, but will be renumbered (g) through (i)."

Auth: Sec. 90-6-507, MCA; IMP, Sec. 90-6-503, 90-6-505, 90-6-506, MCA

REASON: The Eligibility Requirements changes are needed to bring the ARM rules into agreement with the legislative changes that were made this year. They will also make the rules more clear that a current appraisal is needed and that the applicant will be responsible for the closing costs of the loan as well as the RAM loan being in first position at loan closing.

"8.111.409 CASH ADVANCES (1) As part of the loan amount, the board may advance at closing either to the borrower or to the third parties as directed by the borrower, an amount not to exceed $2,500~~.00~~ to allow the borrower to satisfy any liens on the property or make ~~emergency~~ repairs to the property, and in addition, ~~an~~ maximum amount not to exceed ~~$800.00~~ the actual ~~to cover~~ closing costs for items such as, but not limited to, appraisals, title policies, recording of documents~~,~~ and other closing costs. The board may also advance at closing either to the borrower or to third parties as directed by the borrower, an amount in excess of the above advance of $2,500 as approved by the board on a case-by-case basis. Such amounts so advanced shall be added to the initial loan balance. To receive a cash advance, the borrower must submit a request in writing on forms supplied by the board."

Auth: Sec. 90-6-104, 90-6-106, 90-6-507, MCA; IMP, Sec. 90-6-104, 90-6-106, 90-6-502, 90-6-505, MCA

REASON: The Cash Advances changes are to allow the board to adjust lump sum advance payments of $2,500 (repairs, prior liens etc) and $800 (closing costs) to reflect current environment. (i.e. actual closing costs are now $900+). The $2,500 limit could be exceeded on a case-by-case basis approved by the board and the $800 limit would be changed to the actual closing costs of the loan. The board is also recommending deleting the word "emergency" since the repairs may not always be an emergency but are needed.

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 Housing, Department of Commerce, 836 Front Street, P.O. Box 200528, Helena, Montana 59620-0528, no later than 5:00 p.m., February 17, 1998.

4. The Board 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 5:00 p.m., February 10, 1998, to advise us of the nature of the accommodation that you need. Please contact Bruce Brensdal, Board of Housing, Department of Commerce, 836 Front Street, P.O. Box 200528, Helena, Montana 59620-0528; telephone (406) 444-3040; Montana Relay 1-800-253-4091; TDD (406) 444-2978; facsimile (406) 444-4688. Persons with disabilities who need an alternative accessible format of this document in order to participate in this rule-making process should contact Bruce Brensdal at the above-stated address.

5. Persons who wish to be informed of all Board of Housing administrative rulemaking hearings or other administrative hearings may be placed on a list of interested persons by advising the Board at the rulemaking hearing or in writing to the Board of Housing, Department of Commerce, 836 Front Street, P.O. Box 200528, Helena, Montana 9620-0528.

6. Bruce Brensdal, Multi-Family Program Manager, will preside over and conduct the hearing.

BOARD OF HOUSING

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, January 5, 1998.

BEFORE THE FISH, WILDLIFE AND PARKS COMMISSION
OF THE STATE OF MONTANA

In the matter of the proposed amendment of ARM 12.6.901, limiting the use of motor-propelled water craft to ten horsepower on Lake Helena.	)))))	NOTICE OF PUBLIC HEARING

To: All Interested Persons.

1. On February 18, 1998, the Montana Fish, Wildlife and Parks Commission (commission) will hold a public hearing at 7:00 p.m. in the Fish, Wildlife and Parks commission room at 1420 East 6th Avenue, Helena, MT, regarding the amendment of ARM 12.6.901.

2. The proposed rule amendment provides as follows:

12.6.901 WATER SAFETY REGULATIONS (1) In the interest of public health, safety, or protection of property, the following regulations concerning the public use of certain waters of the state of Montana are hereby adopted and promulgated by the Montana fish, wildlife and parks commission.

(a) remains the same

(b) the following waters are closed to the use of all boats propelled by machinery of over 10 horsepower, except in cases of use for search and rescue, official patrol, or for scientific purposes:

(b)(i) remains the same

(b)(ii) other waters of the state as follows:

Hill County:	Beaver Creek Reservoir
Lewis and Clark County:	Lake Helena
Lincoln County:	Carpenter Lake
Missoula County:	(A) Blanchard Lake (on Clearwater River)

(c) through (2) remain the same

AUTH: 87-1-303, MCA IMP: 87-1-303, MCA

3. Rationale: Last Chance Audubon Society, Helena, raised concerns about potential increased motorized recreation on Lake Helena and the potential adverse effects on the Lake Helena Wildlife Management Area, a nesting area for migratory waterfowl. They asked the commission to consider rules to protect the area. The current motorized recreational use on Lake Helena is small motor boats primarily operated by waterfowl hunters. There is no public boat ramp to the lake. With the increasing popularity of water sports and the variety of motorized vessels, there is a potential for increased use which could adversely affect the wildlife. The proposed amendment would restrict boaters to motors of no more than 10 horsepower.

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 Mike Korn, Resource Program Manager, Department of Fish, Wildlife & Parks, P.O. Box 200701, Helena, MT 59620-0701 and must be received no later than February 24, 1998.

5. The Department of Fish, Wildlife and Parks maintains a list of persons interested in both department and commission rulemaking proceedings. Any person wishing to be on the list must make a written request to the department, providing name, address and description of the subject or subjects of interest. Direct the request to Montana Fish, Wildlife and Parks, Legal Unit, PO Box 200701, Helena, MT 59620-0701.

6. Robert N. Lane or another hearing examiner designated by the department will preside over and conduct the hearing.

RULE REVIEWER

Robert N. Lane

FISH, WILDLIFE AND PARKS COMMISSION

Patrick J. Graham, Secretary

Certified to the Secretary of State on January 5, 1998.

BEFORE THE DEPARTMENT OF TRANSPORTATION
OF THE STATE OF MONTANA

In the matter of the adoption of new rules pertaining to the seizure of improperly imported motor fuels	))))	NOTICE OF PUBLIC HEARING ON PROPOSED ADOPTION

TO: All Interested Persons.

1. On February 11, 1998, at 9 a.m., a public hearing will be held in the Commission Room of the Department of Transportation building, 2701 Prospect Avenue, Helena, Montana, to consider the adoption of the above-referenced new rules.

2. The new rules provide as follows:

RULE I DEFINITIONS For the purpose of these rules, the following definitions apply:

(1) "Department" means the department of transportation.

(2) "Licensed Montana distributor list" means a list of all gasoline, aviation, and special fuel dealers currently licensed in the state of Montana and any licenses issued or canceled with an effective date of the first of the month. The department shall update the list the first working day of each month and distribute the updated list by mail to all motor carrier services (MCS) officers within 5 working days. The updated list must also be accessible to MCS officers on the department's computer system within 2 working days of the update.

(3) "Seizure list" means a list containing the names of companies appearing on the warning list that have been issued a notice to appear for improperly importing fuel. The fuel tax management and analysis unit (FTMA) shall establish and maintain the list on the department's computer system. The list must be updated within 2 working days from the date MCS notifies FTMA that a company has been convicted by a court. If a company whose name is placed on the seizure list becomes a licensed distributor in the state of Montana, the company's name will be removed from the seizure list within 2 working days after the effective date of licensure.

(4) "Warning list" means a list established and maintained by the department indicating that a warning notice has been issued to a transporter for improperly importing fuel. The FTMA unit will update the list within 2 working days after notification by MCS. The updated warning list will be accessible to MCS officers on the department's computer system. If a warning notice is issued by an MCS officer for improperly importing fuel, the company name of the transporter, consignor, and consignee of the fuel, as listed on the invoice or bill of lading, will be added to the warning list upon verification by the FTMA unit that none of the listed parties are licensed distributors in the state of Montana. If any or all of the parties issued a warning notice for improperly importing fuel become licensed fuel distributors in the state of Montana, they shall be removed from the warning list within 2 working days of the effective date of the license.

AUTH: 15-70-104, MCA; IMP: 15-70-233 and 15-70-357, MCA

RULE II SEIZING IMPROPERLY IMPORTED FUELS (1) If an MCS officer determines that neither the transporter, consignor, nor consignee is a licensed fuel distributor in the state of Montana and any one of the transporters, consignors, or consignees is listed on the warning list defined above, the MCS officer shall issue a notice to appear to the transporter, consignor, and consignee for violation of 15-70-203 or 15-70-336, MCA, for improperly importing fuel. Upon conviction, the company's name must be placed on the seizure list.

(2) If an MCS officer determines that a load of fuel should be seized, the officer shall first obtain verification and approval from one of the department officials in the following order of precedence:

(a) Administrator, administration division;

(b) Administrator, motor carrier services division;

(c) Chief of the compliance bureau, motor carrier services division;

(d) Area captain, motor carrier services division; or

(e) Manager, FTMA unit.

(3) Upon obtaining approval to seize a load of fuel, an MCS officer shall escort the load to a licensed fuel distributor in the state of Montana that is under contract with the department to receive and purchase seized fuel. The seized fuel must be escorted to the nearest licensed bulk distributor that indicates it can accept the entire load of fuel into bulk storage within 12 hours from the time approval to seize the load of fuel is received by the seizing officer.

(4) If the operator of the transport tanker carrying the seized fuel refuses to operate the vehicle and unload it at the location designated by the MCS officer, the officer shall:

(a) Notify the transport company of the seizure and give it 12 hours to provide another driver to operate the vehicle and unload the tanker at the location specified by the MCS officer; or

(b) Request that a towing company tow the entire tanker to the towing company's location to be impounded at the towing company's lot by the MCS officer. In this case the transport company shall pay any towing and impoundment charges.

AUTH: 15-70-104, MCA; IMP: 15-70-233 and 15-70-357, MCA

RULE III NOTIFICATION OF SEIZURE OF FUEL (1) The department shall notify the transporter, consignor, and consignee in writing by certified mail within 48 hours of seizure that a load of fuel has been seized.

(2) The department shall provide the transporter, consignor, and consignee a blank form with which to claim interest or title to the seized fuel and/or request a hearing. Parties may use the form to claim interest or title to the fuel and request a hearing within 30 calendar days after the date of seizure. Claims received and postmarked after 30 days are automatically denied.

AUTH: 15-70-104, MCA; IMP: 15-70-233 and 15-70-357, MCA

RULE IV CONDUCT OF HEARING FOR CLAIM OR TITLE TO SEIZED FUEL (1) Upon receipt of a timely filed claim or request for

hearing, the department shall schedule a hearing at department headquarters in Helena, Montana, within 5 working days of the receipt of the request. The hearing may be scheduled by telephone, but all interested parties shall be notified of the hearing in writing by certified mail within 2 working days from the date the meeting was scheduled.

(2) The hearing shall be conducted by the department's chief of staff who shall serve as the hearings officer. If the chief of staff is unable to serve as the hearings officer, he shall select as an alternate a division administrator from within the department who was not involved in the decision to seize the fuel in question. The hearing may include representation by the department's legal unit and FTMA unit for the purpose of legal and technical consultation only.

(3) The hearing may include all parties claiming interest or title to the seized fuel and their legal representatives.

(4) Upon the conclusion of the hearing, the hearings officer shall determine that either:

(a) The parties claiming interest or title to the fuel shall forfeit title and interest in the fuel and the department shall deposit the proceeds from the sale of the fuel into the general fund of the state of Montana within 5 working days less tax, penalty, transportation cost and administrative costs; or

(b) The department shall reimburse those claiming interest or title in the fuel the wholesale price of the fuel on the day it was seized, less tax and penalty owed to the state of Montana, within 10 working days from the date of final determination by the department.

(5) The department shall provide written notice of the determination of the hearings officer to those persons claiming interest or title to the seized fuel within 2 working days after the date of the hearing.

AUTH: 15-70-104, MCA; IMP: 15-70-233 and 15-70-357, MCA

RULE V DETERMINATION OF WHOLESALE PRICE OF FUEL (1) The price the department charges a contracted licensed distributor for seized fuel shall be no less than the wholesale price as determined by this rule.

(2) The wholesale price of seized fuel shall be determined by averaging the price of fuel from three major refineries in the state of Montana on the day the fuel was seized.

(3) If the load of seized fuel contains more than one type of fuel, an average price will be determined for each type of fuel seized and the total values of each type of fuel will be added together to determine the wholesale value of the load of fuel.

AUTH: 15-70-104, MCA; IMP: 15-70-233 and 15-70-357, MCA

RULE VI CONTRACTING FOR PURCHASE OF SEIZED FUEL (1) The department's purchasing bureau shall contract for the purchase and disposition of seized fuel.

(2) The following requirements shall be included in any contract for the purchase and disposition of seized fuel:

(a) The distributor must be able to accept an entire load of fuel at a single location within 12 hours of notification by the

department that a load of seized fuel is available.

(b) The distributor may bid on the award of contracts in any or all of the department's 5 districts. Seized fuel may be unloaded at a location within the district where the fuel was seized or at a location in an adjoining district, whichever is closer. The location must be able to accept the entire load of fuel.

(c) Any distributor awarded a contract for purchase and disposition of seized fuel shall accept into storage all grades of gasoline, clear diesel fuel, dyed diesel fuel, aviation fuel, and kerosene.

AUTH: 15-70-104, MCA; IMP: 15-70-233 and 15-70-357, MCA

3. The new rules are necessary to fulfill the intent of the legislature to ensure that gasoline and special fuel improperly imported into the State of Montana is properly taxed and, if necessary, seized by the State according to Montana law. During the 1997 Legislative Session, concerns were brought to the attention of legislators by the licensed fuel distributors of the State of Montana, that large amounts of fuel were being illegally imported into the State by unlicensed fuel distributors and were, therefore, unreported and untaxed. This rule is necessary to implement the intent of the Legislature to collect taxes on improperly imported fuel, and to provide disincentives for such 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 William G. Salisbury, Administration Division, Department of Transportation, P.O. Box 201001, Helena, MT 59620-1001, and must be received no later than 5 p.m. February 13, 1998.

5. Stephen F. Garrison has been designated to preside over and conduct the hearing.

6. The two bill-sponsor-notice requirements of section 2-4-302, MCA, apply and have been complied with.

7. MDT attempts to provide accommodations for any known disability that may interfere with a person participating in any service, program or activity of the Department. Alternative accessible formats of this document will be provided upon request. For further information call (406)444-7284 or TDD users can call 1-800-TDD-NETT.

8. The Department of Transportation maintains a list of interested persons who wish to receive notices of the rulemaking actions it proposes. Persons who wish to have their name added to the list shall make a written request which includes the name and mailing address of the person to receive notices and specifies the subject area or areas of interest of the person requesting notice, including, but not limited to, rules proposed by the Administration Division, Aeronautics Division, Highways and Engineering Division, Maintenance Division, Motor Carrier Services Division, and Rail, Transit and Planning Division. Such written request may be mailed

or delivered to the Montana Department of Transportation, Legal Services, P.O. Box 201001, Helena, MT 59620-1001, faxed to the office at (406)444-7206, or may be made by completing a request form at any rules hearing held by the Department.

MONTANA DEPARTMENT OF TRANSPORTATION

By: _____
MARVIN DYE, Director

_____
Lyle Manley, Rule Reviewer

Certified to the Secretary of State January 5, 1998.

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

In the matter of the proposed amendment of 36.24.104 concerning Types of Bonds; Financial and Other Requirements in the Wastewater Revolving Fund Act	))))	NOTICE OF PROPOSED AMENDMENT NO PUBLIC HEARING CONTEMPLATED

TO: All Interested Persons.

1. On February 16, 1998, the Montana Department of Natural Resources and Conservation proposes to amend ARM 36.24.104 pertaining to types of bonds; financial and other requirements in the wastewater revolving fund act.

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

36.24.104 TYPES OF BONDS; FINANCIAL AND OTHER REQUIREMENTS

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

(vii) the district shall agree not to incur any additional debt payable from the revenues of the system without the written consent of the department, unless the net revenues of the system for the last complete fiscal year preceding the issuance of such additional bonds have equaled at least ~~125~~ 110% of the maximum amount of principal and interest payable from the revenue bond account in any subsequent fiscal year during the term of the then outstanding bonds and the additional bonds proposed to be issued. For the purpose of the foregoing computation, the net revenues must be those shown by the financial reports caused to be prepared by the district, except that if the rates and charges for services provided by the system have been changed since the beginning of the preceding fiscal year, then the rates and charges in effect at the time of issuance of the additional bonds must be applied to the quantities of service actually rendered and made available during such preceding fiscal year to ascertain the gross revenues, from which there shall be deducted, to determine the net revenues, the actual operation and maintenance cost plus any additional annual costs of operation and maintenance which the engineer for the district estimates will be incurred because of the improvement or extension of the system to be constructed from the proceeds of the additional bonds proposed to be issued. In no event shall any such additional bonds be issued and made payable from the revenue bond account if there then exists any deficiency in the balances required to be maintained in any of the accounts of the fund or if the district is in default in any of the other provisions;

Subsection (1)(c)(viii) through (1)(d)(vi) remain the same.

AUTH: 75-5-1105, MCA
IMP: 75-5-1113, MCA

3. The amendment is being proposed to decrease the department's coverage of its wastewater district loans from 125%

to 110% to make this program consistent with other programs available to water and sewer districts that use a 110% coverage. This change makes the State Revolving Fund loan program match the requirements of the other loan programs to districts.

4. Interested parties may submit their data, views or arguments concerning the proposed amendment **in writing to Anna Miller, Montana Department of Natural Resources and Conservation, P.O. Box 201601, Helena, MT 59620-1601, to be received no later than 5:00 p.m., February** 12, **1998.**

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 hearing and submit this request along with any written comments he has to Anna Miller, Montana Department of Natural Resources and Conservation, P.O. Box 201601, Helena, MT 59620-1601. The comments must be received no later than 5:00 p.m., February** 12, **1998.**

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 greater than 25, based on the number of persons who have an interest in the wastewater treatment revolving fund.**

7. The Department of Natural Resources and Conservation maintains a list of interested persons who wish to receive notices of rulemaking actions proposed by this agency. Persons who wish to have their name added to the list have a right to be placed on the department's list. A person must make a written request which includes the name and mailing address of the person to receive notices and specifies whether the person wishes to receive notices of administrative rules regarding conservation districts and resource development, forestry, oil and gas conservation, trust land management, water resources or combination thereof. Such written request may be mailed or delivered to the Department of Natural Resources and Conservation, 1625 11th Avenue, P.O. Box 201601, Helena, MT 59620-1601, faxed to the office at (406) 444-2684, or may be made by completing a request form at any rules hearing held by the Department of Natural Resources and Conservation.

DEPARTMENT OF NATURAL RESOURCES
AND CONSERVATION

ARTHUR R. CLINCH, DIRECTOR

DONALD D. MacINTYRE, REVIEWER

Certified to the Secretary of State January 5, 1998.

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

In the matter of the amendment of 16.38.307 pertaining to laboratory fees for clinical analysis	)	NOTICE OF PROPOSED AMENDMENT
	)	NO PUBLIC HEARING CONTEMPLATED

TO: All Interested Persons

1. On February 14, 1998, the Department of Public Health and Human Services proposes to amend 16.38.307 pertaining to laboratory fees for clinical analysis.

The Department of Public Health and Human Services will make reasonable accommodations for persons with disabilities who need an alternative accessible format of this notice. If you request an accommodation, contact the department no later than 5:00 p.m. on January 26, 1998, to advise us of the nature of the accommodation that you need. Please contact Dawn Sliva, Office of Legal Affairs, Department of Public Health and Human Services, P.O. Box 4210, Helena, MT 59604-4210; telephone (406)444-5622; FAX (406)444-1970.

2. The rule as proposed to be amended provides as follows. Matter to be added is underlined. Matter to be deleted is interlined.

16.38.307 LABORATORY FEES FOR ANALYSES (1) ~~Effective July 1, 1997, fees~~ 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~~ 15.00
Atypical pneumonia panel	~~15.00~~ 76.50
Autoclave, sterility check	~~10.00~~ 15.00
Bact. enteric panel	~~25.00~~ 36.50
Bacteriology culture, identification	~~10.00~~ 26.50
Blood-borne exposure panel	~~35.00~~ 48.00
Blood lead	15.00
C. Difficile cytotoxin	~~14.00~~ 24.60
Chlamydia, direct probe	~~10.00~~ 12.20
Chlamydia, gene amplification	~~17.00~~ 18.75
Chronic fatigue panel	~~20.00~~ 54.00
EHEC toxin	~~15.00~~ 19.60
Encephalitis panel	~~18.00~~ 54.00
Exantham panel	~~20.00~~ 51.35
FTA	~~15.00~~ 24.70

Fungal culture	~~20.00~~	28.16
GC + chlamydia, direct probe	~~18.00~~	21.80
GC + chlamydia, amplification	~~30.00~~	35.00
Hepatitis panel (acute)	~~45.00~~	54.00
Hepatitis C	~~17.00~~	26.50
Hepatitis B, anti HbsAb	~~12.50~~	17.80
Hepatitis B, anti HBsAg	~~10.00~~	15.80
Herpes simplex culture	~~10.00~~	24.50
HIV screen, serum	~~11.00~~	12.80
HIV screen, oral fluid	~~21.00~~	24.60
HIV viral load	~~150.00~~	120.00
HIV western blot	~~15.00~~	44.00
Misc. direct Ag detection	~~14.00~~	17.60
Misc. serologies	~~12.50~~	15.20
Misc. serologies, IgG + IgM	~~25.00~~	42.50
Newborn screening	~~18.50~~	35.50
Newborn screening + CF	~~23.00~~	55.30
Newborn screening, monitor	~~10.00~~	19.80
Parasite identification	~~14.00~~	21.20
Prenatal, short panel	~~25.00~~	30.00
Prenatal + HIV	~~28.00~~	35.00
Respiratory, long panel	~~15.00~~	76.50
Respiratory, short panel	~~10.00~~	54.00
Rubella screen	~~10.00~~	14.60
Syphilis screen	~~9.00~~	14.60
Tb direct amplification	~~100.00~~	140.00
Tb screen	~~20.00~~	35.20
Tick-borne panel	~~18.00~~	54.00
TORCH short panel	~~15.00~~	54.00
TORCH + Parvovirus	~~20.00~~	62.50
Viral culture	~~14.00~~	28.20

(2) and (3) remain the same.

AUTH: Sec. 50-1-202, MCA
IMP: Sec. 50-1-202, MCA

3. Section 50-1-202(17), MCA, requires the department to adopt fees for the tests and services performed by the department's laboratory which reflect the actual costs of the tests or services provided. The same provision requires that the fees do not exceed the cost of performing the tests or services. The existing fee structure in ARM 16.38.307 does not reflect the actual costs of the tests or services currently provided by the laboratory. As a result, the department was required to obtain a loan from the State general fund. The proposed changes in fees are reasonably necessary to reflect the actual cost to the department of the analyses. Fee structures from both private and public laboratories were reviewed and taken into account when establishing the proposed fee structure. The proposed fee structure will eliminate the need to borrow further monies from the general fund and will allow the

department to repay the existing loan.

As an alternative to adjusting the fee schedule in ARM 16.38.307, the department could seek general fund support for the laboratory which would eliminate the need for the proposed fee increases. However, general fund support of the department's laboratory was eliminated by previous legislatures who intended the laboratory to be a "fee for service" laboratory. A second alternative would be to do nothing with the existing fee structure. If the department were to leave the existing fee structure intact, the department would be required to reduce staff and laboratory services offered to the public. Neither of these options appear viable at the current time.

4. Interested persons may submit their data, views or arguments concerning the proposed action in writing to Debbie G. Allen, Office of Legal Affairs, Department of Public Health and Human Services, P.O. Box 202951, Helena, MT 59620-2951, no later than February 12, 1998. The Department also maintains lists of persons interested in receiving notice of administrative rule changes. These lists are compiled according to subjects or programs of interest. For placement on the mailing list, please write the person at the address above.

5. If a person who is directly affected by the proposed action wishes to express data, views and arguments orally or in writing at a public hearing, that person must make a written request for a public hearing and submit such request, along with any written comments to Debbie G. Allen, Office of Legal Affairs, Department of Public Health and Human Services, P.O. Box 202951, Helena, MT 59620-2951, no later than February 12, 1998.

6. If the Department of Public Health and Human Services receives requests for a public hearing on the proposed action from either 10% or 25, whichever is less, of those who are directly affected by the proposed action, from the Administrative Code Committee of the legislature, from a governmental agency or subdivision, or from an association having no less than 25 members who are directly affected, a hearing will be held at a later date and a notice of the hearing will be published in the Montana Administrative Register. Ten percent of those directly affected has been determined to be 25 based on the number of organizations affected by rules covering laboratory fees for clinical analysis.

Russell E. Cater
Rule Reviewer

Nancy Ellenwood
Director, Public Health and Human Services

Certified to the Secretary of State January 5, 1998.

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

In the Matter of the adoption of rules I through XVIII pertaining to tattoo rules	))))	NOTICE OF PUBLIC HEARING ON PROPOSED ADOPTION OF RULES

TO: All Interested Persons

1. On February 4, 1998, 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 adoption of rules I through XVIII pertaining to tattooing.

The Department of Public Health and Human Services will make reasonable accommodations for persons with disabilities who wish to participate in this public hearing or need an alternative accessible format of this notice. If you request an accommodation, contact the department no later than 5:00 p.m. on January 23, 1998, to advise us of the nature of the accommodation that you need. Please contact Dawn Sliva, Office of Legal Affairs, Department of Public Health and Human Services, P.O. Box 4210, Helena, MT 59604-4210; telephone (406)444-5622; FAX (406)444-1970.

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

[RULE I] TATTOOING: DEFINITIONS (1) "Certificate of sanitation" means a written certificate issued by the department to a tattoo shop signifying compliance with these rules.

(2) "Client" means the person, customer or patron whose skin will be tattooed.

(3) "Communicable disease" means a disease which can be transmitted from person to person directly or indirectly, including diseases transmitted via blood or body fluids.

(4) "Department" means the department of public health and human services.

(5) "Disinfectant" means a substance or solution, registered with the United States Environmental Protection Agency (EPA), which kills or inactivates viruses and pathogenic microorganisms, but not necessarily their spores, on cleaned environmental surfaces, and which is formulated for decontamination procedures.

(6) "Disposable" means items which are intended for use and disposal, but not necessarily suitable for cleaning, sanitizing and re-use.

(7) "Germicidal cleanser" means a substance, which when used according to manufacturer's instructions, cleans and

reduces the level of microbial contamination on a surface, and which is suitable for use on the skin.

(8) "Infectious waste" means the definition found in 75-10-1003, MCA.

(9) "Ink cup" means a small container for an individual portion of pigment which may be installed in a holder or palette, and in which a small amount of pigment of a given color is placed.

(10) "Permanent makeup" means tattooing colored pigment along the upper or lower margin of the eyelids, or into the skin on eyelids, lips, cheeks or other parts of the face for cosmetic purposes.

(11) "Physician" means a person licensed to practice medicine in Montana by the Montana board of medical examiners.

(12) "Sharps" means the definition found in 75-10-1003, MCA.

(13) "Single use" means items which are intended for one time, one person use only, then to be discarded.

(14) "Sterilize" means to treat an object or surface with a procedure that kills or irreversibly inactivates all microorganisms, including bacteria, viruses, and pathogenic fungi, including their spores.

(15) "Tattoo" means the definition found in 50-2-116, MCA.

(16) "Tattooist" means a person who engages in the practice of tattooing the skin of a live human being and includes a person administering tattoos to impart permanent makeup on the skin such as permanent lip coloring, permanent eye-liner or permanent skin coloration for any purpose other than noted in (16)(a) through (d), whether or not such activities occur in whole or in part in a tattoo shop, beauty salon, or other business setting. This term does not include:

(a) the practice of electrology as defined in 37-32-102, MCA;

(b) a physician or licensed medical professional employing colors, dyes, pigments for the purposes of obscuring scar tissues or imparting color to the skin for cosmetic, medical or figurative purposes;

(c) a person engaged in body puncturing or piercing for the purpose of creating a perforation in the skin for inserting jewelry or ornamental hardware, unless that person also does tattooing; or

(d) an acupuncturist.

(17) "Tattoo shop" means any room, space or establishment, including a temporary or mobile facility, where tattooing is practiced.

(18) "Temporary or mobile facility" means a facility where tattooing is conducted for not more than 14 days in a calendar year.

AUTH: Sec. 50-1-202, MCA
IMP: Sec. 50-1-202, MCA

[RULE II] TATTOOING: TATTOO SHOP REQUIREMENTS (1) Each tattoo shop must:

(a) have a work room for applying tattoos which complies with [Rule III];

(b) be maintained in good repair at all times during which the shop is operating. All parts of the shop and its premises must be kept clean and free of rubbish and sources of airborne dust;

(c) have an approved water supply and sewage treatment system meeting applicable local and state statutes and rules. If the water source is not served by a public water supply approved by the Montana Department of Environmental Quality, the water source must be sampled for bacteriologic testing at a certified laboratory at least 2 times per year. The testing records must be maintained on the premises and be available for review and verification by the department or its authorized representative. During periods when the public water supply may be contaminated or operating under a boil order of the Montana Department of Environmental Quality, an alternative source of sterilized water or bottled, distilled water must be used for hand washing and other tattooing operations;

(d) have a client toilet and hand washing sink. The toilet room must be vented, well lighted and equipped with a self-closing door and a covered waste receptacle. A hand washing sink must be located either within the toilet room or within 10 feet of the toilet room door, with a sink, soap dispenser, and hot and cold running water. If the hand washing sink is not in the toilet room, an additional covered waste receptacle is required in the immediate location of the hand washing sink. Single service towels must be provided for hand drying; and

(e) maintain its floors and ceilings in good repair and clean condition.

(2) A tattoo shop may not be operated in any room or area used as living or sleeping quarters. A tattoo shop must be separated from any living or sleeping quarters by complete partitioning and solid self-closing doors.

(3) A temporary or mobile facility may be operated in connection with a tattoo shop if the tattoo shop submits to the department:

(a) a written plan that demonstrates to the department how the temporary or mobile facility will meet the provisions of these rules, or will use alternatives which provide equivalent protection as provided by these rules; and

(b) the department or its authorized representative issues written approval of the plan.

(4) At a minimum, the plan referenced in (3) above must include information on the facility's:

(a) water supply source;

(b) sanitation, sterilization, infection control, and record keeping methods and procedures;

(c) waste disposal methods and procedures, including wastes contaminated with blood or body fluids; and

(d) ability to provide adequate toilets and hand washing sinks.

AUTH: Sec. 50-1-202, MCA
IMP: Sec. 50-1-202, MCA

[RULE III] TATTOOING: WORK ROOM REQUIREMENTS (1) The work room in which tattoos are applied must be separated by barrier from the waiting area. The room need not have complete physical separation, but must be segregated by counters, barriers and self-closing doors, such that clients or other employees may not enter the work room unless they open a door to gain access. Animals are not allowed in the work room, except for guide or handicap dogs.

(2) The work room must have:

(a) a minimum of 10 foot-candles of light measured at the level of the tattooing operation or the counter top;

(b) adequate ventilation. If heating ducts, vents or air conditioners discharge into the work room, the intakes for such venting must be filtered to minimize airborne dust and insects;

(c) a hand washing sink with hot and cold running water unless there is a hand washing sink outside the work room within 10 feet of the work room door. If the hand washing sink is outside the work room, the work room door must be a 2-way self-closing door. If controls for wrist or foot activation are not available, single service towels must be used for turning controls off after washing hands. The hand washing sink must be sanitized daily; and

(d) a sufficient number of waste receptacles for the disposal of waste materials. A dedicated container for the disposal of sharps must be located in the work room.

(3) The work room may not be used as a corridor for access to other rooms.

(4) The work room must be maintained in a clean condition to prevent contamination from previous clients and exposure to contaminants during tattooing procedures. Work tables, counter tops and other client contact surfaces must be sanitized between clients with a disinfectant solution having virucidal capability. The floor of the work room must be constructed of smooth and impervious materials and must be wet-mopped daily.

(5) Clients may be tattooed only in the work room.

(6) Closed containers must be maintained in the work room for the storage of instruments, needles, bars, tubes, dyes and pigments, carbon transfer blanks and other materials used in the tattooing procedures. Disinfectants, cleaning compounds, pesticides and other chemicals must be stored in a separate container.

(7) Tables, trays and tattooing utensils may not be shared between or among tattooists tattooing clients at the same time.

(8) Work tables must be constructed of metal or other material which is easily cleanable, smooth, non-absorbent, corrosion-resistant, and easily sanitized.

AUTH: Sec. 50-1-202, MCA
IMP: Sec. 50-1-202, MCA

[RULE IV] TATTOOING: UTENSILS AND SUPPLIES (1) Needles and bars must be:

(a) either single use and discarded after one use or if not single use, sterilized in accordance with [Rule VI]; and

(b) made of commercially manufactured stainless steel, nickel plated carbon steel, or similar corrosion resistant material. The solder used to attach needles to bars must be silver solder and lead free.

(2) Tubes must be:

(a) made of autoclavable stainless steel, anodized aluminum, nickel plated carbon steel, or autoclavable polymer (plastic) and must be sterilized between uses in accordance with [Rule VI]; or

(b) of single use construction and discarded after one use.

(3) A durable tray must be maintained in the work room for the placement of used tweezers, tubes, bars and needles, and other articles which require autoclaving. Single use needles must be disposed of in a sharps disposal container after use. If needles are to be held for autoclaving, the tray on which the needles are placed must be puncture proof.

(4) The tattoo shop must maintain on its premises at all times the following minimum supplies:

(a) one-half gallon of germicidal cleanser or tincture surgical soap;

(b) one-half gallon of 70% isopropyl alcohol;

(c) one-half gallon of distilled water;

(d) twenty-four sets of sterilized needles and bars per tattooist. For purposes of this requirement, one set of needles and bars consists of one liner needle soldered to a bar and one shader soldered to a bar;

(e) twenty-four sterile liner tubes per tattooist;

(f) twenty-four sterile shader tubes per tattooist;

(g) three hundred disposable latex or vinyl examination gloves; and

(h) five hundred single use ink cups.

AUTH: Sec. 50-1-202, MCA
IMP: Sec. 50-1-202, MCA

[RULE V] TATTOOING: HEPATITIS B VACCINATION (1) A tattoo shop owner, employing at least one tattooist, shall offer:

(a) pre-exposure Hepatitis B vaccine to the employee(s), unless serologic testing indicates they are immune to the infection; and

(b) post-exposure Hepatitis B vaccine to the employee(s) who incur a needle stick or other accidental exposure to blood or body fluids, or articles which may be contaminated with blood or body fluids.

(2) Tattooists who contract Hepatitis B, C or D must cease tattooing until the tattooist is no longer infective and does not present a communicable disease risk as evidenced by written medical or serologic evidence.

AUTH: Sec. 50-1-202, MCA
IMP: Sec. 50-1-202, MCA

[RULE VI] TATTOOING: STERILIZATION REQUIREMENTS

(1) Each tattooist must:

(a) use sets of individually wrapped, sterilized needles, bars and tubes for each new client. Rusty, defective or faulty needles may not be used;

(b) except as provided in (2) below, sterilize reusable needles, bars, tubes and any other articles which may come into contact with blood or body fluids, using autoclave sterilization, by placing the wrapped needles, bars and tubes in an autoclave for 20 minutes at 15 pounds pressure at a temperature of 250 degrees Fahrenheit, or in accordance with the manufacturer's instructions. Autoclave packaging must be used to sterilize needles, bars, tubes, and any other articles which may come into contact with blood or body fluids. Testing indicator strips for checking temperature must be used each time the autoclave is operated. After autoclaving, the package must be date marked and initialed by the tattooist. If the sterilized needle, bar or tube is not used within 60 days of the sterilization date, the article must be resterilized before use;

(c) conduct quarterly biological monitoring for autoclave effectiveness using standard spore suspension units available for this purpose. A written record of quarterly reports must be maintained on the premises and be available for review and verification by the department or its authorized representative;

(d) following sterilization, keep the needle sets and tubes in the autoclave packaging. The packages may only be opened in full view of the client;

(e) sterilize, by autoclave sterilization, pen-style tattooing machines and the components intended for reuse; and

(f) use a new pair of disposable latex or vinyl examination gloves for each client.

(2) Any tattoo shop in existence in this state prior to the adoption of this rule which uses dry heat sterilization as its sterilization method may continue to use dry heat sterilization, instead of autoclave sterilization as required under (1)(b), for a period of one year after the adoption of this rule.

AUTH: Sec. 50-1-202, MCA
IMP: Sec. 50-1-202, MCA

[RULE VII] TATTOOING: ULTRASONIC CLEANING UNIT (1) An ultrasonic cleaning unit, when used for needles, tubes or other parts which may become contaminated during the tattooing process, must be used in accordance with the manufacturer's instructions. An ultrasonic cleaning unit does not satisfy the sterilization requirements in [Rule VI], with or without the addition of chemical sanitizers.

AUTH: Sec. 50-1-202, MCA
IMP: Sec. 50-1-202, MCA

[RULE VIII] TATTOOING: SKIN PREPARATION (1) Prior to performing a tattoo, each tattooist must:

(a) clean under and around his or her fingernails with a nail brush, used solely by the particular tattooist;

(b) thoroughly wash and scrub his or her hands with hot running water, a germicidal hand cleanser and an individual hand brush, used solely by the particular tattooist;

(c) wear a clean sleeved outer garment and hair restraint; and

(d) clean and wash the client's skin area to be tattooed with hot water and a germicidal cleanser. If it is not necessary to shave the client's skin area, the tattooist must then rinse the skin area at the tattoo site with a 70% isopropyl alcohol solution.

(2) If it is necessary to shave the client's skin area to be tattooed, the tattooist must use single service disposable razors. Straight razors and replaceable blade units may not be used. After shaving the client's skin, the tattooist must:

(a) wash and scrub his or her hands;

(b) clean the skin at the tattoo site with tincture surgical soap, green soap or other germicidal cleanser using a sterile gauze pad, sponge or single use tissue; and

(c) rinse the skin at the tattoo site with a 70% isopropyl alcohol solution.

AUTH: Sec. 50-1-202, MCA
IMP: Sec. 50-1-202, MCA

[RULE IX] TATTOOING: PATTERN TRANSFER (1) If the method of pattern transfer involves a reusable plastic or acetate stencil, the stencil must be sanitized immediately prior to the application using a germicidal cleanser and a 70% isopropyl alcohol rinse.

(2) If the method of pattern transfer involves a hectograph pencil, a disposable carbon transfer sheet or a thermal spirit transfer sheet or other single use transfer method, the tattooist must meet the following requirements:

(a) The pencil, drawing instrument, transfer sheet, or other single use transfer product must be stored in a closed dust proof cabinet.

(b) The transfer produced by a tattooist for transferring the design to the skin must be single use. The pattern may be reused.

(3) An adherent or emollient applied to facilitate a pattern transfer, or to cover a pattern after transfer, must be from a single use collapsible tube, a spray bottle or a large supply container. If a large supply container is used, the adherent or emollient must be extracted using a disposable, single use utensil such as a disposable tongue depressor to prevent contamination of the adherent or emollient supply.

(4) An adherent or emollient used for a pattern transfer may be a pine oil and alcohol preparation, a tincture green soap, carbolated petrolatum or antibacterial ointment. Deodorant sticks may not be used on a client's skin for adherent or emollient purposes.

(5) After the transfer or design is applied, the tattooist must put on a pair of disposable latex or vinyl examination gloves to be used only for that particular tattooing procedure. If the tattooist wore gloves to wash or shave the client's skin or to transfer the pattern to the client's skin, the tattooist must discard those gloves after completing those procedures. The tattooist must then put on a new pair of disposable latex or vinyl examination gloves before proceeding with the application of the tattoo.

AUTH: Sec. 50-1-202, MCA
IMP: Sec. 50-1-202, MCA

[RULE X] TATTOOING: TATTOO APPLICATION (1) If, during the process of tattooing, the tattooist sustains a needle stick, the tattooist must:

(a) stop tattooing immediately;

(b) replace the tube, needle, and bar sets with a sterile setup; and

(c) wash and reglove before continuing the tattoo procedure.

(2) During the process of tattooing, each tattooist must:

(a) use single use disposable ink cups for pigments. If additional pigment must be added to the ink cup during the tattooing procedure, a disposable handling liner may be used or the tattooist must wash and re-glove. Ink storage containers and other surfaces must be considered as potentially contaminated. Individual pigment portions and ink cups must be disposed of in accordance with [Rule XIII];

(b) use single use disposable gauze or tissue to absorb blood, fluids and ink on the client's skin during the tattooing procedure;

(c) not smoke in the work room during tattooing procedures;

(d) avoid touching his or her eyes, nose or mouth with gloved hands. After gloving, if any object, such as an ink container, a telephone receiver, or door knob, is inadvertently touched or retrieved from the floor or otherwise comes into contact with the gloved hands of the tattooist, the tattooist must rewash and reglove before proceeding with the tattooing procedure; and

(e) prohibit dusting, cleaning, vacuuming or other cleaning of floors, walls, ceilings or attached equipment during times when clients are being tattooed or while tattoos are exposed to the air.

AUTH: Sec. 50-1-202, MCA
IMP: Sec. 50-1-202, MCA

[RULE XI] TATTOOING: AFTERCARE (1) After applying the tattoo, each tattooist must wash the completed tattoo with a piece of sterile gauze or sterile cotton saturated with a germicidal cleanser or tincture surgical soap, and allow the tattooed skin to air dry. After drying, anti-bacterial ointment must be applied from a collapsible metal or plastic tube or single use package. The entire tattooed skin area must be covered with a non-stick sterile gauze and bandage or other effective means of protection and infection prevention.

(2) Aftercare instructions must be provided to the client both verbally and in writing after every tattoo procedure.

AUTH: Sec. 50-1-202, MCA
IMP: Sec. 50-1-202, MCA

[RULE XII] TATTOOING: COLORS, DYES AND PIGMENTS (1) Each tattooist must use only sterile colors, dyes and pigments from reputable suppliers, stored in appropriate containers, to insure and maintain their integrity and sterility. After completing the tattooing procedure, the remaining dye or pigment in the disposable ink cup must be regarded as infectious waste, and must be discarded in accordance with [Rule XIII].

(2) Pigments mixed or prepared in the tattoo shop must be sterilized, stored in sterile containers and kept sterile in accordance with the manufacturer's instructions.

(3) A tattooist who becomes aware of a client who has experienced an apparent reaction, allergy, or sensitivity to a pigment used in tattooing must report the condition and pigment information to the Department of Public Health and Human Services, Food and Consumer Safety Section, Cogswell Building, P.O. Box 202951, Helena, Montana 59620-2951 or the local health officer. Adulterated pigments or those containing deleterious substances may be subject to voluntary hold, manufacturer recall or other action under the Montana Food, Drug and Cosmetic Act, the federal Food, Drug and Cosmetic Act, or other local, state or federal law. This reporting requirement does not apply to

skin sensitivity to antibacterial ointments, soaps, or tape adhesive used in bandaging.

(4) Pigments or dyes disapproved or under recall by the United States Food and Drug Administration or the department under the Montana Food, Drug and Cosmetic Act may not be used.

AUTH: Sec. 50-1-202, MCA
IMP: Sec. 50-1-202, MCA

[RULE XIII] TATTOOING: HANDLING AND DISPOSAL OF INFECTIOUS MATERIAL (1) Each tattooist must ensure that sharps, such as discarded or used needles, razors and any other articles that may cause punctures or cuts, and other articles which are contaminated, or which contain or may contain infectious waste, are handled and disposed of in accordance with the following requirements:

(a) A sharps disposal container must be used in which sharps are placed for storage, transportation, treatment, and subsequent disposal. An adequate supply of sharps containers must be maintained on the premises. A sharps container must:

(i) be sealable, rigid (puncture proof), and strong enough to protect the handler and others from accidental cuts or puncture wounds;

(ii) not be overfilled; and

(iii) be leak proof, and labeled or color-coded.

(b) Infectious disposable waste, other than sharps, must be placed in moisture-proof disposable containers or bags of a strength sufficient to prevent ripping, tearing, or bursting under normal conditions of use. The bags must be securely tied to prevent leakage or expulsion of solid or liquid wastes during storage, handling, and transportation. Waste receptacles must be removed by persons trained in infection control. Single plastic trash can liners may not be used as a vehicle for storing or transporting infectious waste.

(c) A tattooist must use:

(i) an implement or tool, such as tongs or pliers, to bend, separate from the bar or otherwise manipulate used needles; and

(ii) a brush, dust pan or tongs to pick up any broken glassware in the work room. A tattooist, having engaged in such cleanup, must wash his or her hands and reglove before working with a client.

(d) Laundry which may have been contaminated with blood must be handled as little as possible and stored separately in a closed container prior to cleaning. It must be stored and transported in bags or containers which prevent soak-through or leakage of fluids.

(e) All disposable infectious waste or material must be treated and disposed of in accordance with Title 75, chapter 10, part 10, MCA. The department hereby adopts and incorporates by reference Title 75, chapter 10, part 10, MCA, which sets forth the requirements for treating and disposing of infectious waste.

A copy of Title 75, chapter 10, part 10, MCA, may be obtained from the Department of Public Health and Human Services, Food and Consumer Safety Section, Cogswell Building, P.O. Box 202951, Helena, Montana 59620-2951.

AUTH: Sec. 50-1-202, MCA
IMP: Sec. 50-1-202, MCA

[RULE XIV] TATTOOING: CLIENT RECORD (1) Each tattooist must maintain a client record for each client. At a minimum, the client record must include:

(a) a copy of the signed consent form required by [Rule XV];

(b) the name of the tattooist who performed the tattoo, and the address and telephone number of the tattoo shop;

(c) special instructions or notations regarding the client's medical or skin conditions; and

(d) a written physician referral if a referral is required by [Rule XVI].

(2) Client records must be maintained on the tattoo shop premises for a minimum of 2 years. The records must be available for review and verification by the department or its authorized representative.

AUTH: Sec. 50-1-202, MCA
IMP: Sec. 50-1-202, MCA

[RULE XV] TATTOOING: CONSENT FORM (1) Each client must sign a consent form. The consent form must contain:

(a) the client's name and address, the date tattooed, the design of the tattoo, its location on the client's body and any other information that the tattooist may deem appropriate;

(b) pre-service information describing:

(i) possible allergies, skin or systemic reactions, side-effects and potential complications of tattooing, including the possibility of scarring and changes in the appearance of the tattoo over time; and

(ii) the permanent nature of tattoos, including a description of removal methods such as laser treatment or surgery.

(c) a statement by the client that the client:

(i) is free from a current communicable or infectious disease;

(ii) has been provided with the pre-service information, both in writing and verbally by the tattooist; and

(iii) consents to the tattoo.

AUTH: Sec. 50-1-202, MCA
IMP: Sec. 50-1-202, MCA

[RULE XVI] TATTOOING: RESTRICTIONS AND PROHIBITIONS (1) The tattoo application may not proceed:

(a) if either the tattooist or the client is under the apparent influence of alcohol or other mind-altering drugs;

(b) if either the tattooist or the client has a current communicable or infectious disease which may be transmitted during the procedure;

(c) if the client has not signed the consent form required by [Rule XV]; or

(d) if the client is under the age of majority, without the explicit in-person consent of the client's parent or guardian as provided in 45-5-623, MCA.

(2) A written physician referral is required before tattooing a client if:

(a) the client is taking any drug which may induce bleeding tendencies or reduce clotting;

(b) the client shows signs of recent intravenous drug use;

(c) the client has a sunburn or other skin disease or infection such as a rash, wound, or puncture mark, psoriasis, eczema, or lesions at the tattoo site; or

(d) the client declares or evidences allergies or contact sensitivity to pigments, soaps, or other substances used in the tattooing process.

(3) The tattooist may delay tattooing or require a medical referral before tattooing persons whose physical health, understanding or judgment may be in question.

AUTH: Sec. 50-1-202, MCA
IMP: Sec. 50-1-202, MCA

[RULE XVII] TATTOOING: OPERATION (1) A tattoo shop shall:

(a) possess a current certificate of sanitation from the department to operate; and

(b) display the certificate of sanitation in a prominent place in the tattoo shop.

AUTH: Sec. 50-1-202, MCA
IMP: Sec. 50-1-202, MCA

[RULE XVIII] TATTOOING: INSPECTION AND ENFORCEMENT

(1) The department or its authorized representative may conduct inspections at all times when the tattoo shop is operating.

(2) The department may, after providing notice and an opportunity for hearing, refuse to issue a certificate of sanitation to a tattoo shop, or may revoke or suspend a certificate of sanitation, for violations of these rules.

(3) A hearing request must be made in writing to the department within 10 days of the date of the department's notice of its intention to refuse to issue a certificate of sanitation or to revoke or suspend a certificate of sanitation.

(4) A hearing for the refusal, revocation or suspension of a certificate of sanitation is governed by the provisions of the Montana Administrative Procedure Act, Title 2, chapter 4, MCA.

AUTH: Sec. 50-1-202, MCA
IMP: Sec. 50-1-202, MCA

3. The 1995 legislature amended 50-1-202, MCA (Act of April 3, 1995, ch. 324, 1995 Laws of Montana), to require that the department adopt and enforce minimum sanitation requirements for tattooing including regulation of premises, equipment, and methods of operation, solely oriented to the protection of public health and the prevention of communicable disease.

The department began the process of formulating minimum sanitation requirements for tattooing by establishing an ad hoc tattoo committee for advice and consultation. The committee included tattooists, sanitarians, a nurse, a dermatologist, a pharmacist, a legislator, and several interested persons. The department also surveyed the tattoo rules and regulations of other states including South Dakota, Rhode Island, New York, Arkansas, Oregon, and Texas.

Each tattooist who provided input on the proposed rules had considerable tattooing experience. Their input was deemed essential to explain the common practices within the industry. The department also studied tattooists at work, procedures and substances used and the technology of the equipment so that the proposed rules would be relevant to the "real world" practice of tattooing.

The department also relied upon and consulted various other sources of information about tattooing. These sources included the standards adopted by the Alliance of Professional Tattooists and other industry associations and published articles by medical professionals. The recommendations of the Centers for Disease Control and Prevention (CDC) regarding Universal Precautions for Prevention of Transmission of HIV, Hepatitis B and other Blood Borne Pathogens in the Health Care Setting, OSHA standards for Occupational Exposure to Blood borne Pathogens, and data by CDC on the actual incidence of disease transmission and infection via tattooing were also consulted.

Several tattoo requirements were proposed or discussed but dropped from consideration because those particular requirements were not authorized by the plain language of 50-1-202, MCA. Examples of requirements that were dropped from consideration include licensing tattoo shops and establishing minimum competency requirements for tattooists.

Each proposed rule, after its drafting, was again evaluated using commonly known disease spread criteria to determine

whether the disease risk which it was intended to limit was in fact a significant risk and whether the rule, if complied with, would effectively ameliorate the risk.

Many states, who have opted not to regulate tattooing, made that decision because of their fear of driving tattooists "underground," (practicing out of a suitcase or behind the shield of a private residence) where sanitary conditions are poor thereby increasing the risk of disease. These proposed requirements are intended to protect the public from disease risk but not to impose unnecessary or burdensome requirements that would tend to drive tattooists underground.

After careful study and evaluation, the department proposes for adoption 18 minimum sanitation requirements. The requirements in the proposed rules all share a common basis in preventing communicable disease and protecting public health. The requirements are supported by the majority of tattooists consulted by the department and in many cases, parallel minimum sanitation requirements adopted by other states.

RULE I:

Rule I ensures that phrases or words used in the proposed rules are clearly defined so that persons reading the rules will attribute the same meaning to each phrase or word.

RULE II:

The requirements set forth in Rule II are reasonably necessary to minimize sources of filth, bacteria and viruses which would otherwise contaminate the tattoo work room and thereby increase the potential for infection. Tattooing involves needles, bleeding, and a high potential for infections. In addition, certain areas of a tattoo shop must be suitable for sterile operations. The rule establishes the same standards for cleanliness as exists in all public buildings where a risk of contamination or infection exists, but does not impose as high a standard as required for the "work room" in Rule III (where a sterile field is needed).

In developing Rule II, the department, for each requirement, considered the alternative of not retaining that particular requirement. The department wanted the requirement to reduce the potential for infection as opposed to merely improving the appearance of the tattoo shop. For example, the department initially considered imposing a minimum square footage requirement for tattoo shops as did South Dakota in its tattoo regulations. However, the department found no research or data which substantiated that more infections occurred if the shop had, for example, 100 square feet rather than 150 square feet of tattooing area. The space requirement could not be

justified to reduce infection and was discarded from further consideration.

The department has defined a temporary or mobile facility as a facility where tattooing is conducted for not more than 14 days in a calendar year. The 14 day maximum provision is identical to the limitation placed on temporary food services (food vending at fairs and special events) and was selected to be long enough to accommodate most special events, but short enough to avoid undermining the permanent operations.

RULE III:

Rule III is reasonably necessary to reduce or prevent infection by ensuring a sterile work environment. Animals, smoke, dust, unclean contact surfaces, human traffic, coughs and sneezing are known contributors to infection risk. Tattooists throughout the country use a system of work areas or rooms, segregated by walls and doors, in their facilities to limit access during tattooing to prevent infection.

In proposing Rule III for adoption, any requirement not meeting the test of preventing disease risk was dropped from consideration. For example, some states required counter surfaces to be light colored. This requirement was considered for inclusion in the rule. However, the requirement was eliminated because it might be burdensome to the industry and the evidence that infection risk was higher where gray or colored counters were used was not compelling.

RULE IV:

Rule IV is reasonably necessary to prevent infection and the transmission of the Hepatitis B virus (HBV) and human immunodeficiency virus (HIV). These transmission events can happen when a needle used on a client is not sterile and carries blood or body fluids from a previous client or the tattooist. Virtually every state surveyed and the standards of professional organizations all have these same requirements for durability, construction, and sterilization of utensils.

The requirement for maintaining a certain type and number of supplies is to prevent the possibility, during busy periods or special events, of reusing the same supplies for different clients or having no supplies on hand for cleaning and disinfection purposes. Other states found that without sufficient supplies and pre-sterilized utensils on hand, operators were tempted by the presence of waiting customers to shortcut the sterilization requirements. The particular quantities and types of supplies were developed based on a survey of the same type regulations of other states and the input of tattooists as to their daily or weekly supply

requirements. This requirement was considered very carefully due to the capital investment involved in requiring an ongoing inventory of certain supplies. However, the alternative of eliminating the requirement was unacceptable based upon the very real risk of infection where non-sterilized utensils are re-used or cleansers and disinfectants are not available. Eight established tattooists were surveyed in Helena, Missoula and Billings about the minimum supply requirement and all eight supported the proposal.

RULE V:

Rule V is reasonably necessary to prevent the transmission of viral hepatitis to a client during the tattooing process by prohibiting tattooing by persons currently infected (communicable) with Hepatitis B, C or D. This is consistent with recommendations issued by CDC and known modes of disease spread. The alternative of omitting this provision was discarded because tattooing is a sensitive occupation involving the likelihood of contact with blood or body fluids and the risk of viral hepatitis is high. The HIV status of tattooists or clients is protected information and was not considered.

Federal standards require that employers offer the Hepatitis B vaccine to employees whose job requirements necessitate the likelihood of contact with blood or body fluids but do not mandate that such employees be vaccinated. There are several reasons why the department did not propose mandatory immunization, including personal rights issues. Vaccinations (or immune status) are not specifically mentioned in 50-1-202, MCA, as areas of potential regulation. It is noteworthy that vaccinations are not mandatory for health care and hospital workers. None of the states surveyed required mandatory immunization nor did any require post-exposure vaccination. Other reasons include the knowledge that immunization would not prevent the spread of other blood borne diseases and 10% of those vaccinated would not become immune.

RULE VI:

Rule VI is reasonably necessary to ensure that needles and other articles are appropriately sterilized to prevent infection. The Hepatitis B virus can survive for at least a week in dried blood on environmental surfaces. Of the various sterilization methods available, autoclave sterilization was required by this rule because it was the most effective over time, each run could be monitored using color change tape indicators and overall autoclave effectiveness could be monitored through the use of spore suspensions. Dry heat sterilization and chemical sterilization were considered by the

department as alternatives but discarded because they were not conducive to effectiveness monitoring.

The department recognizes, however, that dry heat sterilization is currently being used by some tattooists in Montana and that immediate enforcement of the requirement might result in financial hardship to some shops. The department has allowed for the continued use of dry heat sterilization for up to one year after adoption of this rule for those shops in Montana who currently use dry heat sterilization. The risk of continued use of this sterilization method for one year is minimal.

RULE VII:

Rule VII was reasonably necessary to state that ultrasonic cleaning units are allowed but that the units may not be used as a substitute for autoclave sterilization. Ultrasonic cleaning units are common in the industry and are highly recommended for the removal of blood and body fluid residues on needles and other skin contact utensils. There were reports that in some cases tattooists added chemical sterilants to the ultrasonic unit in order to clean and sterilize in one operation and omitted the autoclave sterilization. The department considered the possibility of not including Rule VII. That alternative was unacceptable because of the potential for misuse of the unit and the resulting disease risk to subsequent clients.

RULE VIII:

The requirements for skin preparation in Rule VIII are reasonably necessary to ensure basic hygiene and reduce infections. The greater the bacterial population on the skin, the greater the chance of infection when the skin is repeatedly pierced. The cleaning and use of bactericidal cleansers or disinfectants is common practice in any situation which will involve perforation of the skin.

Requiring the use of disposable razors as opposed to replaceable blade razors minimizes the need to handle sharp items and reduces the likelihood of contact with blood or body fluids. The tattooists surveyed supported this requirement. All states surveyed required the use of a germicidal cleanser for preparing and disinfecting the skin at the tattoo site.

RULE IX:

All pattern transfer requirements in Rule IX are reasonably necessary to prevent contamination of the tattoo site with organisms which might lead to infection of the perforated skin and parallel the provisions of other states in this area. The disposable sheet and adhering carbon cannot be sterilized, but

must be kept clean and stored away from any possible blood or body fluid contamination. Whatever organisms are on the transfer sheet may be directly transferred to the skin, and during tattooing may be injected into the blood of the client.

Some tattooists surveyed used a deodorant stick as an emollient or adherent. In considering whether to allow the use of a deodorant stick, the department found that there was no way to effectively make the contact end of a deodorant stick single use. Virus and bacteria can be transferred from the skin of one client to the skin of another on the surface of the deodorant stick. An alternative considered was to allow the use of deodorant sticks but require them to be single use -- discarded or given to the client after each pattern transfer. Given the expense of this alternative and the possibility that a deodorant stick could still be used from client to client, the department has proposed that the use of deodorant sticks be prohibited.

RULE X:

All of the provisions of Rule X are reasonably necessary to prevent site infections. Smoking, dust, and touching objects outside the sterile work field are known risk factors for site infections. The spread of HBV and HIV can occur in tattooing where needles and skin contact implements are incompletely sterilized between clients (blood or body fluid contaminated) or the tattooist sustains a needle stick during the procedure (blood of the client injected into the tattooist or vice versa). The risk of HIV transfer to the tattooist cannot be reduced except by avoiding contact with clients' blood and employing barriers and safe procedures. The risk is compounded if the tattooist does not stop tattooing after a needle stick injury.

The requirement to use single use ink cups and to discard unused ink pigment is necessary to ensure that the pigment used on a client is not contaminated with blood or body fluids from a previous client. Disposable ink cups are widely used by and acceptable to tattooists surveyed.

The requirements in this rule are consistent with CDC's "Universal Precautions," the rules employed in various other states, and the OSHA Guidelines on Occupational Exposure to Blood borne Pathogens.

RULE XI:

Rule XI's provisions are reasonably necessary to control infections at the tattoo site after administering the tattoo. Some of the surveyed tattooists objected to the requirement for a sterile gauze bandage. The tattooists cited alternative ways of covering the fresh tattoo which would provide protection and infection prevention equivalent to that of a gauze bandage. The

department revised its language to allow for alternative methods that provide effective protection and infection prevention.

According to surveys of infections related to tattooing, the overwhelming majority occur as a result of errors by the client, such as opening the bandage too soon, getting the tattoo wet, or failing to keep it clean. The requirement for written and verbal after care instructions is important to minimize the occurrence of infection after the client leaves the tattoo shop. This requirement appears in the rules of other states surveyed and have been effective in limiting infections. All tattooists surveyed have written aftercare instructions already in use.

RULE XII:

The requirements of Rule XII are reasonably necessary to prevent infection and the spread of blood borne disease because 1) the risk of site infection is higher if the pigment is not prepared in a sanitary manner and kept clean; 2) the spread of blood borne disease is possible if ink cups with residual colors in them are saved or reused for other clients; and 3) skin sensitivity and reactions to the pigments have been documented, although they are rare.

The reporting requirement is related to Montana's Food, Drug and Cosmetic Act found at Title 50, chapter 31, MCA. A pigment is considered a cosmetic under the Montana Food, Drug and Cosmetic Act. Should a pigment be adulterated so that adverse effects are experienced, it is important that the department relay that information to the FDA and other tattooists using the pigment.

RULE XIII:

Rule XIII's provisions are reasonably necessary to prevent the spread of blood borne disease and to require the appropriate disposal of blood contaminated material. Sharp objects which have been exposed to blood, blood contaminated articles, and blood or body fluids are a bio-hazard. This rule reflects widely accepted requirements found in the standards of other states and in Montana's waste disposal laws. Further, the requirements are consistent with CDC and OSHA standards for handling such wastes in health care settings.

RULE XIV:

The requirements of Rule XIV are reasonably necessary to ensure information is available for tracking and contact purposes. The requirements further ensure that information is available to the department to assess compliance by the shop with certain tattoo requirements. Communicable disease investigations are routinely done by the department or local

health agencies as a control measure to limit the spread of diseases. If a blood borne disease were under investigation and tracking were being done, such records would be important. For example, if a tattooist becomes ill with hepatitis B, the clients tattooed in the previous few days may be appropriate subjects for vaccination. Most tattooists keep such records and support the record keeping requirement.

RULE XV:

The requirements of Rule XV are reasonably necessary to ensure that a client understands the risks of tattooing and the permanent nature of tattoos. Clients do not always comprehend that tattooing may involve scarring, the risk of infection, and the potential for transmission of blood borne disease. To ensure that informed consent is given by the client, the rule requires pre-service information be given verbally and in writing by the tattooist. The client is required to affirm that he or she is free from disease to protect the health of the tattooist and subsequent clients. The requirements are common to those of other states.

RULE XVI:

The requirements of Rule XVI are reasonably necessary to protect public health and to prevent communicable disease either by prohibiting tattooing or requiring a physician referral where certain conditions exist. The department felt that where the tattooist or client were under the influence of alcohol or drugs or had a communicable disease or the client had not given consent, public health mandated that the tattooing not proceed. Section 45-5-623, MCA, prohibits tattooing clients under the age of majority and the department cites the prohibition in the rule for the benefit of those persons who might be unaware of its existence. The survey of tattooists, the standards of their professional associations, and medical opinions on the ad hoc committee confirmed the need for these prohibitions.

The department proposes conditional categories where a physician referral would be required before the tattooing could proceed, for example, where a client has psoriasis. The severity of psoriasis can vary from mild dry skin conditions, which may be amenable to tattooing, to severe psoriasis with persistent lesions at various sites where the skin is abraded or scratched, which may not respond well to tattooing. In such a case, tattooing could easily create a spot which, refusing to heal properly, might develop into a psoriasis lesion. A physician should make such distinctions. Some states surveyed prohibited tattooing of any individual in those conditional categories and did not allow the tattooing to proceed, even with a physician referral. The department considered this alternative but felt it was too restrictive and did not allow

for distinctions to be made by physicians between individuals whose symptoms might range from minor to severe.

Tattooists with whom the department conferred expressed their support for and willingness to comply with these provisions. The alternative of omitting the provisions of Rule XVI was considered but discarded. The department had concerns that some tattooists, without the prohibitions and requirements in this rule, might proceed with tattooing under circumstances that clearly establish an unacceptable risk to public health and safety.

RULE XVII:

The requirements of Rule XVII are reasonably necessary to ensure that tattoo shops in operation meet minimum sanitation requirements to prevent communicable disease and protect public health. The public posting of the certificate allows clients of a tattoo shop to verify that the tattoo shop has met the requirements of these rules.

RULE XVIII:

Section 50-1-202, MCA, requires the department to enforce minimum sanitation requirements for tattooing. The requirements of Rule XVIII are reasonably necessary to enable the department to inspect shops and, where necessary, to deny, suspend or revoke a certificate of sanitation based on a shop's noncompliance.

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 Debbie G. Allen, Office of Legal Affairs, Department of Public Health and Human Services, P.O. Box 202951, Helena, MT 59620-2941, no later than February 12, 1998. The Department also maintains lists of persons interested in receiving notice of administrative rule changes. These lists are compiled according to subjects or programs of interest. For placement on the mailing list, please write the person at the address above.

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

Russell E. Catlow
Rule Reviewer

Laura Clanton
Director, Public Health and Human Services

Certified to the Secretary of State January 5, 1998.

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

In the matter of the amendments of 46.12.303, 46.12.502A, 46.12.522, 46.12.525A, 46.12.526A, 46.12.527A, 46.12.528, 46.12.538, 46.12.573, 46.12.577, 46.12.585, 46.12.905, 46.12.912, 46.12.915, 46.12.1449, 46.12.2003, and 46.12.2013 pertaining to medicaid billing and reimbursement for podiatry, therapy, audiology, clinic, family planning, organ transplant, optometric, eyeglasses, home and community speech pathology and audiology, physician, and mid-level practitioner services	NOTICE OF PUBLIC HEARING ON PROPOSED AMENDMENTS

TO: All Interested Persons

1. On February 5, 1998, at 1:30 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 amendments of 46.12.303, 46.12.502A, 46.12.522, 46.12.525A, 46.12.526A, 46.12.527A, 46.12.528, 46.12.538, 46.12.573, 46.12.577, 46.12.585, 46.12.905, 46.12.912, 46.12.915, 46.12.1449, 46.12.2003, and 46.12.2013 pertaining to medicaid billing and reimbursement for podiatry, therapy, audiology, clinic, family planning, organ transplant, optometric, eyeglasses, home and community speech pathology and audiology, physician, and mid-level practitioner 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 or need an alternative accessible format of this notice. If you request an accommodation, contact the department no later than 5:00 p.m. on January 23, 1998, to advise us of the nature of the accommodation that you need. Please contact Dawn Sliva, Office of Legal Affairs, Department of Public Health and Human Services, 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. Matter to be added is underlined. Matter to be deleted is interlined.

46.12.303 BILLING, REIMBURSEMENT, CLAIMS PROCESSING, AND PAYMENT (1) through (15)(b) remain the same.

(16) A person enrolled as an individual provider may not submit a claim for services that the provider did not personally provide, inclusive of services provided by another person under the provider's supervision, unless authorization to bill for and receive reimbursement for services the provider did not personally provide is stated in administrative rule or a Montana medicaid program manual. Other providers, including but not limited to hospitals, nursing facilities and home health agencies, may bill for and receive reimbursement for services provided by supervised persons in accordance with the medicaid rules and manual.

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

46.12.502A RESOURCE BASED RELATIVE VALUE SCALE (RBRVS) REIMBURSEMENT FOR SPECIFIED PROVIDER TYPES (1) through (1)(a) remain the same.

~~(b) "By report" means a rate of payment for a procedure which does not have a fee assigned to it.~~

(1)(c) through (1)(g) remain the same in text but are renumbered (1)(b) through (1)(f).

(2) remains the same.

(3) Except as set forth in ~~(7),~~(8), ~~and~~ (9) and (10) the fee for a covered service provided by any of the provider types specified in (2) ~~will be~~ is determined by multiplying the relative value units determined in accordance with (7) by the conversion factor specified in (4), and then multiplying the product by a factor of one plus or minus the applicable policy adjustor as provided in (5), if any; provided, however, that rates for procedure codes included in the conversion to the RBRVS reimbursement methodology ~~shall be~~ are:

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

(6) The RVUs for most services ~~will be~~ are adopted from the resource based relative value scale (RBRVS). For most services for which the RBRVS does not specify RVUs, the department ~~will~~ sets those RVUs.

(7) The ~~fee~~ RVUs for a medicaid covered service provided by any of the provider types specified in (2) ~~will be reimbursed in the following manner~~ are calculated as follows:

(a) if medicare sets RVUs, ~~then reimbursement will reflect a~~ the medicare RVUs are applicable;

(b) if medicare does not set RVUs but medicaid sets ~~an~~ RVUs, ~~then reimbursement will reflect a~~ the medicaid RVUs are set in the following manner:

(7)(b)(i) through (7)(b)(iii) remains the same.

~~(c)~~ (8) ~~If~~ If neither medicare nor medicaid sets RVUs, then reimbursement ~~will be~~ is by report.

(a) Through the by-report methodology the department reimburses a percent of the provider's usual and customary charges for a procedure code where no fee has been assigned. The percentage is determined by dividing the previous state fiscal year's total medicaid reimbursement for RBRVS provider covered services by the previous state fiscal year's total medicaid billings.

(b) For state fiscal year 1998, the "by-report" rate is 58% of the ~~providers~~ provider's usual and customary charges.

~~(8)~~ (9) For clinical laboratory services:

(a) the department ~~will~~ pays the lower of the following for procedure codes with fees:

(8)(a)(i) and (8)(a)(ii) remain the same in text but are renumbered (9)(a)(i) and (9)(a)(ii).

(b) the department ~~will~~ pays the lower of the following for procedure codes without fees:

(8)(b)(i) and (8)(b)(ii) remain the same in text but are renumbered (9)(b)(i) and (9)(b)(ii).

~~(9)~~ (10) For anesthesia services the department ~~will~~ pays the lower of the following for procedure codes with fees:

(9)(a) and (b) remain the same in text but are renumbered (10)(a) and (10)(b).

(c) the department ~~will~~ pays the lower of the following for procedure codes without fees:

(9)(c)(i) and (9)(c)(ii) remain the same in text but are renumbered (10)(c)(i) and (10)(c)(ii).

~~(10)~~ (11) Subject to the provisions of ~~(10)~~ (11)(a), when billed with a modifier, payment for procedures established under the provisions of (7) ~~will be~~ is a percentage of the rate established for the procedures.

(10)(a) remains the same in text but is renumbered (11)(a).

(i) The department ~~will~~ obtains information from medicare and other third party payers regarding the comparative value utilized for payment of procedures billed with modifiers.

(ii) The department ~~will~~ establishes a specific percentage for each modifier based upon the purpose of the modifier, the comparative value of the modified service and the medical insurance industry trend of reimbursement for the modifier.

(10)(a)(iii) remains the same in text but is renumbered (11)(a)(iii).

~~(11)~~ (12) In applying the RBRVS methodology set forth in this rule, medicaid ~~will make reimbursement~~ reimburses 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.

(13) Providers must bill for services using the procedure codes and modifiers set forth, and according to the definitions contained in the federal health care administration's common procedure coding system (HCPCS). Information regarding billing codes, modifiers and HCPCS is available upon request from the health policy services division at the address previously stated in this rule.

AUTH: Sec. 53-2-201 and 53-6-113, MCA
IMP: Sec. 53-2-201, 53-6-101 and 53-6-111, 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~~ in accordance with the methodologies described in ARM 46.12.502A and 46.12.2003.

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

46.12.525A THERAPY SERVICES, DEFINITIONS In ARM 46.12.525A through 46.12.529, the following definitions apply:

(1) "Assistant/aide" means an assistant, aide or other person authorized under and practicing in accordance with the applicable provisions of Title 37, MCA, who subject to supervision required by law, assists in the provision of a therapy service.

(1) through (6) remain the same in text, but are renumbered (2) through (7).

~~(7) "Practitioner" means a physical therapist, speech-language pathologist or occupational therapist licensed under the applicable provisions of Title 37, MCA to practice the particular category of therapy services provided. For purposes of ARM 46.12.525A through 46.12.529, practitioner includes an assistant, aide or other person authorized under the applicable provisions of Title 37, MCA to perform the particular category of therapy services provided, if the assistant, aide or other person performs the services in accordance with all applicable requirements, including but not limited to qualification and supervision requirements.~~

(8) "Restorative therapy" means therapy services that are performed with a reasonable expectation that the recipient's ~~condition~~ function will improve significantly in a reasonable and predictable period of time, based upon an assessment of the recipient's restoration potential made by a physician or mid-level practitioner in consultation, ~~if necessary,~~ with the licensed therapist. Therapy services are not restorative therapy if the recipient's expected restoration potential would be insignificant in relation to the extent and duration of services required. Therapy services are no longer restorative therapy if at any time after commencement of treatment it is

determined that the reasonable expectation of significant improvement in function will not materialize.

(9) and (10) remain the same.

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

46.12.526A THERAPY SERVICES, PROVIDER REQUIREMENTS

(1) remains the same.

(2) ~~Therapy service providers, as~~ As a condition of participation in the Montana medicaid program, a therapist must:

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

(3) An assistant/aide may not enroll as a provider.

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

46.12.527A THERAPY SERVICES, SERVICE REQUIREMENTS AND RESTRICTIONS (1) remains the same.

(2) Except as otherwise provided by these rules, therapy services must be provided by a ~~practitioner~~ therapist or assistant/aide within the scope of practice permitted by state law. The provider's records maintained under ARM 46.12.308 must demonstrate compliance with applicable supervision and protocol requirements.

(a) services provided by an assistant/aide may only be billed by a supervising therapist.

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

~~(4) The Montana medicaid program will reimburse restorative therapy services only when the particular restorative therapy services are reasonable and necessary to the treatment of the recipient's condition. As used in this rule, "reasonable and necessary" means:~~

~~(a) The services are considered effective treatment for the recipient's specific disorder under generally accepted standards of practice;~~

~~(b) The complexity or sophistication of the services or the recipient's condition is such that the required services can be performed effectively only by or under the supervision of a licensed therapist; and~~

~~(c) The amount and frequency of services are within generally accepted standards of practice.~~

(5) and (6) remain the same in text but are renumbered (4) and (5).

~~(7) The Montana medicaid program will reimburse speech therapy service providers for medically necessary augmentative speech devices only if the device has been prior authorized by the department and all other requirements have been met. Requests for prior authorization must be made using the form prescribed by the department and must be submitted to the Department of Public Health and Human Services, Health Policy~~

~~and Services Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951. Forms are available from the department at the above address.~~

~~(8) In determining medical necessity for augmentative speech devices, the department will consider the general medical necessity requirements in ARM 46.12.102 and 46.12.306.~~

~~(9) The Montana medicaid program will reimburse speech therapy service providers for group speech therapy services only where the group includes no more than 8 patients. Group speech therapy services are billable in increments of one half hour.~~

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

~~(11)~~ (7) The following limits apply to therapy services:

(11)(a) remains the same in text but is renumbered (7)(a).

(b) Speech therapy services are limited to 70 ~~hours~~ units of service per state fiscal year per recipient without prior authorization and up to an additional 30 ~~hours~~ units of service per state fiscal year per recipient as prior authorized by the department. No more than 100 ~~hours~~ units of speech therapy services per state fiscal year per recipient may be reimbursed by the Montana medicaid program.

(i) one unit is equal to 1 visit code or four 15-minute increment codes as provided in the CPT.

(11)(c) remains the same in text but is renumbered (7)(c).

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

46.12.528 THERAPIES, REIMBURSEMENT (1) remains the same.

(2) Subject to the requirements of this rule, the Montana medicaid program ~~will~~ pays the following for therapy services:

(2)(a) through (2)(a)(i) remains the same.

(ii) 90% of the reimbursement ~~for physicians~~ provided in accordance with the ~~methodology~~ methodologies described in ARM 46.12.502A.

(b) For patients who are eligible for both medicare and medicaid, reimbursement ~~will be~~ is made for the medicare deductible and coinsurance. However, total reimbursement from medicare and medicaid shall not exceed the medicaid fee for the service.

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) remains the same.

(2) Subject to the requirements of this rule, the Montana medicaid program ~~will~~ pays the following for audiology services:

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

(ii) 90% of the reimbursement ~~for physicians~~ provided in accordance with the ~~methodology~~ methodologies described in ARM 46.12.502A.

(b) For patients who are eligible for both medicare and medicaid, reimbursement ~~will be~~ is made for the medicare deductible and coinsurance. However, total reimbursement from medicare and medicaid shall not exceed the medicaid fee for the service.

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

46.12.573 CLINIC SERVICES, REIMBURSEMENT (1) through (3) remain the same.

(4) Public health department services ~~will be~~ are reimbursed at the lowest of the following:

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

(c) ~~any applicable fees~~ reimbursement for either physician services, ~~set forth~~ provided in accordance with the methodologies described in ARM 46.12.502A and 46.12.2003, or mid-level practitioner services, ~~as set forth~~ provided in accordance with the methodologies described in ARM 46.12.502A and 46.12.2013.

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

46.12.577 FAMILY PLANNING SERVICES, REIMBURSEMENT

(1) Reimbursement for family planning services is as follows:

(a) for physicians ~~those fees~~ reimbursement is provided in accordance with the methodologies described ~~for~~ in ARM 46.12.502A and 46.12.2003;

(b) for mid-level practitioners ~~those fees~~ reimbursement is provided in accordance with the methodologies described ~~for~~ in ARM 46.12.502A and 46.12.2003;

(c) for local delegate agencies the lowest of the following medicare fee, the provider's ~~actual (submitted)~~ usual and customary charge for this service or the department's fee schedule.

(2) and (3) remain the same.

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

46.12.585 ORGAN TRANSPLANTATION, REIMBURSEMENT

(1) Reimbursement for ~~P~~physician services in organ transplantation ~~will be reimbursed as provided for~~ is provided in accordance with the methodologies described in ARM 46.12.502A and 46.12.2003.

(2) All hospital services for organ transplantation ~~will be~~ are reimbursed as provided for in ARM 46.12.509

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

46.12.905 OPTOMETRIC SERVICES, REIMBURSEMENT (1) Subject to the requirements of this rule, the Montana medicaid program ~~will~~ pays the following for optometric services:

(1)(a) and (1)(a)(i) remains the same.

(ii) the reimbursement ~~for physicians~~ provided in accordance with the ~~methodology~~ methodologies described in ARM 46.12.502A.

(b) For patients who are eligible for both medicare and medicaid, reimbursement ~~will be~~ is made for the medicare deductible and coinsurance. However, total reimbursement for medicare and medicaid shall not exceed the medicaid fee for the service.

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

46.12.912 EYEGLASSES, SERVICES, REQUIREMENTS AND RESTRICTIONS (1) remains the same.

(2) The dispensing service may be provided by an ophthalmologist, an optometrist, an optician, or their employees.

~~(2) Providers~~ (3) Ophthalmologists, optometrists, or opticians dispensing eyeglasses or contact lenses 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.

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

~~(4)~~ (5) A recipient may obtain replacement lenses only 365 days after the ~~365 day period~~ existing eyeglasses were dispensed if the ~~eyeglasses~~ lenses are unusable.

~~(5)~~ (6) Contact lenses may be provided only if medically necessary.

(a) The limits stated in ~~(1)~~ (4) and ~~(2)~~ (5) apply to contacts.

(5)(b)remains the same in text, but is renumbered (6)(b).

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

46.12.915 EYEGLASSES, REIMBURSEMENT (1) and (2) remain the same.

(3) Reimbursement for dispensing fees is as follows:

(a) the department pays the lowest of the following:

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

(ii) the department's fee schedule maintained in accordance with the methodologies described in 46.12.502A.

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

AUTH: Sec. 53-6-113, MCA
IMP: Sec. 53-6-101, 53-6-113 and 53-6-141, 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 46.12.538.

AUTH: Sec. 53-2-201, 53-5-205, 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)remains the same.

(2) Subject to the requirements of this rule, the Montana medicaid program ~~will~~ pays the following for physician services:

(a) For ~~patients~~ services provided to persons who are eligible for medicaid, the lower of:

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

(ii) the department's fee schedule maintained in accordance with the ~~methodology~~ methodologies described in (3) and ARM 46.12.502A.

(b) For ~~patients~~ services provided to persons who are eligible for both medicare and medicaid, reimbursement ~~will be~~ is made for the medicare deductible and coinsurance. However, total reimbursement from medicare and medicaid shall not exceed the medicaid fee for the service.

(3) Reimbursement to physicians for physician-administered drugs which are billed under HCPCS "J" and "Q" codes ~~will be~~ is either according to a fee schedule established by the department and updated at least annually based upon the Montana estimated acquisition cost or maximum allowable cost, as defined in ARM 46.12.102 or the provider's usual and customary charge, whichever is lower. No dispensing fee ~~will be~~ is paid to physicians.

(3)(a) remains the same.

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) remains the same.

(2) Medicaid coverage of mid-level practitioner services is available according to the requirements~~,~~ and procedures~~, and fees~~ specified for physicians under ARM 46.12.2001, 46.12.2002 and 46.12.2003.

(3) and (4) remain the same.

(5) Reimbursement for services, except as otherwise provided in this rule, is the lower of:

(a) usual and customary charges; or

(b) 90% of the reimbursement for physicians provided in accordance with the methodologies described in ARM 46.12.502A and 46.12.2003.

(6) Reimbursement for immunizations, family planning services, services billed under HCPCS "J" codes, radiology, laboratory and pathology, cardiography and echocardiography services and for ~~kids count~~ early and periodic screening, diagnostic and treatment services is the lower of:

(a) ~~billed~~ usual and customary charges; or

(b) 100% of the reimbursement for physicians provided in accordance with the methodologies described in 46.12.502A and 46.12.2003.

(7) remains the same.

(8) Reimbursement for drugs which are billed under HCPCS "J" and "Q" codes is the lower of:

(a) the ~~billed~~ usual and customary charge; or

(8)(b) through (9)(g) remain the same.

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

3. The proposed amendments are to several rules, generally or specifically, governing billing and reimbursement for services provided through the medicaid services program.

The proposed rule amendments, in part, make textual and cross-reference corrections in relation to the recently adopted resource based relative value scale (RBRVS) methodology of reimbursement for individual provider services generally. Notice of adoption of the rule and rule amendments implementing the RBRVS reimbursement methodology appeared in the Montana Administrative Register, Issue #14, July 21, 1997, at pages 1269 through 1287.

The proposed changes to ARM 46.12.502A, concerning the RBRVS and other methodologies, and to the other reimbursement rules for specific services, are necessary in part to ensure consistency in application and terminology throughout those rules that pertain in matters of reimbursement and to provide appropriate notice of the application of the methodologies to providers. Consistency is necessary for purposes of assuring providers of services that there is fair administration and correct reimbursement.

The proposed amendments to therapy services rules reflect, in part, changes in terminology and coverage. In addition, many proposed amendments are to improve clarity of the rules through language and structure changes. The proposed amendments to ARM 46.12.303 and some of the amendments to the therapy and eyeglasses services rules serve to explicitly state limitations

concerning appropriate providers for enrollment in the medicaid program and certain parameters for billing practices.

The proposed amendments do not substantively change the currently established medicaid reimbursement methodologies, including RBRVS, and billing practices.

Implementation of the RBRVS reimbursement methodology was authorized by the 1997 Montana Legislature as the most appropriate methodology for medicaid reimbursement of physician and other individual medical services because it is a nationally established and well-received methodology used by medicare and many private insurers. Providers are generally familiar with the methodology. The use of the RBRVS reimbursement methodology can significantly improve accuracy for the medicaid program in the processing of so-called cross over claims; those being claims that are presented to both medicaid and medicare. There is no other system that is as universally recognized or comprehensive as the RBRVS system.

Unlike the previously established methodologies for reimbursement of these services, the RBRVS methodology generally provides for a comprehensive system of reimbursement for the various individual services purchased with medicaid monies. Previously, the reimbursement rates for the various individual services had been set without a comprehensive system. The existing rates for individual services were often more a result of historical happenstance rather than the application of consistent procedures and criteria across the services.

The RBRVS system in setting rates comprehensively weighs across each service the efforts and expenses of providing those services relative to the other services. Thus the RBRVS system has a fundamental fairness in its application.

ARM 46.12.303

The proposed amendment to ARM 46.12.303, BILLING, REIMBURSEMENT, CLAIMS PROCESSING, AND PAYMENT, explicitly limits billing by and reimbursement of individual providers to those services directly provided by the provider unless otherwise authorized. The proposed amendment eliminates textual confusion that in the recent past has led to administrative appeals in relation to the denial of reimbursement for services provided by persons working under or with a provider and billed for through the provider. The Department has historically maintained a policy of not reimbursing for services provided by assistants and aides to recognized medical professionals unless the reimbursement of such people is specifically authorized by department rule. Even in those circumstances where such reimbursement is authorized, the Department policy requires that the billing and reimbursement for the services of assistants and

aides be done by and through the supervising medical professional. The inclusion of explicit language concerning appropriate billing for services provided with the assistance of staff is necessary for program integrity in terms of billing practices and accountability for service delivery.

The option, presented by the proposed amendment, of prohibiting more specifically reimbursement for the services of aides and assistants, is being selected in that it reflects the current policy which is well-based on program and consumer interests. That policy has been selected in that it is in the best interest of consumers of medical services to receive quality services that represent the best practices of each medical profession. The Department allows for aides or assistants to deliver medical services, only when the Department determines within its discretion that the service is appropriate and there is assurance of quality in delivery due to the presence of established standards for such performance and of appropriate supervision by a licensed medical professional.

The option of leaving the rule unchanged may result in consumers receiving inappropriate services or services that are of less than adequate quality. Leaving the rule unchanged would also result in continuing confusion and conflict over billing practices in the circumstance addressed.

ARM 46.12.502A

The proposed amendments to ARM 46.12.502A, RESOURCE BASED RELATIVE VALUE SCALE (RBRVS), REIMBURSEMENT FOR SPECIFIED PROVIDER TYPES, are generally necessary to correct mistakes in cross-references and text that occurred during the rule adoption. The proposed amendments do not substantively change the RBRVS reimbursement methodologies or any other matters appearing in the rule.

The proposed amendments, deleting the definition of "by report" and inserting further descriptive material of the "by report" methodology into (8), corrects the inadvertent deletion of material that occurred in the previous final adoption notice for the rule and consolidates the criteria of the methodology in order to improve comprehension of the methodology. The additional material expresses the formula for deriving the percentage multiplier upon which the "by report" methodology of reimbursement is predicated.

The proposed amendment, deleting the cross-reference in subsection (3) to subsection (7) as an exception to the RBRVS methodology, corrects a mistake. Subsection (7) provides the RVU calculation that is an integral aspect of the RBRVS methodology and therefore should not be excepted out.

The proposed amendment, providing that subsection (7)(c) become (8), corrects a mistake made during the previous rule change. The subsection provides for the applicability of the by report methodology and should stand separate from the calculation of relative value units (RVUs) for the RBRVS methodology. The current rule incorrectly encompasses the by report methodology within the RVUs provision.

The proposed amendment, providing for the applicability of the procedures codes and modifiers from the federal Health Care Administration's common procedure coding system (HCPCS), corrects the inadvertent omission of this material when this rule was adopted. The RBRVS reimbursement system is predicated upon the HCPCS system.

The other proposed amendments to the rule generally provide appropriate text and cross-references that aid in comprehension of the rule.

The proposed amendments to this rule along with several of those to other reimbursement related rules are the options that clearly inform providers of the applicable reimbursement methodologies for the services they provide through the medicaid program. The option of leaving the mistakes as to structure, cross-references and terminology in place is not feasible in that it would mislead and confuse providers and administrative staff.

ARM 46.12.522, 46.12.528, 46.12.538, and 46.12.905

The proposed amendments to ARM 46.12.522, PODIATRY, SERVICES, REIMBURSEMENT; 46.12.528, THERAPIES, REIMBURSEMENT; 46.12.538, AUDIOLOGY SERVICES, REIMBURSEMENT; and 46.12.905, OPTOMETRIC SERVICES, REIMBURSEMENT, removing the referential language to physicians that modifies reimbursement, corrects the misimpression of the existing language that the RBRVS methodology concerns physicians only. The RBRVS methodology referenced in those provisions is a methodology for reimbursement of medical procedures and is not limited in applicability to just physicians.

The option, removing the referential language to physicians that modifies reimbursement, is being selected in that it eliminates the potential confusion that could result from the reference. The CPT codes upon which the RBRVS methodology is developed encompasses services generally provided by physicians. The use of the CPT codes, however, is not limited to the provision of those services by physicians. The option of leaving the term intact in these rules is not being selected in that it would result in potential confusion as to which types of providers and services are subject to the RBRVS methodology.

ARM 46.12.525A, 46.12.526A, and 46.12.527A

The proposed amendments to ARM 46.12.525A, THERAPY SERVICES, DEFINITIONS, do the following: 1) inserts a definition of "assistant/aide"; 2) removes a definition of "practitioner"; and 3) modifies the definition of "restorative therapy". The proposed amendment to ARM 46.12.526A, THERAPY SERVICES, PROVIDER REQUIREMENTS, changes the terminology from "therapy service providers" to "therapist", and specifically states a prohibition on assistant/aides enrolling as providers.

The proposed amendments provide appropriate definitions for purposes of coverage and further provide that the coverage for therapy services relates specifically to therapists, as professional practitioners, and is not inclusive of anyone providing services.

The proposed amendments to ARM 46.12.527A, THERAPY SERVICES, SERVICE REQUIREMENTS AND RESTRICTIONS, would do the following:
1) require that services provided by assistant/aides be billed through a supervising therapist; 2) delete provisions concerning the medical necessity of restorative therapy services and augmentative speech devices; 3) delete the provisions for the reimbursement of group speech therapy services, and 4) implement units as the basis for limitations upon the amount of speech therapy services that may be delivered.

The proposed amendment, concerning billing for services provided by assistant/aides, is necessary in that while the enrollment of providers for therapy services is limited to the independent professional status recognized in law, certain services under the nationally recognized CPT billing system may be provided under the supervision of those professionals by assistants or aides. The inclusion of explicit language concerning appropriate billing for services provided with the assistance of staff is necessary for program integrity in terms of billing practices and accountability for service delivery.

The proposed amendment for deletion of the medical necessity statement for restorative therapy is necessary in that the statement of a medical necessity standard for restorative therapy was unnecessary and duplicative of the established general medical necessity standard for medicaid and the language defining restorative therapy.

The proposed amendment for the deletion of the medical necessity criteria for augmentative speech devices removes inapplicable criteria since augmentative speech devices are now reimbursed in accordance with the medicaid program rules for durable medical equipment.

The proposed amendment for the deletion of the language relating to group therapy removes limitations that are no longer appropriate based on the CPT codes for speech therapy used in the RBRVS system of reimbursement.

The proposed amendment, basing reimbursement for speech therapy on visit units as opposed to time increments, brings reimbursement for the service into accord with the RBRVS methodology. Previously, reimbursement for the service has been based upon local codes, rather than national codes, that were based strictly on time increments.

The proposed amendments, concerning permissible providers for enrollment and concerning billing practices in relation to services provided by assistant/aides, are the only options for clearly stating in accordance with current departmental policy who is qualified as a provider and how to appropriately bill for services provided with the assistance of assistant/aides. This option protects the interests of consumers in receiving appropriate quality services and the interest of the Department in the integrity of program performance. The option of leaving the rules unchanged is not being selected in that it may result in inappropriate services and less than desirable quality to the services being provided to consumers and would also result in continuing confusion and conflict over billing in the circumstances addressed.

The options of providing a language change in the definition of restorative therapy and removing the medical necessity criteria for restorative therapy are being selected in that those options eliminate the redundancy that had occurred between the definition and the substantive provision on criteria. The option of maintaining the substantive criteria in a provision and eliminating the definition would not have been as practical for stating the criteria since the provision contained some inappropriate criteria and in part had language that was duplicative of the general medical necessity standard for all medicaid services. In addition, a definition for the service must be maintained. Particular services available through the medicaid program are by necessity defined. Because restorative therapy definitionally is a unique service, the limits upon the service are inherent to its definition.

The option of removing the language concerning the medical necessity for augmentative speech devices is being selected in that it is the option that eliminates the confusion that has resulted since augmentative speech devices, as a medicaid service, were subsumed through the medicaid program for durable medical equipment. The option of leaving the language intact is not being selected in that there would continue to be confusion as to the appropriate medicaid coverage for these items.

The options, removing group speech therapy and implementing unit based reimbursement for speech therapy services, are being selected in that those options appropriately implement the RBRVS methodology for speech therapy services. The newly implemented and pervasive RBRVS methodology bases speech therapy reimbursement upon units and does not provide for a group speech therapy category for purposes of reimbursement. The option of leaving the provisions intact is not being selected in that medicaid coverage in relation to these services would continue to be incorrectly stated.

ARM 46.12.573 and 46.12.577

The proposed amendments to ARM 46.12.573, CLINIC SERVICES, REIMBURSEMENT, and 46.12.577, FAMILY PLANNING SERVICES, REIMBURSEMENT, replacing "fees" with "reimbursement" and inserting the cross-references to ARM 46.12.502A and the phrase "provided in accordance with the methodologies described", are for appropriately characterizing and incorporating the methodologies of reimbursement for physicians and mid-level practitioners who are the providers of clinic services and family planning services.

The proposed amendment to ARM 46.12.577 replacing the term "actual (submitted)" with the term "usual and customary", provides the appropriate term of art for reimbursement calculations as defined in the RBRVS methodology rule at ARM 46.12.502A.

The options presented by these amendments are being selected in that they will correctly state for clinic and family planning services the reimbursement methodologies that apply to the providers who provide services in these service settings. The option of not making the corrective changes would result in potential confusion as to what reimbursement methodologies are applicable in the service settings.

ARM 46.12.585

The proposed amendments to ARM 46.12.585, ORGAN TRANSPLANTATION, REIMBURSEMENT, inserting the cross-reference to ARM 46.12.502A and the phrase "provided in accordance with the methodologies described", are for appropriately characterizing and incorporating the methodologies of reimbursement for physicians who are the providers of organ transplantation services.

The options presented by these amendments are being selected in that they will correctly state for organ transplantation services the reimbursement methodologies that apply to physicians who are the providers of that service. The option of not making the corrective changes would result in

potential confusion as to what reimbursement methodologies are applicable to the service.

ARM 46.12.912 and 46.12.915

The proposed amendments to ARM 46.12.912, EYEGLASSES, SERVICES, REQUIREMENTS AND RESTRICTIONS, do the following: 1) specify those professionals and others who may dispense eyeglasses and those professionals who may bill for dispensing; 2) change the language relating to replacement to state lenses rather than eyeglasses; and 3) change the cross-references for limitations upon contact lenses.

The proposed amendments, concerning dispensing and billing, are for the purpose of definitively stating the scope of professionals and staff persons who may dispense while limiting billing only to the professionals who may be enrolled providers. The actual dispensing of eyeglasses and contacts conducted by nonprofessionals under the supervision of a licensed professional does not pose any significant risks to consumers or impair program performance. The inclusion of explicit language concerning appropriate billing for services provided with the assistance of staff is necessary for program integrity in terms of billing practices and accountability for service delivery.

The proposed amendments, concerning eyeglass replacement, are for the purpose of correctly stating that replacement is in relation to the lenses rather than to the eyeglasses as a whole.

The proposed amendments, concerning the limitations upon contacts, are for correctly stating the limitations upon contacts by providing appropriate cross-references.

The option represented by the proposed amendments, concerning permissible providers for enrollment and concerning billing practices in relation to services provided by staff, is being selected in that it explicitly states the professionals who are qualified to be providers while allowing for staff of those professionals to do the routine task of dispensing. The inclusion of explicit language concerning appropriate billing for services provided with the assistance of staff is necessary for program integrity. The option of leaving the rules unchanged is not being selected in that there would continue to be confusion and conflict over billing in the circumstances addressed.

The proposed amendments, concerning eyeglass replacement and limitations upon contacts, are the options that will most effectively communicate the correct coverage in those matters. The option of not amending those rules is not appropriate in that it would continue the misleading language that appears to

provide for replacement of the eyeglasses as a whole and therefore results in confusion and conflict over coverage.

The proposed amendment to ARM 46.12.915, EYEGLASSES, REIMBURSEMENT provides a reimbursement methodology for dispensing fees. This methodology was inadvertently left out of the recent rule changes that implemented the RBRVS reimbursement system and modified this particular reimbursement rule for conformity with that new system.

The option presented by the proposed amendments is being selected in that it explicitly states the RBRVS reimbursement methodology for the service which has been administratively adopted for the service. The option of leaving the rules unchanged is not being selected in that there would be potential confusion as to what reimbursement methodology is applicable.

ARM 46.12.1449

The proposed amendment to ARM 46.12.1449, SPEECH PATHOLOGY AND AUDIOLOGY SERVICES, REIMBURSEMENT, deleting the cross-reference to ARM 46.12.532, is necessary in that ARM 46.12.532 has been previously repealed.

The option presented by the proposed rule change is being selected in that it is the option that removes the cross-reference to the now nonexistent rule.

ARM 46.12.2013

The proposed amendments to ARM 46.12.2013, MID-LEVEL PRACTITIONER SERVICES, REQUIREMENTS AND REIMBURSEMENT, provide correct and complete cross-references and appropriate terminology. The requirements and reimbursement for mid-level practitioners are for the most part adopted from those for physicians as expressed in ARM 46.12.2001 et. seq.

The proposed amendment to subsection (2), removing the term "fees" and adding cross-references to ARM 46.12.2001 and 46.12.2002, limits the provision to its intended purpose which is to provide for requirements and procedures and not for fees. ARM 46.12.2001 and 46.12.2002 provide the majority of provisions and definitions relating to requirements and procedures.

The proposed amendments to subsections (5), (6) and (7), inserting the complete phrase "usual and customary charges" conform the usage in this reimbursement rule with that used in the RBRVS methodology rule, ARM 46.12.502A, which provides the principal reimbursement methodology.

The proposed amendments to subsection (5) and (6), inserting a cross-reference to 46.12.2003 and the phrase "in accordance with the methodologies as described," are for the purpose of including those aspects of reimbursement methodologies for physician services that are not expressed in the RBRVS rule and for appropriately characterizing and incorporating the methodologies of reimbursement for physicians.

The option presented by the proposed rule amendments is being selected in that it incorporates those reimbursement methodologies that are appropriate for the procedures available through the service and as have been adopted through the RBRVS rule notice previously. The option of leaving the rules unchanged is not being selected in that it could result in confusion, mistakes and conflict over billing for the service.

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 Dawn Sliva, Office of Legal Affairs, Department of Public Health and Human Services, P.O. Box 4210, Helena, MT 59604-4210, no later than February 12, 1998. The Department also maintains lists of persons interested in receiving notice of administrative rule changes. These lists are compiled according to subjects or programs of interest. For placement on the mailing list, please write the person at the address above.

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

Russell E. Cater
Rule Reviewer

Director, Public Health and Human Services

Certified to the Secretary of State January 5, 1998.

BEFORE THE DEPARTMENT OF REVENUE
OF THE STATE OF MONTANA

IN THE MATTER OF THE AMENDMENT) NOTICE OF PROPOSED AMENDMENT
of ARM 42.31.131 relating to)
Cigarette Tax Refunds/)
Distributions) NO PUBLIC HEARING CONTEMPLATED

TO: All Interested Persons:

1. On February 27, 1998, the Department of Revenue proposes to amend ARM 42.31.131 relating to cigarette tax refunds/distributions.

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

42.31.131 CIGARETTE TAX REFUNDS/DISTRIBUTIONS (1) remains the same.

(2) Refund claims by a cigarette manufacturer must contain a notarized affidavit that the cigarette tax refund claimed is for state of Montana cigarette tax insignia which are affixed to the unsalable cigarettes; that credit or refund for the net cost of the tax insignia has been given to a Montana cigarette dealer; and that the cigarettes will not be sold at any time. Refund claims must be accompanied by a copy of the credit memo or invoice issued to the Montana dealer. In lieu of the credit memo or invoice the manufacturer may summit a printout showing each customer name, customer credit invoice number, number of Montana stamped cigarettes, tax amount and the date the cigarettes were returned for credit. Refunds will be allowed for stale or damaged merchandise during the first 90 days after a change in the tax rate at the previous rate of tax unless it can be verified conclusively that the new tax has been paid on the specific product for which such refund is claimed.

(3) through (5) remain the same. (AUTH: Sec. 16-11-103 MCA; IMP, Secs. 15-1-503, 16-11-112, and 16-11-156, MCA.)

3. The amendment to ARM 42.31.131 will allow a manufacturer to request a refund for un-saleable cigarettes returned by a wholesaler where the Montana stamp has been affixed. Presently the manufacturer must send in a copy of the invoice or credit memo. This option is still available, but the added language will also allow a computer printout which shows several customers rather than a separate sheet of paper for each customer. The information on the printout must be the same as that on the credit memo or invoice sent to the wholesaler.

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

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

no later than February 12, 1998.

5. If a person who is directly affected by the proposed amendments wishes to express his data, views and arguments orally or in writing at a public hearing, he must make written request for a hearing and submit this request along with any written comments he has to Cleo Anderson at the above address no later than February 12, 1998.

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

7. All parties interested in receiving notification of any change in rules pertaining to this subject should contact the Rule Reviewer in writing at the address shown in section 4 above.

Cleo Anderson
CLEO ANDERSON
Rule Reviewer

Mary Bryson
MARY BRYSON
Director of Revenue

Certified to Secretary of State December 17, 1997

BEFORE THE DEPARTMENT OF REVENUE
OF THE STATE OF MONTANA

IN THE MATTER OF THE AMENDMENT) NOTICE OF PUBLIC HEARING ON THE
of ARM 42.15.507 AND ADOPTION) PROPOSED AMENDMENT AND ADOPTION
of NEW RULES I through VI)
relating to Charitable Endow-)
ment Funds)

TO: All Interested Persons:

1. On February 6, 1998, at 9:00 a.m., a public hearing will be held in Fourth Floor Conference Room of the Mitchell Building, at Helena, Montana, to consider the amendment of ARM 42.15.507 and the adoption of new rules I through VI relating to charitable endowment funds.

2. The amendments to ARM 42.15.507 as proposed reflect earmarking which is from a previous amendment to this rule which are being adopted in the adoption section of this register. Those amendments appeared on MAR p. 1975 of the 1997 Montana Administrative Register, issue no. 21.

3. The amendments to ARM 42.15.507 are as follows:

42.15.507 DEFINITIONS (1) "Allowable contribution" for the purposes of the qualified endowment credit is a charitable gift made to a qualified endowment. The contribution from an individual to a qualified endowment must be by means of a planned gift as defined in 15-30-165, MCA. A contribution from a corporation, small business corporation, estate, partnership, or limited liability company may be made by means of a planned gift or may be made directly to a qualified endowment.

~~(1)~~ (2) "Amenities" are items that enhance the pleasantness or desirability of rental or retirement homes, or contribute to the pleasure and enjoyment of the occupant(s), rather than to their indispensable needs.

~~(2)~~ (3) "Beneficial interest" is a taxpayer who has a beneficial interest in a business when ~~he/she is~~ they are either a sole proprietor, partner or shareholder in an S corporation.

~~(3)~~ (4) "Finished product" means a marketable product that has economic value and is ready to be used by a consumer.

~~(4)~~ (5) "Gross household income" as defined under 15-30-171, MCA, is further defined as:

(a) all capital gains income transactions less return of capital;

(b) federal refunds received during the tax year to the extent that the amount recovered reduced the claimant's Montana income tax in a prior year; and

(c) Montana state income tax and Elderly Homeowner/Renter Credit refunds received.

~~(5)~~ (6) Land ownership surrounding a homestead in excess of one acre but less than 19.99 acres will be computed as follows: total amount of property tax billed on the land,

divided by the total acreage to equal the allowable amount of property tax used in the credit calculation.

(a) Land ownership of 20 acres or more must go to the county assessor's office for computation of the allowable amount of property tax used in the credit calculation.

~~(6)~~ (7) "Machinery or equipment" is property having a depreciable life of more than one year, whose primary purpose is to collect or process reclaimable material or is depreciable property used in the manufacturing of a product from reclaimed material.

(8) "Paid-up life insurance policies" are life insurance policies in which the donor has paid all the premiums prior to the policies being contributed to a qualified endowment. The donor must make the tax-exempt organization the owner and beneficiary of the policy.

(9) A "permanent irrevocable fund" is a fund which receives the charitable gift portion of a planned gift or a direct charitable contribution and holds the charitable gift or contribution on behalf of a tax-exempt organization under 26 U.S.C. 501(C)(3) for the life of the organization. The corpus of the fund is not expendable by the tax exempt organization on a current basis under the terms of the applicable gift document or other governing documents. For the purpose of the qualified endowment credit, the fund must be used exclusively for the benefit of Montana communities and citizens.

(10) "Present value of the charitable gift portion of a planned gift" is the allowable amount of the charitable contribution as defined in 15-30-121, MCA, or for corporations as defined in 15-31-114, MCA, prior to any percentage limitations.

~~(7)~~ (11) "Primarily" means over 50% of time, usage, or other appropriate measure.

~~(8)~~ (12) "Process or processing" means preparation, treatment, including treatment of hazardous waste as defined in 75-10-403, MCA, or conversion of a product or material by an action, change or function or a series of actions, changes, or functions that bring about a desired end result.

~~(9)~~ (13) "Reclaimed material" is post-consumer material that has been collected and used in a process designed to produce recycled material.

~~(10)~~ (14) "Recycled material" means a material that can be readily utilized without further processing in place of raw or virgin material in manufacturing a product. ~~and~~ It consists of materials derived from post-consumer waste, industrial scrap, material derived from agricultural wastes and other items, all of which can be used in the manufacture of new products.

~~(11)~~ (14) "Rent" is the amount of money charged to a tenant for the occupying of a dwelling. "Rent" does not include amenities such as meals, housekeeping, nursing care, etc.

AUTH: Sec. 15-30-305, 15-31-501, and 15-32-611, MCA; IMP, Sec.

15-30-165, 15-30-166, 15-30-167, 15-31-161, 15-31-162, 15-32-601 15-32-602, 16-32-603, 15-32-604, 15-32-609, and 15-32-610, MCA

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

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

NEW RULE I ELIGIBILITY REQUIREMENTS TO HOLD A QUALIFIED ENDOWMENT (1) To hold a qualified endowment an organization must be:

(a) incorporated or otherwise formed under the laws of Montana and is exempt from federal income tax under 26 U.S.C. 501(C)(3); or

(b) a bank or trust company, as defined in 15-30-165, MCA, holding an endowment fund on behalf of a Montana or foreign 501(C)(3) organization.

AUTH: 15-30-305 and 15-31-501, MCA; IMP: 15-30-165, 15-30-167, 15-31-161 and 15-31-162, MCA

NEW RULE II TAX CREDIT AND DEDUCTION LIMITATIONS (1) The credit allowed against the corporate, estate or individual tax liability is equal to 50% of the present value of the allowable contribution as defined in ARM 42.15.507. The maximum credit that may be claimed in one year is $10,000 per taxpayer. A contribution made in a previous tax year cannot be used for a credit in any subsequent tax year.

(2) The balance of the allowable contributions, if not used in the credit calculation, may be used as a deduction subject to the limitations and carryover provisions found in 15-30-121, MCA, or for corporations the limitations and carryover provisions found in 15-31-114, MCA.

Example 1:

Credit Allowed	
Allowable contributions	$50,000
Credit calculation (50,000 x 50%)	25,000
Maximum credit allowed	$10,000
Excess Contribution Deduction Allowed	
Allowable contributions amount	$50,000
Less maximum contribution used in credit computation ($10,000 x 2)	-20,000
Balance allowed as an itemized deduction	$30,000

Example 2:

Credit Allowed	
Allowable contributions	$15,000
Credit calculation (15,000 x 50%)	7,500
Maximum credit allowed	$7,500
Excess Contribution Deduction Allowed	
Allowable contributions	$15,000
Less contribution used in credit	-15,000

computation ($7,500 x 2)
Balance allowed as an itemized deduction $0

(3) The contribution to a qualified endowment from a small business corporation, partnership or limited liability company is passed through to the shareholders, partners, or members or managers in the same proportion as their distributive share of the entity's income or loss for Montana income tax purposes. The proportionate share of the contribution passed through to each shareholder, partner or member or manager becomes an allowable contribution for that taxpayer for that year, and the credit allowed and the excess contribution deduction allowed are calculated as set forth in (1) and (2).

(4) Deductions and credit limitations for an estate are as follows:

(a) if an estate claims a credit based on the computation of the full amount of the contribution, there is no credit available to beneficiaries;

(b) any portion of a contribution not used in the calculation of credit for the estate may be passed through to the beneficiaries, in the same proportion as their distributive share of the estate's income or loss for Montana income tax purposes; however, beneficiaries may deduct only that portion of allowable contributions not used toward the credit or deduction claimed by the estate; or

(c) if the estate has deducted the full amount of the contribution, the credit may not be claimed by either the estate or the individual beneficiaries.

(5) At no time can a corporation, small business corporation, partnership, limited liability company, estate or individual be allowed to receive the benefit of both a contribution deduction and a credit from the same money.

(6) The maximum credit that may be claimed in a tax year by any taxpayer for allowable contributions from all sources is $10,000. In the case of a married couple that makes a joint contribution, the contribution is assumed split equally. If each spouse makes a separate contribution, each may be allowed a credit up to the maximum of $10,000.

Example 1:

Assume a married couple makes a joint planned gift to a qualified endowment. The allowable contribution made by the couple is $40,000. That couple is eligible to take a credit of up to $20,000 with each claiming a credit of $10,000.

Example 2:

Assume a married couple makes separate planned gifts to qualified endowments, which result in an allowable contribution of $20,000 for each person. They each would be eligible to take

a credit of up to $10,000.

AUTH: 15-30-305, 15-31-501, MCA IMP: 15-30-165, 15-30-166, 15-30-167, 15-31-161 and 15-31-162 MCA

NEW RULE III CREATING A PERMANENT IRREVOCABLE FUND (1) A permanent, irrevocable fund can be created by a restriction in the applicable planned gift document indicating the donor's intention that the contribution shall be held in a permanent, irrevocable fund. For planned gifts other than paid-up life insurance policies, the applicable planned gift document is the trust document, gift annuity contract, life estate agreement or pooled income fund agreement.

(2) A permanent irrevocable fund may be created by one of the qualified organizations referenced in Rule I under a separate governing document.

(3) All funds created by donors or qualified organizations must meet the requirements of a permanent irrevocable fund provided in these rules.

AUTH: 15-30-305, 15-31-501, MCA IMP: 15-30-165, 15-30-167, 15-31-161 and 15-31-162, MCA.

NEW RULE IV REPORTING REQUIREMENTS (1) The taxpayer must attach a copy of the following information to the tax return reporting the credit:

(a) a receipt acknowledging the amount of the allowable contribution from:

(i) the tax-exempt organization under 26 U.S.C. 501(C)(3) holding the qualified endowment receiving the contribution;

(ii) from the trustee of the trust administering the planned gift; or

(iii) from the bank or trust company holding a qualified endowment on behalf of a tax exempt organization.

(b) the date of the contribution to the qualified endowment or the planned gift;

(c) the name of the organization incorporated or established in Montana holding the qualified endowment fund or the name of the tax exempt organization on behalf of which the qualified endowment fund is held; and

(d) a description of the type of gift, i.e. outright gift, charitable remainder unitrust, charitable gift annuity, etc.

(2) The information required by these rules will be reported on forms prescribed and made available by the department of revenue.

AUTH: 15-30-305, 15-31-501, MCA IMP: 15-30-166, 15-30-167, 15-31-161 and 15-31-162, MCA

RULE V APPLICABILITY DATES (1) The rules in this subchapter which apply to qualified endowment funds are applicable for tax years beginning after December 31, 1996 and to allowable contributions made on or before December 31, 2001.

AUTH: 15-30-305, 15-31-501, MCA IMP: 15-30-165, 15-30-166, 15-30-167, 15-31-161 and 15-31-162, MCA

RULE VI QUALIFIED ENDOWMENT CREDIT (1) For purposes of the qualified endowment credit, as applied to corporations, the department adopts by reference ARM 42.15.507, RULE I, RULE II, RULE III, RULE IV and RULE V.

AUTH: 15-31-501, MCA IMP: 15-30-165, 15-30-166, 15-30-167, 15-31-161, and 15-31-162, MCA

6. The Department is proposing the amendment and adoption of these rules to implement the recent legislative enactment of 15-30-165, 15-30-166, 15-30-167, 15-31-161, and 15-30-162, MCA. The act provides an income, corporate or an estate tax credit for making charitable gifts to a qualified endowment fund.

The amendment to ARM 42.15.507 is necessary because the new laws refer to terms which are not defined in the statutes and are used when describing the administration of these laws through rulemaking.

New rule I clarifies what type of organization may hold a qualified endowment fund.

New rule II denotes the limitations regarding this credit. It clarifies the contribution amount to be used in the credit calculation and any deduction resulting from additional contributions. It is necessary to explain the limitations so that any contributions are not being used as both a credit and a contribution. The rule eliminates double deductions. The credit/contribution can flow through to an individual from an estate, sub-s corporation, partnership or limited liability company.

New rule III clarifies the procedures for creating a permanent irrevocable fund. Eligibility for this credit depends upon the contribution being made to a qualified fund.

New rule IV explains the filing requirements for applying for this credit.

New rule V is necessary because the law states that the allowable contributions to a qualified endowment fund will only be allowed for a specific time period.

New rule VI adopts by reference ARM 42.15.507 and new rules I through V for the corporation license tax chapter of Title 42.

7. Interested parties may submit their data, views, or arguments either orally or in writing at the hearing. Written data, views, or arguments may also be submitted to:

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

no later than February 17, 1998.

8. Cleo Anderson, Department of Revenue, Office of Legal Affairs, has been designated to preside over and conduct the hearing.

9. All parties interested in receiving notification of any change in rules pertaining to this subject should contact the Rule Reviewer in writing at the address shown in section 7 above.

Cleo Anderson
CLEO ANDERSON
Rule Reviewer

Mary Bryson
MARY BRYSON
Director of Revenue

Certified to Secretary of State December 22, 1997

BEFORE THE DEPARTMENT OF ADMINISTRATION
OF THE STATE OF MONTANA

In the matter of the amendment of ARM 2.21.1422 related to employment preference for persons with disabilities	))))	CORRECTED NOTICE OF AMENDMENT

TO: All Interested Persons.

1. On December 15, 1997, the department published a notice at page 2277 of the Montana Administrative Register, Issue No. 24, of the amendment of the above-captioned rule.

2. The notice of amendment neglected to properly renumber within a rule. The corrected rule amendment reads as follows:

2.21.1422 EMPLOYMENT COVERED (1)-(5)(g) Same as amended.

~~(4)~~ (6) Also excluded is appointment by lawful authority to fill an unexpired term in an elected office.

~~(6)~~ (7) A temporary employee shall not be considered a current employee for purposes of ARM 2.21.1423. If a temporary employee is considered in the applicant pool for permanent or seasonal employment, the selection is considered an initial hire and the employment preference must be applied.

(Auth. 39-30-106, MCA; Imp. 39-30-101 et seq., MCA)

3. Replacement pages for the corrected notice of amendment were submitted to the Secretary of State on December 31, 1997.

BY: _____
Dal Smilie
Rule Reviewer

_____
Lois Menzies
Director

Certified to the Secretary of State January 5, 1998.

BEFORE THE BOARD OF THE
STATE COMPENSATION INSURANCE FUND
OF THE STATE OF MONTANA

In the matter of the adoption of new rule I on employers' liability; and the amendment of rules 2.55.321; 2.55.322; 2.55.324; 2.55.325; 2.55.327; and 2.55.402.	NOTICE OF ADOPTION OF NEW RULE I (2.55.328) AND AMENDMENT OF RULES PERTAINING TO PREMIUM RATES

TO: All Interested Persons:

1. On October 6, 1997, the State Compensation Insurance Fund Board published notice of the proposed adoption of New Rule I (2.55.328) pertaining to Employers' Liability; and the proposed amendment of rules 2.55.321, 2.55.322, 2.55.324, 2.55.325, 2.55.327, and 2.55.402 pertaining to premium rates at page 1697 of the 1997 Montana Administrative Register, issue number 19.

2. The Board adopted new Rule I (2.55.328) and amended rules 2.55.321, 2.55.322, 2.55.324, 2.55.325, 2.55.327, and 2.55.402 as proposed.

3. No comments or testimony concerning the rules were received.

Dal Smilie, Chief Legal Counsel
Rule Reviewer

Jim Brouelette
Chairman of the Board

Nancy Butler, General Counsel
Rule Reviewer

Certified to the Secretary of State December 31, 1997.

BEFORE THE BOARD OF COSMETOLOGISTS
DEPARTMENT OF COMMERCE
STATE OF MONTANA

In the matter of the amendment, repeal and adoption of rules pertaining to the practice of cosmetology, electrology, manicuring and esthetics	CORRECTED NOTICE OF AMENDMENT

TO: All Interested Persons:

1. On October 6, 1997, the Board of Cosmetologists published a notice of proposed amendment, repeal and adoption of rules pertaining to cosmetology, electrology, manicuring and esthetics at page 1709, 1997 Montana Administrative Register, issue number 19. On December 1, 1997, the Board of Cosmetologists published a notice of adoption of the rules at page 2181, 1997 Montana Administrative Register, issue number 23.

2. ARM 8.14.603 was adopted with changes in the adoption notice. Subsections (9) through (14) were inadvertently omitted in the adoption notice but should have been adopted as shown below:

"8.14.603 SCHOOL OPERATING STANDARDS (1) through (8) will remain the same as published in the adoption notice.

(9) through (14) will remain the same as proposed."

3. ARM 8.14.803 was adopted exactly as proposed in the adoption notice, but should have been adopted with changes as follows. The new language published in the original notice was inadvertently not underlined.

"8.14.803 APPLICATIONS FOR EXAMINATION - TEMPORARY PERMITS (1) through (3) will remain the same as proposed.

(4) Applicants who register for the first available Montana examination are eligible for a temporary permit.

(5) through (9) will remain the same as proposed.

4. ARM 8.14.805 was adopted exactly as proposed, but should have been amended as follows in the adoption notice. The title should have cited "Estheticians" instead of "Esthetics" and the new language in the last sentence of (2)(a) published in the original notice was inadvertently not underlined.

"8.14.805 APPLICATION - OUT-OF-STATE COSMETOLOGISTS, MANICURISTS, ~~ESTHETICS~~ ESTHETICIANS (1) through (2) will remain the same as proposed.

(a) To qualify for licensure by endorsement, an out-of-state manicurist must submit an application prescribed by the board with the appropriate fees and proof of completion of 350 hours of training in an approved school of manicuring or manicuring course, a certified true copy of applicant's birth

certificate or other verifiable proof of birth date, a certified true copy of applicant's high school graduation or equivalency, a certified true copy of a current out-of-state license and an original board transcript from each state in which you hold a license. The applicant will be credited for the number of hours currently required in that state or the number of hours in the transcript."

5. The replacement pages for these amendments were submitted for the December 31, 1997 filing date.

BOARD OF COSMETOLOGISTS
VERNA DUPUIS, CHAIRMAN

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

Ann M. Bartos
ANNIE M. BARTOS, RULE REVIEWER

Certified to the Secretary of State, January 5, 1998.

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

In the matter of the amendment of a rule pertaining to an application for licensure	)))	NOTICE OF AMENDMENT OF 8.34.414A APPLICATION FOR LICENSURE

TO: All Interested Persons:

1. On August 18, 1997, the Board of Nursing Home Administrators published a notice of public hearing on the proposed amendment of the above-stated rule at page 1423, 1997 Montana Administrative Register, issue number 16. The hearing was held on September 29, 1997, in Helena, Montana.

2. The Board has amended the rule as proposed, but with the following changes:

"8.34.414A APPLICATION FOR LICENSURE (1) In addition to passing the examination referred to in ARM 8.34.414, an applicant must submit a completed application form documenting education, training, experience or a combination thereof totaling 1200 points.

(2) through (3)(a) will remain the same as proposed.

(i) management experience, ~~with responsibility for a function or a department, but who also receives general~~ with or without supervision, no more than ~~400~~ 600 points/year;

(ii) through (b) will remain the same as proposed.

(i) minimum of an associate degree in health care or business equals 1200 points;

(ii) college/university coursework in a health or business related course ~~(no degree earned)~~, (completed with a grade of not less than "C") equals 20 points/credit hour.

(c) through (4) will remain the same as proposed."

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

COMMENT NO. 1: Commentor stated that the language in 8.34.414A should be amended to clearly reflect that education, training, experience, or a combination thereof is sufficient to obtain a nursing home administrator's license.

RESPONSE: The Board accepted the comment and amended the rule as set forth above.

COMMENT NO. 2: Commentor states that the language of 8.34.414A(3)(a)(i) should be clear in that management experience of whatever nature is sufficient regardless of supervision.

RESPONSE: The Board accepted the comment and amended the rule as set forth above.

COMMENT NO. 3: Commentor states that the rule proposal set forth by the Board's rule subcommittee requested that the

point value in 8.34.414A(3)(a)(i) is 600 points, not 400 as stated in the notice.

RESPONSE: The Board accepts the comment and amended the rule as set forth above.

COMMENT NO. 4: Commentor stated that the rule in 8.34.414A(3)(b)(i) should clarify that a minimum of an associate degree is required.

RESPONSE: The Board accepts the comment and amended the rule as set forth above.

COMMENT NO. 5: Commentor states that for purposes of clarity, the rule should be amended to remove the phrase "(no degree earned)" as the phrase implies that college/university coursework will only be credited toward the point total if the coursework did not lead to a degree. The subcommittee's intent was to credit all coursework, including that which is earned in a course of study leading to a degree other than health care or business, which is germane to the nursing home administrator profession.

RESPONSE: The Board accepts the comment and amended the rule as set forth above.

BOARD OF NURSING HOME ADMINISTRATORS
DONNA KAY JENNINGS, CHAIRMAN

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

Anne M. Bartos
ANNIE M. BARTOS, RULE REVIEWER

Certified to the Secretary of State, January 5, 1998.

BEFORE THE BOARD OF PHARMACY
DEPARTMENT OF COMMERCE
STATE OF MONTANA

In the matter of the amendment of rules pertaining to fees, internship regulations and pharmacy technicians	))))	CORRECTED NOTICE OF AMENDMENT

TO: All Interested Persons:

1. On September 22, 1997, the Board of Pharmacy published a notice of proposed amendment of rules pertaining to fees, internship regulations and pharmacy technicians at page 1628, 1997 Montana Administrative Register, issue number 18. On November 17, 1997, the Board published a notice of adoption of the rules at page 2060, 1997 Montana Administrative Register, issue number 22. The Board adopted ARM 8.40.404, 8.40.901 through 8.40.904, 8.40.906, 8.40.1303 and 8.40.1308 exactly as proposed.

2. ARM 8.40.902(6) should have been proposed in the original notice as follows:

"8.40.902 INTERNSHIP PROGRAM DEFINITIONS (1) through (5) remain the same as proposed in original notice.

(6) "Internship period" means 1500 hours of practical experience in an approved pharmacy, hospital or other facility. The intern must acquire a minimum of 20 hours experience per calendar week in not less than ~~5~~ five days per calendar week, and may acquire a maximum of 48 hours experience per calendar week. However, the student may acquire up to ~~700~~ 1000 hours concurrently with school attendance in approved courses, ~~clinical pharmacy programs~~ externships and clerkships, or demonstration projects ~~which have been approved by the Tri-Partite Committee and/or the board~~ in the B.S. program and up to 1500 hours concurrently with school attendance in approved courses, externships and clerkships, or demonstration projects in the Pharm.D. program.

(7) through (11) remain the same as proposed in the original notice."

3. The word "clerkships" should have been underlined and the language "which have been approved by the Tri-Partite Committee and/or the board" should have been stricken in the original proposed notice.

4. Replacement pages for this notice were submitted for the December 31, 1997 filing date.

BOARD OF PHARMACY
ANN PASHA, PRESIDENT

ANNIE M. BARTOS
RULE REVIEWER

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

Certified to the Secretary of State, January 5, 1998.

BEFORE THE BUILDING CODES BUREAU
DEPARTMENT OF COMMERCE
STATE OF MONTANA

In the matter of the amendment of a rule pertaining to the Building Codes Bureau	)))	CORRECTED NOTICE OF AMENDMENT

TO: All Interested Persons:

1. On November 17, 1997, the Building Codes Bureau published a notice of amendment, repeal and adoption of rules pertaining to the Building Codes Bureau at page 2061, 1997 Montana Administrative Register, issue number 22.

2. The Bureau amended ARM 8.70.541 as proposed but with one change to (1), the language "or until withdrawn or revised by the manufacturer" currently in this rule was inadvertently omitted from the original proposal and should remain.

3. The proposed amendment of ARM 8.70.541 should have appeared as follows in the original notice:

"8.70.541 PLAN REVIEW TERMINATION (1) A plan review issued by the bureau shall remain in effect through December 31 of the year following the original year of approval and through December 31 of each subsequent year of renewal as established in ARM 8.70.549 or until withdrawn or revised by the manufacturer or until revoked by the bureau. A plan review will be revoked by the bureau upon a finding that a manufacturer is not complying with the plan as reviewed or that such manufacturer has used materials not listed and reviewed by a listing agency or reviewed as an alternate or equivalent by the bureau."

4. Replacement pages for this rule were submitted on December 31, 1997.

BUILDING CODES BUREAU

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, January 5, 1998.

BEFORE THE CONSUMER AFFAIRS DIVISION
DEPARTMENT OF COMMERCE
STATE OF MONTANA

In the matter of the repeal of rules pertaining to proprietary schools	)))))	NOTICE OF REPEAL OF RULES 8.78.401 DEFINITIONS, 8.78.402 LICENSE - BOND REQUIREMENTS AND 8.78.403 LICENSE - GENERAL REGULATIONS

TO: All Interested Persons:

1. On November 17, 1997, the Consumer Affairs Division published a notice of proposed repeal of the above-stated rules at page 2016, 1997 Montana Administrative Register, issue number 22.

2. The Division has repealed the rules exactly as proposed.

3. No comments or testimony were received.

CONSUMER AFFAIRS DIVISION

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

_____
ANNIE M. BARTOS, RULE REVIEWER

Certified to the Secretary of State, January 5, 1998.

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

In the matter of the adoption of a new rule defining guiding services for use of class B-10 and B-11 licenses which are outfitter-sponsored nonresident, big game, combination licenses.	))))))	NOTICE OF ADOPTION

To: All Interested Persons.

1. On October 6, 1997, the Fish, Wildlife and Parks Commission (commission) published notice at page 1753 in the 1997 Montana Administrative Register, issue number 19, of a public hearing regarding the commission's consideration of a proposed rule defining guiding services for class B-10 and B-11 license use. The rule would apply to those class B-10 and B-11 nonresident, big game, combination licenses that are outfitter-sponsored.

2. On November 12, 1997, a public hearing was held in Helena. Written comments were accepted through November 21, 1997.

3. After consideration of public written and oral comments, the commission adopted Rule I (12.3.125) as proposed.

AUTH: 87-1-301, MCA IMP: 87-2-511(4), MCA

4. A total of 28 comments were received on the proposed rule. The Montana outfitters and guides association (MOGA) and the Montana board of outfitters supported the rule. Sixteen outfitters supported the rule, and three supported the rule but wanted it more restrictive. Seven outfitters opposed the rule. The following is a summary of the comments received opposing the rule or suggesting changes, along with the commission's responses to those comments:

COMMENT 1: One outfitter wanted to require the guide to be with the hunter all day, and two outfitters wanted to add limits on the number of hunters per guide, suggesting a two or three hunter per guide limit.

RESPONSE 1: The intent of the rule is to limit the use of guaranteed outfitter-sponsored licenses to hunters who employ outfitters for fully-guided hunts. Limited outfitter services, such as drop camps or even more limited services, would not qualify a hunter to obtain and use one of the limited guarantee licenses. The commission did not feel the rule needed to be made even more restrictive to accomplish this purpose.

COMMENT 2: Two outfitters wanted the rule to be rewritten, or not adopted, so that they did not have to be with their clients.

RESPONSE 2: The intent of the rule would not be accomplished under this suggestion.

COMMENT 3: An outfitter wanted the rule to read "escorting or directing" instead of "escorting and directing" so he did not have to stay with his whitetail deer hunting clients while they are in tree stands.

RESPONSE 3: The intent of the rule could not be accomplished if this suggested wording was adopted. Also, while this particular outfitter may or may not be in technical violation of the rule, depending on the amount of time he spends guiding his clients, he is not operating as a provider of drop camp services and, under the intent of the rule, would not be subject to prosecution.

COMMENT 4: Two outfitters thought that the rule was contrary to the statutes because the outfitter licensing statutes already defined the term "accompany" and also define "guiding services" through the statutory definition of "outfitting."

RESPONSE 4: The term "accompany" is defined in the statutes regulating the outfitting business, but that definition only applies to those statutes. The term "guiding services" is not specifically defined in the outfitter statutes, only the term "outfitter" is defined. Section 87-2-511(4)(b), MCA, does use the term "guiding services" as a requirement for the use of an outfitter-sponsored, nonresident license. The adopted rule defines the meaning of guiding services for hunting license use. How to define this term is a policy decision of the commission. Under the rule as adopted, some outfitter services, although requiring an outfitter's license, are not enough to constitute a fully-guided hunt necessary to obtain and use a guaranteed outfitter-sponsored license.

COMMENT 5: A number of outfitters generally opposed the rule and some believed it serves no purpose. Those opposing the rule argued the following: the rule does not serve the main purpose of outfitter-sponsored licenses which is to aid in securing advance registrations; does not make the outfitting business more viable; does not serve clients who want to hunt on their own; creates difficulty establishing how much time a guide must spend with a client to be in compliance with the rule; will result in outfitters no longer being responsible for clients in drop camps; and will cause a drop in the demand, and therefore, the price of the guaranteed B-10 license.

RESPONSE 5: The commission, relying on the advice of the board of directors of MOGA, the Montana board of outfitters, and the majority of outfitters who commented, believe that the intent of the term "guiding services" was to ensure that only hunters who

went on full-guided hunts would be entitled to purchase the guaranteed, outfitter-sponsored licenses. Under the rule as adopted, outfitters who furnish fully-guided hunts would be serving clients who would now not be "competing" for the guaranteed licenses with hunters who did not purchase a fully-guided hunt. The demand for the guaranteed, outfitter-sponsored license will be less, which may or may not be enough difference to cause a decrease in the price of the market-based, guaranteed, outfitter-sponsored licenses. Outfitters will still have the same responsibilities for clients in drop camps because they will still be providing outfitting services to their clients.

COMMENT 6: Three outfitters said that the rules would impact their established uses of drop camps in wilderness areas or national forests where outfitting is limited by use permits. One said that no guides are allowed in a drop camp under forest service regulations. He requested that the rule either be rejected or an exception be made for currently permitted drop camps.

Another outfitter said that the rule would be a death warrant for those making a living on federal lands, that wilderness use permits have been frozen, and that outfitters lose permitted days if they do not use their allocation. Another said only 70% of priority use days had been used by outfitters during the last five-year permit reevaluation period. He said this was a trend of decreasing demand for fully-guided hunts and that there had been a surplus during the last two years of outfitter-sponsored class B-10 licenses at the end of the first 30 days of sales. These outfitters opposed the rule.

RESPONSE 6: The commission recognizes that the rule will have impacts on outfitters with established drop camp operations, especially where forest service or wilderness area use permits are required. According to Steve Morton, a forest service employee who supervises the outfitter program on federal lands, no guides are allowed in outfitter permitted drop camps. This is a forest service rule in force throughout the state, including the Bob Marshall Wilderness complex. An outfitter can continue to use drop camps by using nonresident licenses obtained through the drawings. For example, 11,400 nonresident elk combination licenses are available on a drawing basis. The drawing is modified with a preference given those who applied but were unsuccessful in the prior license drawing. During the 1997 nonresident license drawing, approximately 5,000 applicants had been unsuccessful the year before, so they had preferences. Thus, the first 5,000 licenses went to those with preference. This may help modify the otherwise uncertain availability of licenses through the drawing. The commission does recognize that outfitters offering drop camp services will lose many of the advantages of the guaranteed licenses.

Other adjustments will have similar impacts. Outfitters might be able to change drop camp services to guided hunts. However, the forest service would have to approve any changes from drop camps to spike or base camps. Depending on the impacts, the forest service may or may not approve a change. Also a change to a guided hunt means a change in the service provided and the fee and it means a permitted use day will be needed each day for each guide. The commission understands that the forest service may be considering allocating more use days because the use day cap established in 1978 has never been reached. However, the commission recognizes that changing to guided hunts would mean changes in an outfitter's business.

The commission recognizes that those clients desiring less than full services will not be able to use the guaranteed licenses and that some outfitters will be impacted. The commission has balanced these concerns with the benefits to the outfitting industry as a whole of reserving the guaranteed licenses for fully-guided hunts and decided to adopt the rule as proposed.

ROBERT N. LANE
RULE REVIEWER

PATRICK J. GRAHAM, SECRETARY

Certified to the Secretary of State on January 5, 1998.

BEFORE THE DEPARTMENT OF TRANSPORTATION
OF THE STATE OF MONTANA

In the matter of the amendment of rule 18.8.101 to include a definition of F.O.B. Factory List Price and F.O.B. Port-of-Entry List Price as it relates to the Motor Carrier Services program	)))))	NOTICE OF AMENDMENT

TO: All Interested Persons.

1. On November 3, 1997, the Department of Transportation published notice of the proposed amendment of rule 18.8.101 concerning the Motor Carrier Services program at page 1969 of the Montana Administrative Register, issue number 21.

2. The agency has amended rule 18.8.101 as proposed.

3. At the public hearing on this proposed amendment, Brenda Nordland appeared on behalf of the Attorney General and testified in support of the proposed amendment. No other comments or testimony were received.

MONTANA DEPARTMENT OF TRANSPORTATION

By: _____
MARVIN DYE, Director

_____
Lyle Manley, Rule Reviewer

Certified to the Secretary of State January 5, 1998.

BEFORE THE DEPARTMENT OF TRANSPORTATION
OF THE STATE OF MONTANA

In the matter of the amendment of rules 18.8.509, 18.8.517 and 18.8.1101 concerning the Motor Carrier Services program	)))))	NOTICE OF AMENDMENT

TO: All Interested Persons.

1. On September 22, 1997, the Department of Transportation published notice of the proposed amendment of the above-referenced rules concerning the Motor Carrier Services program at page 1638 of the 1997 Montana Administrative Register, issue number 18.

2. The agency has amended the rules as proposed.

3. No comments or testimony were received.

MONTANA DEPARTMENT OF TRANSPORTATION

By: _____
MARVIN DYE, Director

_____
Lyle Manley, Rule Reviewer

Certified to the Secretary of State December 31, 1997.

BEFORE THE DEPARTMENT OF CORRECTIONS
OF THE STATE OF MONTANA

In the matter of the adoption of new rules I through VI pertaining to the siting and construction standards of private correctional facilities in Montana	NOTICE OF ADOPTION OF NEW RULES I THROUGH VI 20.27.101 THROUGH 20.27.106

TO: All Interested Persons

1. On October 20, 1997, the Department of Corrections published a notice of public hearing on the proposed adoption of new rules I through VII, pertaining to the siting and construction standards of private correctional facilities in Montana, as authorized by 53-30-601 through 611, MCA. The notice was published on pages 1895 through 1900 of the 1997 Issue Number 20 of the Montana Administrative Register.

2. The Department has adopted rules I (20.27.101), II (20.27.102), and III (20.27.103) exactly as proposed. The Department is not adopting rule VII. The Department has adopted rules IV (20.27.104), V (20.27.105), and VI (20.27.106), with the following changes:

RULE IV (20.27.104) OBTAINING PUBLIC SUPPORT FOR PROPOSED PRIVATE CORRECTIONAL FACILITY SITES (1) Proposed sites for private correctional facilities must have community support~~, including endorsement by local officials~~. Proposers must obtain approval of the location of the private correctional facility from the local governing body or bodies.

(2) To gain public support and input into the siting process for private correctional facilities, proposers shall ~~ensure~~ hold at least two public hearings ~~are held~~ in the county~~ and municipality~~ of the proposed site.

(a) If the nearest municipality to the proposed site is also the county seat, the public hearings shall be held in the municipality~~ and shall be conducted by the county governing body~~.

(b) remains the same as proposed.

(3) If the proposed site is located within a municipality, the governing body of the municipality and the governing body of the county shall ~~conduct the hearings~~ approve the location of the facility.

(4) If the proposed site is not located within a municipality, the county governing body shall ~~conduct the hearings~~ approve the location of the facility.

(5) If the proposed site is located within seven and one-half air miles of an adjacent county, the proposers shall also hold a third public hearing in the municipality of the adjacent county that is located within closest proximity of the proposed site. ~~The hearing shall be conducted by the county governing body of that adjacent county.~~

(6) remains the same as proposed.

(7) The ~~governing body conducting the hearing~~ proposer shall provide adequate public notice of the hearings, which shall, at a minimum, meet the following criteria:

(a) if the proposed site is located in a rural area, the ~~governing body~~ proposer shall publish notice of the public hearing in a local weekly newspaper as well as in the nearest daily newspaper;

(b) if the proposed site is located in or near a major municipality, the ~~governing body~~ proposer shall publish notice of the hearing in at least one major newspaper of general circulation in the proposed site area;

(c) through (e) remain the same as proposed.

(8) In addition to the public notices, the ~~governing body~~ proposer shall also provide specific notice to:

(a) through (f) remain the same as proposed.

(9) and (10) remain the same as proposed.

(11) The governing body may conduct the public hearings required herein.

AUTH: 53-30-604, MCA IMP: 53-30-607, MCA

RULE V (20.27.105) LETTERS IN SUPPORT OF PROPOSED SITES FOR PRIVATE CORRECTIONAL FACILITIES (1) The ~~governing body~~ proposer shall obtain evidence of approval by the local governing entity or entities of the political subdivision in which the proposed facility is to be located ~~shall adopt a resolution in support or in opposition to the proposed facility~~.

~~(2) If the proposed facility is located within a municipality, the county governing body shall also adopt a resolution in support or in opposition to the proposed facility.~~

~~(3)~~ (2) If the governing ~~body~~ entity or entities approve ~~adopts a resolution in support of~~ the proposed facility, proposers shall obtain letters of support and/or concern regarding the proposed facility from:

(a) through (g) remain the same as proposed.

(4) and (5) remain the same as proposed but are renumbered (3) and (4).

AUTH: 53-30-604, MCA IMP: 53-30-607, MCA

RULE VI (20.27.106) DESIGN AND CONSTRUCTION OF PRIVATE CORRECTIONAL FACILITIES (1) remains the same as proposed.

(2) remains the same as proposed.

~~(a)~~(3) ~~In addition to being awarded the contract,~~ Prior to commencing operations, the prevailing proposer must obtain letters of approval from A&E and the department.

(3) remains the same but is renumbered (4).

~~(4)~~(5) Any contractor or subcontractor performing construction of any type on private correctional facilities shall:

~~(a) Provide a copy of a labor and materials bond to the department and A&E; and~~

~~(b)~~ Pperform work in accordance with all state and local laws, rules and ordinances.

AUTH: 53-30-604, MCA IMP: 53-30-604 and 53-30-606, MCA

3. On Monday, November 17, 1997, at 9:30 a.m., a public hearing was held in the downstairs conference room at the Department of Corrections, 1539 11th Avenue, Helena, Montana, to consider the proposed adoption of new rules I through VII pertaining to siting and construction criteria for private correctional facilities in Montana. Nine persons attended the public hearing. No person who attended the hearing submitted data, views, or arguments on the proposed rules. One written comment was received. The Department has fully considered all submissions received respecting the proposed rules and responds as follows:

COMMENTS REGARDING RULE IV (20.27.104):

COMMENT 1: Subsection (1): Commentor suggests that "endorsement by local officials" is either ambiguous or conflicts with 53-30-607(2), MCA.

Response: The department accepted the comment and amended the rule.

COMMENT 2: Subsection (2): Commentor suggests that it is unclear who is responsible for holding the public hearings and the number of hearings which are required.

Response: The department accepted the comment and amended the rule.

COMMENT 3: Subsections (2),(3),(4),(5), and (8): Commentor suggests that the department does not have the authority to adopt these rules because they require a local government to perform functions not required by statute.

Response: The department accepted the comment and amended the rule.

COMMENT 4: Subsections (6), (7), (9), and (10): Commentor suggests that these rules are not necessary.

Response: The department believes that the rules set parameters to ensure adequate public participation in the siting of a correctional facility, in conformity with legislative intent.

COMMENTS REGARDING RULE V (20.27.105):

COMMENT 5: Subsections (1) and (2): Commentor suggests that requiring a local governmental entity to adopt a resolution is not consistent with the statutory language of 53-30-607(2), MCA.

Response: The department accepted the comment and amended the rule.

COMMENT 6: Subsections (3) and (4): Commentor suggests that the rules exceed the scope of statutory authority granted to the department.

Response: The department disagrees. The legislature intended to ensure public participation in the siting of a private correctional facility. The rule ensures a process for the public to provide input into the siting and selection process.

COMMENTS REGARDING RULE VI (20.27.106):

COMMENT 7: Subsection (2): Commentor suggests that subsection (2)(a) seems redundant with subsection (2).

Response: The department accepted the comment and amended the rule.

COMMENT 8: Subsection (4)(a): Commentor questions the rationale for this subsection.

Response: The department accepted the comment and amended the rule.

COMMENTS REGARDING RULE VII:

COMMENT 9: Commentor questions the statutory authority for this rule, and suggests that the rule more properly should be part of the Request for Proposals.

Response: The department accepted the comment, and will not adopt Rule VII.

Rick Day, Director
Department of Corrections

David L. Ohler
Rule Reviewer

Certified to the Secretary of State, January 5, 1998.

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

In the matter of the amendment of 46.8.1510 pertaining to exceptions to placement rules for developmental disabilities service positions	))))))	NOTICE OF AMENDMENT

TO: All Interested Persons

1. On November 17, 1997, the Department of Public Health and Human Services published notice of the proposed amendment of 46.8.1510 pertaining to exceptions to placement rules for developmental disabilities service positions at page 2045 of the 1997 Montana Administrative Register, issue number 22.

2 The Department has adopted the rule 46.8.1510 as proposed.

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

COMMENT #1: The Montana Association for Independent Disabilities Services (MAIDS) and AWARE, Inc. submitted a comment opposing the rule change. The association asserted that the rule change represented major changes in the system of developmental disabilities services and that prior to the rule change there should be substantial discussion and planning. The rule making process does not allow for adequate discussion and planning for a change of this magnitude.

RESPONSE: The proposed rule amendment allows for the development of legislatively authorized new community developmental disabilities services based on an individually based model. The specifics for implementation of the new services are being currently planned for. The proposed amendment does not specify how the expansion is to be implemented, how the individuals are to be selected, how the individuals will be offered residential or work opportunities, or when the expansion is to be implemented. Resolution of the specifics is currently under discussion with a variety of interests, particularly consumers and their family members. Providers, advocates and other interests are welcome to assist in this process.

The rule change is necessary at this time to assure that the opportunity to provide new services based on this new model is available as soon as possible in order to expend the appropriated monies in accordance with the legislative

appropriation for the biennium. Further delay at this time in implementation would directly result in the loss of the new service opportunities during the current fiscal year and perhaps into the next. That would be administratively reprehensible.

There are currently two primary models nationally for the development of new services. The older well-established model which has been the primary model in Montana for some time provides for the development of placements into which people are placed after establishment. The newer model, used on a limited basis in Montana currently, provides that service development proceeds oriented to the needs of a person selected to be most in need of services.

The State has chosen to proceed with the individually based method of service development because it is in accordance with current philosophy in community services, it is in place in the Montana services system for medicaid eligible persons who have been placed out of nursing facilities due to federal direction for community placement, and further implementation of the method should inform the Department more about the challenges and outcomes of such a method. Proceeding under the current method that creates new placements and then attempts to identify persons to occupy those new placements was considered but was rejected in that the opportunity to learn more about the implementation of the individually based method would be foregone and in that the persons to receive services would appear to be better served if the new services that are developed are tailored to their individual needs.

COMMENT #2: MAIDS and AWARE, Inc. submitted a comment that there has not been opportunity provided for discussion by the public of the proposed change.

RESPONSE: The rule making process provides the public with opportunities both through written and oral testimony for the record to state their opinions as to the course being selected by the State and to provide and advocate for other options not selected by the State. In addition, the developmental disabilities program welcomes informal queries and comments as to this decision.

COMMENT #3: Alternatives and options available to the State have not been discussed or explored and the consequences of the proposed changes have not been discussed.

RESPONSE: The Department appreciates the concern that this proposed method appears to not have been fully analyzed relative to other methods of development of new services. As previously noted this is not a new method, it is already in place for those persons who have been removed from nursing facilities at the direction of federal law. The method is highly touted in

studies and literature as the most appropriate for the dignity of the person and the most effective for the delivery of services. It is one focus of remedies being sought in litigation throughout the nation relative to developmental disabilities services. The Department has for some time been hearing from many consumers and their family members that the State needs to explore and consider adoption of this method for development of services for individuals.

The Department does appreciate that the change to this method is troublesome to providers of services who are accustomed to the predominant method of service development based on static placements that has been in place since community services were initiated some 20 years ago.

The proposed rule change does insure that the residential opportunities that come into being under the expanded use of the individually based service development will become static at such time as the person should leave that service setting. This limitation will minimize the impacts of the broader use of the new method.

Further use of the individually based method of development of new services will provide the State with information and experiences that will allow the State to better judge efficacy of the method and, if it proves to be desirable, will guide the State in broader implementation in the future.

The Department has been involved with the Strategic Planning About Montana (SPAM) task force for almost a year. This task force is comprised of providers of services, developmental disabilities program staff, developmental disabilities planning and advisory council members, parents of persons with developmental disabilities, and persons with developmental disabilities. The focus of this task force is to provide guidance in the future configuration of services for persons with developmental disabilities. The broader use of the individually based service development will inform this task force as to efficacy of this method of service development.

COMMENT #4: MAIDS and AWARE, Inc. commented that inadequate discussion and planning as to the use of the individually based method of service development could lead to a fragmentation of the existing services and a reduction of the quality and availability of services to the people most in need of the services.

RESPONSE: The Department agrees that there is possible risk of fragmentation in services and for that reason has chosen to provide that the services developed upon an individualized basis will become static at such time as the persons for whom they were developed leave those services. This approach greatly

reduces the risk by limiting the scope of the method while still providing the consumers entering into these new services with a good fit in services initially.

Based on information available to the Department, it is anticipated that there may be some improvement in the quality and availability of services to the people most in need of the services.

COMMENT #5: MAIDS and AWARE, Inc. commented that the initial implementation of the proposed changes is scheduled for December 12, 1997, which will precede the timelines of the rule making process and requested that the Department allow for the timelines of the rule making process to be followed so that adequate discussion and planning may occur.

RESPONSE: The date referred to appeared as one of many timelines in a document being used in the implementation of the development of the new services. The date concerned the collection of certain information and did not in any way reflect actual physical implementation of the method. The actual implementation of the method will not proceed until such time as the rule change is in effect.

COMMENT #6: MAIDS and AWARE, Inc. commented that the rule making process should not be allowed to be the primary process for input into the planning for change by the State.

RESPONSE: The Department is bound to the rule making process as the legally required means for receiving and considering public testimony in matters of rule adoption. The Department does agree that in reality the principal means by which the public provides input to the Department is through formal and informal processes other than the rule making process. Public participation occurs through the legislative process, formal advisory groups, individual expression, and other means. The SPAM process for providing guidance towards future developments of the developmental disabilities system currently is serving as an important vehicle for public input from consumers and providers.

Dawn Sliva
Rule Reviewer

Russell E. Cater, acting for
Director, Public Health and Human Services

Certified to the Secretary of State January 5, 1998.

BEFORE THE DEPARTMENT
OF PUBLIC SERVICE REGULATION
OF THE STATE OF MONTANA

In the Matter of the Amendment of Rules Pertaining to Pipeline Safety, including Drug and Alcohol Testing, and a Rule Pertaining to the National Electric Safety Code	))))))	NOTICE OF AMENDMENT

TO: All Interested Persons

1. On November 3, 1997, the Department of Public Service Regulation published notice of public hearing on the proposed amendment of rules pertaining to pipeline safety and the National Electric Safety Code, at pages 1972 through 1974, issue number 21 of the 1997 Montana Administrative Register.

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

38.5.1010 INCORPORATION BY REFERENCE OF NATIONAL ELECTRICAL SAFETY CODE

38.5.2202 INCORPORATION BY REFERENCE OF FEDERAL PIPELINE SAFETY REGULATIONS

38.5.2302 INCORPORATION BY REFERENCE OF FEDERAL PIPELINE SAFETY REGULATIONS -- DRUG AND ALCOHOL TESTING AND PREVENTION PROGRAMS

38.5.2304 DRUG AND ALCOHOL TESTING -- EXCEPTIONS

3. No comments were received on the proposed amendments.

Dave Fisher
DAVE FISHER, Chair

CERTIFIED TO THE SECRETARY OF STATE DECEMBER 12, 1997.

Robin A. McHugh
Reviewed By Robin A. McHugh

BEFORE THE DEPARTMENT
OF PUBLIC SERVICE REGULATION
OF THE STATE OF MONTANA

In the Matter of Adoption of Rules Pertaining to the Montana Interim Universal Access Program.	)))))	CORRECTED NOTICE OF ADOPTION OF RULES ON MONTANA INTERIM UNIVERSAL ACCESS PROGRAM

TO: All Interested Persons

1. On October 20, 1997 the Department of Public Service Regulation published a notice, at page 1921, of the Montana Administrative Register, Issue No. 20, of the adoption of the above-captioned rules.

2. The notice of adoption showed incorrect rule numbering (38.5.2001 through 38.5.2009). The text of the rules remains as adopted. The corrected rules will be numbered as follows:

RULE I. 38.5.3001 DEFINITIONS

RULE II. 38.5.3002 DESIGNATION AS A PUBLIC ACCESS POINT

RULE III. 38.5.3003 PRIORITY FOR FUNDING FROM THE MONTANA INTERIM UNIVERSAL ACCESS PROGRAM

RULE IV. 38.5.3004 DETERMINATION OF DISCOUNT AMOUNT

RULE V. 38.5.3005 APPLICATION FOR DISCOUNTED SERVICES

RULE VI. 38.5.3006 APPLICATION DEADLINES AND DISBURSEMENT OF FUNDS

RULE VII. 38.5.3007 REDUCTION OF DISCOUNTS

RULE VIII. 38.5.3008 AUDITING

RULE IX. 38.5.3009 MONTANA INTERIM UNIVERSAL ACCESS PROGRAM SURCHARGE RATE

3. Replacement pages for the corrected notice of adoption were submitted to the Secretary of State on December 31, 1997.

Dave Fisher
DAVE FISHER, Chair

CERTIFIED TO THE SECRETARY OF STATE DECEMBER 17, 1997.

Robin A. McHugh
Reviewed By Robin A. McHugh

BEFORE THE DEPARTMENT OF REVENUE
OF THE STATE OF MONTANA

IN THE MATTER OF THE AMENDMENT) NOTICE OF AMENDMENT
of ARM 42.14.102, 42.14.103,)
and 42.14.105 relating to)
Accommodation Tax rules)

TO: All Interested Persons:

1. On November 3, 1997 the Department published notice of the proposed amendment of ARM 42.14.102, 42.14.103, and 42.14.105 relating to accommodation tax rules at page 1983 of the 1997 Montana Administrative Register, issue no. 21.

2. No comments were received regarding the rules.

3. The Department has amended the rules as proposed.

CLEO ANDERSON
Rule Reviewer

MARY BRYSON
Director of Revenue

Certified to Secretary of State December 17, 1997

BEFORE THE DEPARTMENT OF REVENUE
OF THE STATE OF MONTANA

IN THE MATTER OF THE AMENDMENT) NOTICE OF AMENDMENT
of ARM 42.15.506 and 42.15.507)
relating to Elderly Homeowner)
Renter Credit)

TO: All Interested Persons:

1. On November 3, 1997 the Department published notice of the proposed amendment of ARM 42.15.506 and 42.15.507 relating to elderly homeowner renter credit at page 1975 of the 1997 Montana Administrative Register, issue no. 21.

2. No comments were received regarding these rules.

3. The Department has amended the rules as proposed.

CLEO ANDERSON
Rule Reviewer

MARY BRYSON
Director of Revenue

Certified to Secretary of State December 17, 1997

BEFORE THE DEPARTMENT OF REVENUE
OF THE STATE OF MONTANA

IN THE MATTER OF THE ADOPTION of NEW RULES I (ARM 42.15.520), II (42.15.521), and III (ARM 42.15.522) relating to Income Tax Credit for the Preservation of Historic Buildings	NOTICE OF ADOPTION

TO: All Interested Persons:

1. On November 3, 1997 the Department published notice of the proposed adoption of new rules I (ARM 42.15.520), II (42.15.521), and III (ARM 42.15.522) relating to income tax credit for the preservation of historic buildings at page 1980 of the 1997 Montana Administrative Register, issue no. 21.

2. No comments were received regarding these rules.

3. The Department has adopted the rules as proposed.

CLEO ANDERSON
Rule Reviewer

MARY BRYSON
Director of Revenue

Certified to Secretary of State December 17, 1997

BEFORE THE DEPARTMENT OF REVENUE
OF THE STATE OF MONTANA

IN THE MATTER OF THE AMENDMENT of ARM 42.31.401 relating to Emergency Telephone Service rules	NOTICE OF AMENDMENT of ARM 42.31.401

TO: All Interested Persons:

1. On November 3, 1997 the Department published notice of the proposed amendment of ARM 42.31.401 relating to emergency telephone service rules at page 1978 of the 1997 Montana Administrative Register, issue no. 21.

2. No comments were received regarding this rule.

3. The Department has amended the rule as proposed.

Cleo Anderson
CLEO ANDERSON
Rule Reviewer

Mary Bryson
MARY BRYSON
Director of Revenue

Certified to Secretary of State December 17, 1997

BEFORE THE COMMISSIONER OF POLITICAL PRACTICES
OF THE STATE OF MONTANA

In the matter of the amendment of Rule 44.10.331 pertaining to limitations on receipts from political committees to legislative candidates	)))))	NOTICE OF AMENDMENT OF ARM 44.10.331

TO: All Interested Persons.

1. On November 3, 1997, the Commissioner of Political Practices published notice of the proposed amendment of Rule 44.10.331 that pertains to limitations on receipts from political committees to legislative candidates at page 1986 of the 1997 Montana Administrative Register, Issue Number 21.

2. The Commissioner has amended Rule 44.10.331 as proposed.

3. No comments or testimony were received.

4. Authority for amending rules is section 13-37-114, MCA. The amendment to Rule 44.10.331 implements section 13-37-218, MCA.

Ed Argenbright, Ed.D.
Commissioner

Jim Scheier
Rule Reviewer

Certified to the Secretary of State January 5, 1998.

VOLUME NO. 47 OPINION NO. 10

LAND USE - Application of Subdivision and Platting Act to parcels created by United States Government Survey;
PUBLIC LANDS - Survey by United States Government and application of Subdivision and Platting Act;
SUBDIVISION AND PLATTING ACT - Parcels created by United States Government Survey;
SURVEYORS - Application of Subdivision and Platting Act to parcels created by United States Government Survey;
MONTANA CODE ANNOTATED - Sections 76-3-102, 76-3-103(3), (15), 76-3-206, 76-3-609(1);
OPINIONS OF THE ATTORNEY GENERAL - 42 Op. Att'y Gen. 36 (1987), 42 Op. Att'y Gen. 16 (1987), 41 Op. Att'y Gen. 40 (1986), 40 Op. Att'y Gen. 57 (1984), 38 Op. Att'y Gen. 106 (1980), 38 Op. Att'y Gen. 66 (1980), 35 Op. Att'y Gen. 55 (1973);
UNITED STATES CODE - Title 43, section 753.

HELD: Parcels of land are not exempt from the requirements of the Subdivision and Platting Act solely by virtue of the fact that they are described by reference to boundaries established by a United States Government Survey.

December 30, 1997

Mr. Bob Slomski
Sanders County Attorney
P.O. Box 519
Thompson Falls, MT 59873

Dear Mr. Slomski:

You have requested my opinion on a question which I have framed as follows:

> Are parcels of land exempt from the requirements of the Subdivision and Platting Act solely by virtue of the fact that they are described by reference to boundaries established by a United States Government Survey?

Resolution of this question requires an understanding of United States Government Survey Maps and their relevance to state statutes regulating divisions of land.

United States Government Survey Maps (U.S. Survey Maps) evolved during the establishment of the United States in the late eighteenth century and its westward expansion during the nineteenth century. The first public land surveys were made under an ordinance passed by the Continental Congress in 1775. The Land Ordinance of 1785 adopted the rectangular grid system of surveying which provided a means of dividing the public domain into an orderly arrangement of square mile sections and placing monuments upon the ground to locate and fix land divisions for all time. See Pointner v. Johnson, 695 P.2d 399, 401 (Idaho 1985). Eight subsequent clarifying acts were passed by Congress, and a Manual of Surveying Instructions for the Surveying of the Public Lands of the United States and the Federal Government was published and updated on a regular basis.

The federal law and surveying manual provided a common method of property description which facilitated settlement of the West and disposition of the public domain. George Cameron Coggins and Charles F. Wilkinson, Federal Public Land and Resource Law 43 (1981). Public lands were surveyed by the General Land Office which prepared a U.S. Survey Map. The U.S. Survey Map was recorded at the office of the United States Surveyor General. The surveyed lands could then be disposed through a federal patent that simply identified the particular section, quarter section or government lot to be conveyed with reference to the U.S. Survey Map. See Chapman v. Polack, 11 P. 764 (Cal. 1886).

The federal survey system resulted in the establishment of townships composed of 36 sections each. A standard section comprises a square mile of land, or 640 acres, and consists of aliquot parts of sections (half section, quarter section, quarter-quarter section) originally established by the U.S. Survey Map.

In addition to these regular fractions of government sections, thousands of "government lots" exist in Montana. "Government lots" are rectangular or irregularly shaped parcels which were surveyed or projected in the course of laying out the rectangular grid system which is the framework of the government survey system. Due to the curvature of the earth, a township of land commonly includes some sections which comprise slightly more or less than the traditional 640 acres. According to the survey system, these irregular sections are found along the west and north borders of the township.

Rather than comprising 640 acres divided into four quarter sections of equal size, these irregular sections might, for example, comprise only 630 acres, more or less, divided into two full quarter sections of 160 acres each, two half quarter sections of 80 acres each, and four smaller rectangular "government lots" of somewhat less than 40 acres each. Other "government lots" are irregular in size and shape and resulted from the presence of irregularly shaped bodies of water or other features that prevented the surveying of an entire section into regularly sized and shaped aliquot parts. Your question essentially asks whether a property owner may convey these component aliquot parts of sections and government lots, described and identified in a deed on file with the county clerk and recorder and less than 160 acres in size (see Mont. Code Ann. § 76-3-103(15) (1997)), without complying with the requirements of the Subdivision and Platting Act.

The Subdivision and Platting Act's review requirements only apply to the conveyance of parcels that were created after the effective date of the Act, July 1, 1973. 35 Op. Att'y Gen. 55 (1973); see Mont. Code Ann. § 76-3-206. The argument has been advanced that the work of the Government Land Office in the late nineteenth century preparing the U.S. Survey Maps "subdivided" the public domain land, that government lots and aliquot parcels were created and described in deeds that predated the Subdivision and Platting Act and, thus, that the Act cannot be applied to their subsequent conveyance. It is suggested that any interpretation of the Subdivision and Platting Act that would require review of these federal "subdivisions" would void the federal law under which the U.S. Survey Maps were prepared.

From the perspective of surveying, as well as in common parlance, it may be said that the U.S. Survey Maps "subdivided" the public domain. Federal statutes dealing with the creation and application of the federal survey system refer to aliquot parts of sections as having been "subdivided." See, e.g., 43 U.S.C. § 753 ("fractional sections containing one hundred and sixty acres or upwards shall in like manner as nearly as practicable be subdivided"). However, the proper focus of my analysis is not whether in some sense the federal survey system accomplished what in another context might be called a "subdivision," but rather whether the process of surveying these lands accomplished a "division of land" for purposes of the Montana Subdivision and Platting Act.

I note initially that the objectives of the federal survey laws and those of the Montana Subdivision and Platting Act are distinct. Federal survey laws were adopted to facilitate the conveyance of lands in the public domain into private ownership. See generally 4 Robert M. Anderson, American Law of Zoning § 25.01, at 263-64 (3d ed. 1986). The purpose of the Subdivision and Platting Act, in contrast, is generally to regulate divisions of land and conveyances of property among private landowners. It does not generally regulate conveyance of federal lands, see 42 Op. Att'y Gen. 36 at 149 (1987), and therefore does not conflict directly with the purpose of the federal land survey system.

Moreover, compliance with the federal survey laws does not accomplish all the purposes of the Subdivision and Platting Act. Mont. Code Ann. § 76-3-102 sets forth the purposes of the Act as follows:

> It is the purpose of this chapter to:
>
> (1) promote the public health, safety, and general welfare by regulating the subdivision of land;
>
> (2) prevent overcrowding of land;
>
> (3) lessen congestion in the streets and highways;
>
> (4) provide for adequate light, air, water supply, sewage disposal, parks and recreation areas, ingress and egress, and other public requirements;
>
> (5) require development in harmony with the natural environment;
>
> (6) protect the rights of property owners; and
>
> (7) require uniform monumentation of land subdivisions and transferring interests in real property by reference to a plat or certificate of survey.

See 38 Op. Att'y Gen. 106 at 369-70 (1980). While some of these purposes, particularly in the monumentation and transfer clause found in subsection (7), are consistent with those supporting the federal survey laws, the overarching objectives of the state statutes--to provide safeguards against social and environmental effects of unregulated land development, see 42 Op. Att'y Gen. 16 at 60 (1987)--are not advanced by compliance with the federal

law. The Subdivision and Platting Act achieves these goals through ensuring the proper arrangement of streets, installation of utilities, access for fire and emergency equipment, and other worthy objectives which are not advanced by the federal land survey laws.

Regulated subdivision activity occurs under Montana's Act when there has been a "division of land." This keystone phrase is defined as follows:

> "Division of land" means the segregation of one or more parcels of land from a larger tract held in single or undivided ownership by transferring or contracting to transfer title to or possession of a portion of the tract or properly filing a certificate of survey or subdivision plat establishing the identity of the segregated parcels pursuant to this chapter. The conveyance of a tract of record or an entire parcel of land that was created by a previous division of land is not a division of land.

Mont. Code Ann. § 76-3-103(3) (1997). The last sentence of this definition was added by an amendment in 1997 and will be discussed below.

Under the Act, a "division of land" consists of "segregation of one or more parcels from a larger tract held in single or undivided ownership," and occurs in one of two ways: (1) by conveying or contracting to convey ownership or possession of a portion of the tract, or (2) by the proper filing of a plat or certificate of survey "establishing the identity of the segregated parcels pursuant to [the Act]." Mont. Code Ann. § 76-3-103(3). The establishing of boundaries for a tract of land through the federal survey system does neither. That is, the acts of surveying a section of land, monumenting the results of the survey on the ground, and depicting the results of the survey on a federal survey map do not convey or contract to convey ownership or possession of the tract. Neither do they constitute "properly filing a certificate of survey or subdivision plat . . . pursuant to" the Subdivision and Platting Act. Cf. John Taft Corp. v. Advisory Agency, 207 Cal. Rptr. 840 (Cal. Ct. App. 1984) (surveying of parcels under federal survey laws did not create a "subdivision" under California subdivision laws).

In 38 Op. Att'y Gen. 66 (1980), Attorney General Greely concluded that the "division of land" definition includes the segregation of an aliquot part of a government section from a larger tract, even though the parcel to be segregated is separately described in an underlying deed. "The crucial factor is single or undivided ownership of a larger tract, not the description in the deed by which the owner obtained the tract." 39 Op. Att'y Gen. 66 at 231. Under this opinion the "division of land" definition applies to any segregation of a parcel of fewer than 160 acres "from a larger tract" unless otherwise exempted from the Act's provisions. It has been suggested that legislative amendments adopted since 1980 have undermined the authority of this opinion, and I now turn to that question.

Prior to 1993, the term "tract of record" appeared only in one section of the Act dealing with minor subdivisions. See Mont. Code Ann. § 76-3-609(1) (1991). In 1993, for reasons that do not clearly appear from either the statute or its legislative

history, the legislature adopted a statutory definition of the term "tract of record," defining it as follows: "'Tract of record' means a parcel of land, irrespective of ownership, that can be identified by legal description, independent of any other parcel of land, using documents on file in the records of the county clerk and recorder." 1993 Mont. Laws, ch. 272, § 2. In 1997, the legislature further amended this definition, inserting the word "individual" to modify "parcel of land" where the term first appears in the definition and adding two new subsections dealing with the process for taking affirmative action to aggregate individual parcels into a single tract of record. 1997 Mont. Laws, ch. 503, § 1. The same bill also added the following language to the definition of "division of land" in Mont. Code Ann. § 76-3-103(3), quoted above: "The conveyance of a tract of record or an entire parcel of land that was created by a previous division of land is not a division of land." Id., codified at § 76-3-103(16). This sentence clarified the effect of the statute by stating that an individual parcel remaining after a prior "division of land" could be conveyed without accomplishing a second "division of land."

It is argued that the effect of the addition of a definition of "tract of record" and the provision that conveyance of a "tract of record" is not a "division of land" effectively overrules 38 Op. Att'y Gen. 66 (1980), at least with respect to property which is described in a deed on file with the county clerk and recorder by reference to aliquot parts of a government section or government lots depicted on survey maps. This assertion is advanced in reliance on the observation that reference to such aliquot parts or lots in a deed would allow identification of each aliquot part "by legal description, independent of any other parcel of land."

However, this argument overlooks the fact that in order to qualify as a "tract of record" the parcel must first be an "individual parcel of land." If, for example, a deed conveys adjoining quarter-sections found in different sections, it has been assumed for purposes of the Act that a single "parcel" is conveyed, albeit described by reference to two aliquot parts of different government sections. That is the effect of 38 Op. Att'y Gen. 66 (1980). Neither aliquot part constitutes an "individual parcel" although either could be separately identified by reference to the deed. Rather, the earlier conveyance transferred a single parcel described by reference to two aliquot parts of two government survey sections. Nothing in the 1997 amendments to the Act undermines this assumption, and there is no indication in the legislative history of the amendments that it was the intention of the legislature to do so.

To the contrary, during the same legislative session that adopted the 1997 amendments a separate bill was proposed, House Bill 450, that would have had the effect of exempting conveyance of these parcels from subdivision review. As proposed, the bill would have specifically included in the definition of "tract of record" the following:

> [A] parcel of land, irrespective of ownership, that can be identified by legal description, independent of any other parcel of land, using documents on file in the records of the county clerk and recorder's office or federal repository and includes a quarter quarter

section or government lot created by an approved survey conducted under federal law.

(Emphasis added.) The underscored language would have specified that an aliquot portion (or at least one that could be described as a "quarter quarter section") or government lot was a "tract of record." House Bill 450 was tabled in committee, suggesting that its objective was not within the legislature's intent. See Montana Contractors' Ass'n, Inc. v. Department of Highways, 220 Mont. 392, 396, 715 P.2d 1056, 1059 (1986) (legislative rejection of proposed bill supports inference that object of rejected legislation was not within legislative intent).

In my opinion, a government lot or an aliquot part of a government survey section is not a "tract of record" simply by virtue of the fact that its description appears in a deed on file with the clerk and recorder, unless it satisfies the requirement that it be an "individual parcel of land," either through its having been segregated and conveyed individually prior to the effective date of the Act or through segregation or conveyance in compliance with the Act. A government lot or an aliquot part that is aggregated with other contiguous lots or aliquot parts in an earlier conveyance is not an "individual parcel" and cannot later be segregated from the other lots or aliquot parts without compliance with the Act unless otherwise exempted from review.

I note that neither Montana statute nor case law has specifically recognized parcels created by U.S. Survey Maps as existing "divisions of land" for purposes of the Subdivision and Platting Act. The Act in particular is silent on this point. In the absence of statutory language addressing government surveys, it is difficult to construe such an exemption by implication, and I do not do so here.

The U.S. Survey Map is a method of property description and survey. Government lots and survey sections were created by federal map to facilitate their disposition, not to ensure orderly growth of future communities. As I have indicated, the goals of federal surveying statutes and state subdivision law are distinct; compliance with the federal law does not supplant the need for state review. Similarly, recognition of state subdivision review authority does not conflict with federal law. Boundaries and monuments established by the U.S. Survey Map are given their full legal effect regardless of subsequent state review of property division and conveyance.

Finally, I note that the Subdivision and Platting Act is legislation enacted for the promotion of public health, safety and general welfare. Mont. Code Ann. § 76-3-102(1). As such, it is entitled to liberal construction with a view toward the accomplishment of its highly beneficent objectives. Exemptions should be given a narrow interpretation. State ex rel. Dreher v. Fuller, 257 Mont. 445, 448-49, 849 P.2d 1045, 1047 (1993); State ex rel. Florence-Carlton Sch. Dist. v. Board of County Comm'rs, 180 Mont. 285, 291, 590 P.2d 602, 606 (1978); see 41 Op. Att'y Gen. 40 at 157-58 (1986); 40 Op. Att'y Gen. 57 at 233-34 (1984). This rule of law is more than a mere form of words. It has specific legal effect in construing doubtful language in the Act, and counsels against resolving ambiguities in the Act in favor of creating a broad new exemption to its coverage. A holding that parcels of land identified in filed deeds by reference to aliquot portions of government survey sections or

government lots could on that basis alone be conveyed without compliance with the Act would have the effect of exempting conveyance of hundreds, if not thousands, of parcels of land in Montana from subdivision review under the Act. As the above discussion shows, there is no clear indication in the Act that the legislature intended such a dramatic change in the law in framing the language that now exists in the statutes.

THEREFORE, IT IS MY OPINION:

Parcels of land are not exempt from the requirements of the Subdivision and Platting Act solely by virtue of the fact that they are described by reference to boundaries established by a United States Government Survey.

Sincerely,

JOSEPH P. MAZURAK
Attorney General

jpm/cdt/dm

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

In the Matter of the Petition	)	FINAL ORDER
For Declaratory Judgment by	)	
the City of Deer Lodge.	)	
B-No. 97514-76G	)	

After notice and hearing in the matter of the petition for declaratory judgment by the City of Deer Lodge, the Department of Natural Resources and Conservation made the following disposition of this matter.

BACKGROUND

The City of Deer Lodge filed a "Petition for Declaratory Judgment" with the Department of Natural Resources and Conservation (hereinafter DNRC) on October 30, 1995, seeking a declaratory ruling on the issue of what, if any, administrative approval by the DNRC must the City of Deer Lodge obtain before it proceeds to land apply its sewage effluent for treatment rather than discharging it into the Clark Fork River as it has historically done.

The City of Deer Lodge seeks confirmation that it does not need administrative approval from the DNRC before proceeding to implement its plan of sewage effluent land application. The City contends neither a new water use permit pursuant to Mont. Code Ann. § 85-2-311 (1995) nor a change authorization pursuant to Mont. Code Ann. § 85-2-402 (1995) is required. The following water rights are claimed by the City of Deer Lodge for municipal purposes: 76G-W-010392 (well), 76G-W-010393 (well), 76G-W-010394 (well), 76G-W-010395 (surface - Tin Cup Joe Creek), and 76G-W-010396 (well).

A notice of the petition dated January 9, 1996, was mailed out to water users in the vicinity of the historic discharge, mayors of cities throughout Montana, the Montana Stockgrowers Association, various environmental groups, and others, and was published as well in the Silver State Post, the Missoulian, and the Montana Standard. Interested persons were given the opportunity to intervene in the proceedings by filing a "Notice of Intervention" by February 20, 1996.

"Notices of Intervention" and briefs were timely filed by the City of Missoula, the City and County of Butte-Silver Bow, the City of Helena, the Clark Fork PendOreille Coalition, and the Montana Department of Environmental Quality (hereinafter DEQ). Arco also intervened but later withdrew its intervention.

After briefing was completed by the parties, oral argument was held on April 17, 1996, in Deer Lodge before Hearing Examiner Tim D. Hall, a DNRC attorney, and DNRC Director Arthur R. Clinch. Present to orally argue were attorneys for the City of Deer Lodge, the City of Missoula, the City and County of Butte-Silver Bow, and DEQ. All intervenors supported the City of Deer Lodge's petition.

Authority for the hearing and declaratory ruling can be found at Mont. Code Ann. § 2-4-501 (1995), Mont. Admin. R. 36.2.101, and Mont. Admin. R. 1.3.226 to 229.

DISCUSSION

This case presents an issue of first impression in Montana. The issue is one of importance and relevance because of water quality considerations concerning the streams in this state and the increasing water quality demands being placed on municipalities by federal and state authorities. The City of Deer Lodge wants to quit discharging its sewage effluent into the Clark Fork River to cut down on the pollution in that river and so it can meet its water quality requirements, yet in doing so it also wants to make sure that it is not violating state water law requirements found in the Water Use Act. Mont. Code Ann. §§ 85-2-101 et seq. (1995).

Unlike state water quality law, which is completely codified and further set forth in myriad regulations, see, e.g., Mont. Code Ann. § 75-5-101 et seq. (1995) and Mont. Admin. R. 16, Title 20, chapters 6, 7 and 13, what water law applies in a given situation is much more elusive. Although the Water Use Act now codifies the law applying to water use, that act codified a century of prior case law on water rights from Montana and the rest of the arid West. Being a relatively new codification, it is still subject to much interpretation with reference to the case law from which it was drawn and so it is no wonder that this declaratory ruling has been sought.

Although no downstream water users objected to the City of Deer Lodge's petition, the issue still remains as to what right, if any, do downstream users have to the continued discharge of the City of Deer Lodge's sewage effluent into the Clark Fork River? Typically, an appropriator is entitled to the continuation of the stream conditions found at the time they initiated their appropriation.[1] They can object to new appropriators coming onto the stream[2] or changes by existing users that would adversely affect them.[3] They cannot, however, insist on continued waste or seepage.[4] And in some states, when the water is foreign (imported from another basin), other appropriators cannot insist on its continuance because as that foreign water was never historically in the stream, the importer

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[1] Farmers Highline Canal & Reservoir Co. v. City of Golden, 129 Colo. 575, 272 P.2d 629 (1954); Smith v. Duff, 39 Mont. 382, 102 P. 984 (1909); Spokane Ranch & Water Co. v. Beatty, 37 Mont. 342, 96 P. 728 (1908).

[2] Mont. Code Ann. §§ 85-2-308 and 311 (1995).

[3] Mont. Code Ann. §§ 85-2-308 and 402 (1995).

[4] Newton v. Weiler, 87 Mont. 164, 286 P. 133 (1960); Popham v. Holloron, 84 Mont. 442, 275 P.2d 1099 (1929); Galiger v. McNulty, 80 Mont. 339, 260 P. 401 (1927).

of water is allowed to completely consume it.[5]

In some water law situations, potential impacts to downstream appropriators are scrutinized in great detail while in others with comparable impacts there is little or no scrutiny. For example, the leasing of water to the Department of Fish, Wildlife and Parks for instream flows is heavily regulated with detailed statutes and regulations[6], yet irrigators converting from flood irrigation to sprinkler irrigation can do so without going through any statutory or regulatory requirements.[7]

When courts and commentators have analyzed the impacts to downstream appropriators of the cessation of sewage effluent discharge it has produced contrasting results. Some view sewage effluent as return flow[8], some view it as waste[9], some view it as something different than waste or surplus water,[10] one discusses it using all of those terms interchangeably,[11] and one without ever clearly defining how it legally views it.[12] The right to

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[5] Thayer v. City of Rawlins, 594 P.2d 951 (Wyo. 1979); City & County of Denver v. Fulton Irrigating Ditch Co., 179 Colo. 47, 506 P.2d 144 (1973)(en banc); Brighton Ditch Co. v. Englewood, 124 Colo. 366, 237 P.2d 116 (1951); but cf. Rock Creek Ditch & Flume Co. v. Miller, 93 Mont. 248, 17 P.2d 1074 (1933)(once such foreign water leaves the possession of the importer, it is subject to appropriation by others who can demand its continuation); Galiger v. McNulty, 80 Mont. 339, 260 P.2d 401 (1927).

[6] Mont. Code Ann. § 85-2-436 (1996) (water can be leased by the Department of Fish, Wildlife and Parks (FWP) only after a water leasing study is performed and then only on designated streams if the change criteria of Mont. Code Ann. § 85-2-402 (1995) are satisfied); Mont. Code Ann. § 85-2-437 (1995) (stream reaches for which water leasing may occur are designated by the DNRC only after FWP, with the consent of the FWP Commission, applies for such designation).

[7] A change from flood irrigation to sprinkler irrigation is not covered by the change statute definition found at Mont. Code Ann. § 85-2-102(4) (1995): "'Change in appropriation right" means a change in the place of diversion, the place of use, the purpose of use, or the place of storage."; cf. Power v. Switzer, 21 Mont. 523, 55 P.2d 32 (1938)(a lawful appropriation of water for a specified purpose gives the owner the right to change the use of his appropriation so long as it does not injure subsequent appropriators in their acquired rights).

[8] Comment, Water Law - Cessation of Return Flow as a Means of Complying with Pollution Control Laws, 12 Land & Water L. Rev. 432 (1977).

[9] Arizona Public Service Co. v. Long, 160 Ariz. 429, 773 P.2d 988 (1989)(en banc).

[10] Reynolds v. City of Roswell, 99 N.M. 84, 654 P.2d 537 (1982); Wyoming Hereford Ranch v. Hammond Packing Co., 33 Wyo. 14, 236 P. 764 (1925).

[11] Metro Denver Sewage District No. 1 v. Farmers Reservoir & Irrigation Co., 179 Colo. 36, 499 P.2d 1190, 1191 (1972)(en banc)("return flow of waste and seepage waters").

[12] State by and through Christopulos v. Husky Oil, 575 P.2d 262 (Wyo. 1978).

reuse water is examined as well.[13]

The exact nature of water discharged by municipalities is not entirely clear, perhaps, because the majority of water law cases have been decided in terms of irrigation uses and the reasonable and proper consumptive amounts of water associated with that type of use. Municipal cases are much different, however, because it is not clear what amount of water can be properly consumed by a municipality. In Metro Denver Sewage District No. 1 v. Farmers Reservoir & Irrigation Co., 179 Colo. 36, 499 P.2d 1190 (1972)(en banc) appropriators who had formerly used sewage effluent were held not to have suffered legal harm from a municipality's new sewage plant began making discharges at a new point of return downstream. The Colorado Supreme Court ruled the no-injury rule that applies to changes in points of diversion does not apply to changes in points of discharge:

> Changes in points of return of waste water are not governed by the same rules as changes of points of diversion.
>
> ....
>
> We believe ... that there is no vested right in downstream appropriators to maintenance of the same point of return of irrigation waste water.
>
> At least in the absence of bad faith or of arbitrary or unreasonable conduct, the same rule should be applicable to sewage waste or the effluent therefrom of a municipality or sanitation district.

Id. at 1193.[14] (emphasis added).

A Wyoming case from 71 years ago demonstrates that sewage effluent and the rights to it has long been an issue in the west. Wyoming Hereford Ranch v. Hammond Packing Co., 33 Wyo. 14, 236 P. 764 (1925), dealt with a city's contractual disposition of its sewage effluent, is often cited by other courts in support of the proposition that downstream users have no right to municipal discharge.[15] What the Wyoming Supreme Court discussed in that case is not unlike the City of Deer Lodge's situation in the present case:

> It is well known that the disposition of sewage

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[13] Pulaski Irrigation Ditch Co. v. City of Trinidad, 70 Colo. 565, 203 P. 681 (1922).

[14] Colorado's ruling that a change in the point of diversion can be objected to, but a change in point of discharge cannot, has been criticized. David H. Getches, Water Law in a Nutshell (1984) at 172-73 (an "aberration" that avoided the question of how much of the water diverted by the city had to return to the stream); Comment, Water Law - Cessation of Return Flow as a Means of Complying with Pollution Control Laws, 12 Land & Water L. Rev. 432 (1977)(the author stated the case is authority, in an analogous fact situation, for an exception to the rule protecting junior appropriators from changes in stream conditions -- "it is anomalous to protect junior appropriators from changes in point of diversion, but not changes in point of discharge"). It must be pointed out, however, that unlike the present case, Metro Denver Sewage did not deal with the treatment of sewage effluent.

[15] See, e.g., Arizona Service Co. v. Long, infra, and Reynolds v. City of Roswell, 99 N.M. 84, 654 P.2d 537 (1982).

> is one of the important problems that embarrass municipalities. In order to dispose of it without injury to others, a city may often be confronted with the necessity of choosing between several different plans, and in the selection of the plan to be followed we think it should be permitted to exercise a wide discretion. In determining how it will make proper disposition of that which may be termed a potential nuisance, we think the city should not be hampered by a rule that would always require the sewage to be treated as waste or surplus waters. Sewage is something which the city has on its hands, and which must be disposed of in such a way that it will not cause damage to others. It would often be considered the height of efficiency if it could be disposed of in some other manner than by discharging it into a stream. Even in this state, where the conservation of water for irrigation is so important, we would not care to hold that in disposing of sewage the city could not adopt some means that would completely consume it. It might, we think, be diverted to waste places, or to any chosen place where it would not become a nuisance, without any consideration of the demands of water users who might be benefitted by its disposition in some other manner. In providing such a place, the city might acquire the right to discharge the sewage on the lands of any person willing to suffer such a use of his lands, and we see no reason why this right might not be gained by the city in consideration of the landowner's right to use or dispose of the sewage in any lawful way.

236 P. at 772. (emphasis added).

In Arizona Public Service Co. v. Long, 160 Ariz. 429, 773 P.2d 988 (1989)(en banc), the Arizona Supreme Court upheld the district court's ruling that (1) the multitude of Arizona cities involved in that case could sell their sewage effluent to utilities, and (2) the cities did not have to continue the discharge of effluent to satisfy the needs of downstream users. An obvious factor in the case was that approximately $290,000,000 had already been spent on pipelines and treatment plants in furtherance of the plan. The Arizona Supreme Court ruled:

> We therefore hold that the Cities may discontinue the discharge of sewage effluent without violating the rights of those persons or entities which previously appropriated it.

773 P.2d at 997.

In Reynolds v. City of Roswell, 99 N.M. 84, 654 P.2d 537 (1982), the issue was whether the state engineer, in granting a permit for change of place of use and after determining it would not impair existing rights, could apply conditions which require that sewage effluent resulting from the use of water must be returned to the river because the effluent is "public" water and not private water. The district court held the effluent was

private, or artificial, water pursuant to a New Mexico statute. The New Mexico Supreme Court upheld the district court, ruling that the city had the right to consumptively use all waters legally appropriated it under its water rights. That is something other courts have been unwilling to say outright. The New Mexico court described the nature of a city's municipal water right and sewage effluent as follows:

> The State Engineer contends strongly that if the City is permitted to change the place or purpose of use of the sewage effluent, this increases the "actual usage" by the City beyond its 2,500 water right. We do not believe such a conclusion is warranted. The City has a right to use all of the 2,500 acre feet of water for municipal purposes. The fact that the City had previously used the water right in one part of the City and now desires to use that same right in other parts of the City does not detract from its right to use the entire amount.

654 P.2d at 540. (emphasis added).

Finally, the New Mexico court cited the Metro Denver Sewage case in support stating that no appropriator had the right to rely on the same point of discharge or return of municipal sewage effluent. The court said its decision was supported by "strong policy considerations", quoting the passage out of Wyoming Hereford Ranch concerning a city's responsibility to dispose of sewage. How sewage effluent is defined legally is important because different legal implications follow from each definition.[16] A downstream appropriator has the right to insist on continued return flow, but does not have right to insist on the continuation of waste or seepage water.[17] An appropriator cannot waste water[18] and only beneficial uses of water can be protected.[19] So words matter a great deal in discussing water rights and reaching conclusions concerning the rights, duties and privileges associated with water use. Clearly, sewage effluent and how it fits into water law has given courts much trouble with no clear consensus as to how it should be considered.[20]

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[16] City of Boulder v. Boulder & Left Hand Ditch Co., 192 Colo. 219, 557 P.2d 1182, 1185 (1977): "Return flow is not waste water."

[17] Id.; Newton v. Weiler, 87 Mont. 164, 286 P. 133 (1930).

[18] Dern v. Tanner, 60 F.2d 626 (D. Mont. 1932); See Mont. Code Ann. § 85-2-505 (1995); Mont. Code Ann. § 85-2-113 and 114 (1995); Mont. Code Ann. § 85-2-102(18) (1995); Weibert v. Roth Bros., 200 Colo. 310, 618 P.2d 1367, 1371 (1980).

[19] Huffine v. Miller, 74 Mont. 50, 237 P.2d 1103 (1925); see also McDonald v. State of Montana, 220 Mont. 519, 722 P.2d 598 (1986).

[20] See dissents in Arizona Public Service Co. v. Long, 160 Ariz. 429, 773 P.2d 988 (1989)(en banc); Thayer v. City of Rawlins, 594 P.2d 951 (Wyo. 1979); and State by and Through Christpulos v. Husky Oil, 575 P.2d 262 (Wyo.

Rather than analyzing the City of Deer Lodge's sewage effluent in terms of whether it is return flow or waste in regard to the rights of downstream appropriators, the DNRC finds it is better analyzed in terms of whether the treatment of sewage effluent falls within the City of Deer Lodge's municipal use.[21] Clearly, a municipality's use of water within its city limits varies a great deal, from water for domestic uses (including watering lawns and gardens) to water for businesses, fire protection, and industrial uses. After municipal water has served a variety of uses, a municipality still has the obligation to properly treat and dispose of the byproduct of many of those uses, sewage effluent, to avoid a nuisance[22] and in order to comply with federal and state water pollution laws.[23] The DNRC finds that the treatment of sewage by a municipality is as much a part of its municipal use of water as anything else that is done with it. The Wyoming Supreme Court recognized as long as 71 years ago in Wyoming Hereford Ranch that cities face unique problems and should be permitted to exercise wide discretion in how to make the proper disposition of their sewage effluent, including total consumption, and the DNRC agrees. As part of its municipal water right, the City of Deer Lodge can treat the water, even totally consume it, without objection or interference by downstream demands for that water. The state and other water users have to recognize the unique position municipalities find themselves in wherein after appropriated water has run the gauntlet of municipal uses, there remains sewage effluent which must be dealt with pursuant to stringent federal and state laws. It would be short-sighted to require the dumping of contaminated water into streams by municipalities because of the downstream demands by others, or to force costly treatment when less expensive treatment options are available. Municipalities must be able to have flexibility the dispose of their sewage effluent in whatever variety of ways become available to them.

This is not to say, however, that downstream appropriators are without any opportunity to appropriate sewage effluent because in 1979 the Montana legislature amended the definition of water to include "sewage effluent."[24] Thus, although the City of Deer Lodge after many various uses of water within the

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1978); and Metro Denver Sewage, 179 Colo. 36, 499 P.2d 1190, 1196 (1972).

[21] Compare Thayer v. City of Rawlins, 594 P.2d 951 (Wyo. 1979), where the City of Rawlins argued its proposed aerated lagoon system was not a change in use, expansion of use, or change in place of use because the use would still be for municipal purposes. The court did not address that issue, however, because the case turned on the fact only imported water was involved, thereby allowing the municipality to do whatever it pleased with its sewage effluent.

[22] See, e.g., Wyoming Hereford Ranch, supra.

[23] See, e.g., Mont. Code Ann. § 75-5-605(2) (1995).

[24] § 1, ch. 327, Mont. Laws 1979.

city limits still has the responsibility to treat the sewage effluent and has the ability to do so in a variety of ways as part of its municipal use, the legislature has made clear that other appropriators who want to beneficially use the sewage effluent at issue here can apply to the DNRC to do so, but it will be up to the appropriator to properly convey the water to its place of intended use - the DNRC will not insist that the sewage effluent be returned to the Clark Fork River by the City of Deer Lodge.

A municipality can beneficially use water only within its defined city limits. Since the City of Deer Lodge plans to land apply its sewage effluent on land outside its city limits, the issue remains as to whether a change authorization is needed. When a water user changes the place of use of a water right, a change authorization from the DNRC is required[25]. Therefore, any new beneficial use of a municipal water right outside the city limits requires a change authorization. However, in this case the City of Deer Lodge in treating its sewage effluent is not actually intending to put it to a new beneficial use outside the city limits in the ususal sense -- it simply wants to treat it and get rid of it without creating a nuisance or without violating state and federal water pollution laws. Although some type of crop or plant will most likely be growing on the land where the sewage effluent is applied, and will benefit from the land application of sewage effluent, the City does not intend[26] to irrigate or farm a crop through its land treatment, and has the option of not objecting to someone else's application to appropriate it.

Since the City of Deer Lodge plans to land apply its sewage effluent as part of its treatment of municipal water, and does not intend to irrigate with it, the DNRC does not consider it a new beneficial use in a new place of use for which a change authorization is required.[27] The DNRC is persuaded to this

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[25] Mont. Code Ann. §§ 85-2-102(4) and 402 (1995).

[26] As in other situations in western water law, intent must be examined. Toohey v. Campbell, 24 Mont. 13, 60 P. 396 (1900); 79 Ranch Co. v. Pitsch, 204 Mont. 426, 666 P.2d 215 (1983); Rodda v. Best, 68 Mont. 205, 217 P. 669 (1923); Sweetland v. Olsen, 11 Mont. 27, 27 P. 339 (1891).

[27] This is unlike an irrigation water right situation where a irrigators try to reuse their appropriation on additional lands for the first time. In Montana, a reuse of return flows by an irrigator on new lands would require a new use permit. As Professor Stone sees it, "the recapture and re-use [of return flows] does not smack of mere 'changes in appropriation rights' under the code...," but rather "[a]dditional uses of the water by means of recapture and re-use would seem to be more of the character of new appropriations, for which permits must be obtained...." A. Stone, Selected Aspects of Montana Water Law (1978), p. 21.

Professor Stone's states that "[l]anguage in some of our own cases would prohibit any such re-use which is not part of the original appropriation, as is the case in Oregon," where the reuse of return flows must have been part of the appropriator's original appropriation, and the appropriator must have commenced to recapture the return flows within a reasonable time. Id. at 20-21; Jones v. Warmsprings Irrigation District, 91 P.2d 542 (Ore. 1939). See also City of Los Angeles v. City of San Fernando,

exception to the usual requirement since the City of Deer Lodge as a municipality is not attempting to expand its beneficial use outside its established boundaries and because the City as a municipality has the unique problem of treating its sewage effluent in response to federal and state law. The DNRC wants to make clear to the City of Deer Lodge and other municipalities, however, that the DNRC is recognizing a narrow exception here for the treatment of sewage effluent only. Any new beneficial use of municipal water or sewage effluent outside of the City's defined limits requires a change authorization or new water use permit.[28] In conclusion, pursuant to its authority under Mont. Code Ann. § 2-4-501 (1995), Mont. Admin. R. 36.2.101, and Mont. Admin. R. 1.3.226 to 229, the DNRC rules that the City of Deer Lodge is not required to obtain either a new water use permit nor a change authorization from the DNRC before land treating its sewage effluent in this case. Downstream appropriators cannot insist upon the continued discharge of the sewage effluent into the Clark Fork River.

NOTICE

This Final Order of the DNRC may be appealed in accordance with the Montana Administrative Procedure Act by filing a petition for judicial review in the appropriate district court within 30 days after service of the Final Order.

DONE AND DATED this 4th day **of June 1996.**

Arthur R. Clinch
Director, Department of Natural Resources and Conservation

537 P.2d 1250 (Cal. 1975).

[28] Compare In the Matter of Application For Beneficial Water Use Permit No. 19084-s41I by the City of Helena (August 25, 1981), where the City of Helena actually applied for a new water use permit to beneficially use its sewage effluent for the irrigation of 473.6 acres of lands for the cultivation of hay and/or grass. There, the effect on the ground may have been the same, but the difference was the City of Helena's intent to beneficially use the water for the irrigation of land for the first time, not merely treat its sewage effluent.

Nor would further treatment and sale of the water be allowed. See, e.g., Pulaski Irrigation Ditch Co. v. City of Trinidad, 70 Colo. 565, 203 P. 681 (1922), where the court held that the reuse of water from a local watershed would in effect be a second appropriation and so would not be allowed (except as a new appropriation). The City of Trinidad had constructed purification plants and had attempted to sell water purified after municipal use for irrigation. Deciding against such reuse, the court reasoned that purified water is not developed water, and that any surplus remaining after the city's use must be returned to the stream.

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 September 30, 1997. This table includes those rules adopted during the period October 1, 1997 through December 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 September 30, 1997, 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.

GENERAL PROVISIONS, Title 1

1.2.419	Filing, Compiling, Printer Pickup and Publication of the Montana Administrative Register, p. 1913, 2301

ADMINISTRATION, Department of, Title 2

I	and other rules - State Procurement, p. 1107, 1816
I-VI	and other rules - Payroll Administration - Decedent's Warrants, p. 1855, 2278
2.13.201	and other rules - 9-1-1 Emergency Telephone Systems, p. 1691, 2178
2.21.122	and other rules - Sick Leave, p. 971, 1440, 2057
2.21.216	and other rules - Annual Vacation Leave, p. 966, 1442
2.21.619	and other rules - Holidays, p. 962, 1444
2.21.1412	and other rules - Employment Preference for Persons with Disabilities, p. 1845, 2277
2.21.3603	and other rules - Veterans' Employment Preference, p. 956, 1445
2.21.3704	and other rules - Recruitment - Selection, p. 1861, 2279
2.21.3802	and other rules - Probation, p. 952, 1446
2.21.5006	and other rule - Reduction in Work Force, p. 946, 1447

(Board of Alternative Health Care)
8.4.405 and other rules - Naturopathic Physician Continuing Education Requirements - Licensing by Examination - Midwives Continuing Education Requirements - Natural Substances Formulary List, p. 2134

(Board of Architects)
8.6.405 and other rules - Licensure of Out-of-State Applicants - Examinations - Individual Seal - Renewals - Unprofessional Conduct - Fees - Architect Partnerships - Screening Committee - Solicitation of Business by Architects from other States - Use of Title, p. 2142

(Chemical Dependency Counselors Certification Program)
I Fees, p. 1008, 1451

(Board of Cosmetologists)
8.14.401 and other rules - Practice of Cosmetology - Electrology - Manicuring - Esthetics, p. 1709, 2181

(Boilers, Blasters and Crane Operators Program)
8.15.103 and other rules - Construction Blasters - Hoisting Operators - Crane Operators - Boiler Engineer Training, p. 2149

(Board of Dentistry)
8.16.405 and other rule - Fees - Dentist Licensure by Credentials, p. 2157

(State Electrical Board)
8.18.402 and other rules - Applications - General Responsibilities - Screening Panel, p. 1625, 2161

(Fire Prevention Program)
8.19.108 and other rules - Practice of Selling, Servicing or Installing Fire Prevention Systems, p. 2163

(Board of Hearing Aid Dispensers)
8.20.401 and other rules - Traineeship Requirements and Standards - Examinations - Definitions - Transactional Document Requirements, p. 1743, 2281

(Board of Medical Examiners)
8.28.414 and other rules - Physician Temporary Certificate - Fee Schedule - Acupuncture - Podiatry - Nutrition Practice Rules, p. 1746, 2197

(Board of Nursing)
8.32.413 and other rules - Conduct of Nurses - Survey and Approval of Schools - Annual Report - Definitions - Registered Nurse's Responsibility to the Nursing Process - Standards for Schools of Nursing - Standards for IV Therapy - Charge Nurse for Licensed Practical Nurses, p. 2638, 626, 1176

(Board of Nursing Home Administrators)
8.34.414A Application for Licensure, p. 1423

(Board of Outfitters)
I Watercraft Identification, p. 2224
8.39.505 and other rules - Outfitter Applications and Renewals - Guide or Professional Guide Licenses and Qualifications - Safety Provisions - Unprofessional Conduct, p. 1330
8.39.512 and other rule - Licensure - Inactive - Fees for Outfitter, Operations Plan and Guide or Professional Guide, p. 530, 667, 1178

(Board of Pharmacy)
8.40.404 and other rules, Fees - Internship Regulations - Pharmacy Technicians, p. 1628, 2060

(Board of Physical Therapy Examiners)
8.42.402 and other rules - Fees - Temporary Licenses - Continuing Education, p. 2169
8.42.402 and other rules - Examinations - Fees - Temporary Licenses, p. 852, 1359

(Board of Plumbers)
8.44.402 and other rule - Definitions - Fee Schedule, p. 2226
8.44.402 and other rule - Definitions - Fees, p. 1751

(Board of Professional Engineers and Land Surveyors)
8.48.507 Classification of Experience, p. 1504

(Board of Public Accountants)
8.54.408 and other rules - Education Requirements - Fees - Enforcement Against Licenses, p. 2172

(Board of Radiologic Technologists)
8.56.602C and other rules - Permit Examinations - Permit Fees - Inspections - Continuing Education - Continuing Education--Waiver, p. 977, 1576

(Board of Real Estate Appraisers)
8.57.411 Continuing Education, p. 532, 1360

(Board of Realty Regulation)
8.58.410 Foreign Land Sales Practices Act, p. 1010
8.58.411 and other rules - Fees - Continuing Education - Renewal of License, p. 1333, 1819
8.58.419 Grounds for License Discipline - General Provisions - Unprofessional Conduct, p. 467, 1026

(Board of Sanitarians)
8.60.413 Fee Schedule, p. 1243, 1578

(Board of Social Work Examiners and Professional Counselors)
8.61.403 and other rules - Practice of Social Work and Licensed Professional Counseling, p. 239, 986

(Hard-Rock Mining Impact Board)
8.104.203A Administration of the Hard-Rock Mining Impact Act - Definitions, p. 981, 1337, 2070

(Travel Promotion and Development Division)
I Tourism Advisory Council, p. 619, 987

(Burial Preservation Board)
I-VI Unmarked Burial Within the State of Montana, p. 2233

EDUCATION, Title 10

(Board of Public Education)
10.55.603 Accreditation - Curriculum Development and Assessment, p. 756, 871, 1185
10.56.101 Student Assessment, p. 754, 870, 1186
10.57.211 Teacher Certification - Test for Certification, p. 757, 872, 1187
10.57.215 Teacher Certification - Renewal Requirements, p. 759, 873, 1188
10.57.301 Teacher Certification - Endorsement Information, p. 1962
10.58.527 Teacher Certification - Areas of Permissive Special Competency, p. 1964
10.65.101 and other rules - Hours and Days of Instruction - Pupil Instruction-Related Days, p. 1966

(State Library Commission)
10.101.101 and other rule - State Library Commission - Library Service Advisory Council, p. 1119, 1991

FISH, WILDLIFE, AND PARKS, Department of, Title 12

(Fish, Wildlife, and Parks Commission)
I Defining Guiding Services for Use of Class B-10 and B-11 Licenses Which are Outfitter-sponsored Nonresident Big Game Combination Licenses, p. 1753
12.6.901 Restriction of Motor-propelled Water Craft on Hauser Reservoir, p. 669, 1029

ENVIRONMENTAL QUALITY, Department of, Title 17

17.36.303 Subdivisions - Authority of the Department to Allow Use of Alternative Water Systems in Subdivisions, p. 375, 1458
17.50.412 and other rules - Solid Waste Management - Conform with EPA Flexibility - Allow Reduced Regulatory Requirements for Certain Wastes, p. 671, 1031

(Board of Environmental Review)
I Water Quality - Temporary Water Standards for Daisy Creek, Stillwater River, Fisher Creek, and the Clark's Fork of the Yellowstone River, p. 1652, 1872, 2211, 1049, 2502, 534, 1636

JUSTICE, Department of, Title 23

I-VII Valuation and Taxation of Light Motor Vehicles - Imposition of Fees in Lieu of Tax on Buses, Heavy Trucks, Truck Tractors and Trailers, p. 1901, 2292
23.16.101 and other rules - Public Gambling, p. 2023

(Board of Crime Control)
23.14.801 Definition of "Uncertifiable Officer", p. 536, 1036

LABOR AND INDUSTRY, Department of, Title 24

I-XI Workers' Compensation Administrative Assessment, p. 380, 686, 1364
24.16.9007 Prevailing Wage Rates - Service Occupations and Certain Bricklayer Rates, p. 621, 1037
24.29.4314 Workers' Compensation Data Base System, p. 1021

LIVESTOCK, Department of, Title 32

(Board of Livestock)
32.3.212 Brucellosis Vaccination(s), p. 1641

(Board of Milk Control)
32.24.504 and other rules - Quota Rules, p. 1339, 1662

NATURAL RESOURCES AND CONSERVATION, Department of, Title 36

I&II Streamside Management Zone, p. 1552, 1992
I-III and other rule - Extensions of Time to Complete a Water Use Permit or Change Authorization - Application and Special Fees, p. 1643, 2084
36.17.601 and other rules - Renewable Resources Grant and Loan Program, p. 983, 1268

(Board of Oil and Gas Conservation)
36.22.1231 and other rules - Notice of Application and Objections - Injection Fee and Well Classification - Disposal by Injection - Application--Contents and Requirements - Board Authorization - Notice of Commencement of Discontinuance--Plugging of Abandoned Wells - Records Required, p. 1245, 1589
36.22.1303 and other rules - Well Plugging Requirement - Plugging and Restoration Bond - Financial Responsibility, p. 1646, 2038

PUBLIC HEALTH AND HUMAN SERVICES, Department of, Title 37

Establishment of a Negotiated Rulemaking Committee on Bed and Breakfast Establishments, p. 1774
Establishment of a Negotiated Rulemaking Committee on Guest Ranches and Outfitting and Guide Facilities, p. 1778
I and other rules - Medicaid Outpatient Drugs, p. 2241

PUBLIC SERVICE REGULATION, Department of, Title 38

REVENUE, Department of, Title 42

SECRETARY OF STATE, Title 44

(Commissioner of Political Practices)

CROSS REFERENCE INDEX

Montana Code Annotated to Administrative Rules of Montana

July 1997 - December 1997

MCA	Rule or A.G.'s Opinion No.	Register Page No.
1-1-301	Opinion No. 9	2200
1-2-101, 102	Opinion No. 7	1394
1-2-201	Opinion No. 9	2200
2-3-103	8.63.203	1960
2-3-201, 202	8.63.302	1960
2-3-203	8.63.203, 301, 302	1960
2-3-212	8.63.302	1960
2-4-103	6.6.8301	1419
2-4-201	8.63.101, 201 - 203, 301, 302	1960
2-4-201	10.101.101	1119
2-4-312	1.2.419	1913
2-17-301, 302	2.5.202	1107
2-18-102	2.21.3001 - 3006	1855
2-18-102	2.21.3704, 3708, 3715, 3718, 3719, 3723, 3726	1861
2-18-102	2.21.3726	2279
2-18-401	Rules III - VI (Administration)	1855
2-18-405	Rules III, IV (Administration)	1855
2-18-412	Rule V (Administration)	1855
2-18-501	42.14.102, 103, 105	1983
2-18-604	2.21.123	2057
2-18-618	2.21.123	2057
2-18-1201	2.21.3704	1861
5-2-102, 103	Opinion No. 9	2200
5-2-401, 402	Opinion No. 9	2200
5-2-406	Opinion No. 9	2200
5-7-102	44.12.102	1994
5-7-111	44.12.102, 202	1994
5-7-208	44.12.202	1994
7-1-114	Opinion No. 4	1288
7-14-2501	Opinion No. 6	1389
7-16-4104	Opinion No. 8	1926
10-4-101	2.13.202	1691
10-4-101 - 303	2.13.201	1691
10-4-102	Rule I (Administration)	1691
10-4-102	2.13.202, 203, 205	1691
10-4-102	2.13.205	2178
10-4-103, 104	2.13.203	1691
10-4-121	2.13.205	1691

MCA	Rule or A.G.'s Opinion	Register Page No.
10-4-121	2.13.205	2178
10-4-201 - 204	42.31.401	1978
10-4-206, 207	42.31.401	1978
10-4-211, 212	42.31.401	1978
10-4-301, 302	2.13.205	1691
10-4-301, 302	2.13.205	2178
10-4-301 - 303	Rule I (Administration)	1691
13-1-101	44.10.327	1354
13-27-202	Opinion No. 9	2200
13-27-312	Opinion No. 9	2200
13-27-401 - 410	Opinion No. 9	2200
13-37-114	44.10.327, 411	1354
13-37-114	44.10.331	1986
13-37-114	44.10.411	1828
13-37-218	44.10.331	1986
13-37-226	44.10.327, 411	1354
13-37-226	44.10.411	1828
15-1-201	Rules I, II (Revenue)	1591
15-1-201	Rules I - XIII (Revenue)	1153
15-1-201	Rules I - XIII (Revenue)	1165
15-1-201	42.2.601	1814
15-1-201	42.18.106, 107, 109, 110, 112, 113, 115, 116, 118, 119, 122, 124, 126	1153
15-1-201	42.18.106, 107, 109, 110, 112, 113, 115, 116, 118, 119, 122, 124, 126	1165
15-1-201	42.19.1203, 1222, 1235, 21.106, 107, 113, 122 - 124, 131, 137 - 140, 151, 153, 155, 156, 301 - 303, 305, 307, 308, 310, 22.1311, 1312	1782
15-1-201	42.20.140, 147 - 149, 157, 159	1438
15-1-201	42.31.401	1978
15-1-211	42.2.601	1814
15-6-134	Rule VI (Revenue)	1153
15-6-134	Rule VI (Revenue)	1165
15-6-134	42.18.124	1153
15-6-134	42.18.124	1165
15-6-135	42.19.1203, 1222, 1235, 21.131, 314	1782
15-6-136	42.21.113, 124	1782
15-6-138	42.21.106, 107, 123, 131, 137 - 140, 151, 153, 155, 22.1311, 1312	1782
15-6-139	42.21.106, 107, 156	1782
15-6-140	42.21.106	1782
15-6-152	42.19.1222	1782
15-6-201	42.21.107	1782

MCA	Rule or A.G.'s Opinion	Register Page No.
15-6-207	42.21.122, 124	1782
15-7-102	Rule V (Revenue)	1153
15-7-102	Rule V (Revenue)	1165
15-7-103	42.18.124	1153
15-7-103	42.18.124	1165
15-7-111	Rules I, II (Revenue)	1591
15-7-111	Rules I - XIII (Revenue)	1153
15-7-111	Rules I - XIII (Revenue)	1165
15-7-111	42.18.106, 107, 109, 110, 112, 113, 115, 116, 118, 119, 122, 124, 126	1153
15-7-111	42.18.106, 107, 109, 110, 112, 113, 115, 116, 118, 119, 122, 124, 126	1165
15-7-133	42.18.106, 107	1153
15-7-133	42.18.106, 107	1165
15-7-201 - 203	42.20.140, 147 - 149, 157, 159	1438
15-7-206 - 210	42.20.140, 147 - 149, 157, 159	1438
15-7-212	42.20.140, 147 - 149, 157, 159	1438
15-8-111	42.22.1311, 1312	1782
15-8-202	42.21.301 - 303, 305, 307, 308, 310	1782
15-10-402	Opinion No. 6	1389
15-23-108	42.21.113, 122	1782
15-24-921, 922	42.21.124	1782
15-24-925	42.21.124	1782
15-24-1401, 1402	42.19.1222, 1235	1782
15-30-111	Rules I - IV (Revenue)	2175
15-30-176	42.15.506	1975
15-30-180	Rules I - III (Revenue)	1980
15-30-305	Rules I - III (Revenue)	1980
15-30-305	Rules I - IV (Revenue)	2175
15-30-305	42.15.506	1975
15-30-305	42.21.314	1782
15-30-305	42.15.601 - 604	2273
15-31-151	Rules I - III (Revenue)	1980
15-32-601 - 604	42.15.507	1975
15-61-201	42.15.601	2273
15-61-203	42.15.603, 604	2273
15-61-204	42.15.602	2273
15-62-201	Rules I - IV (Revenue)	2175
15-65-101	42.14.102, 103	1983
15-65-102	42.14.102, 103, 105	1983
15-65-111	42.14.102, 103, 105	1983
16-1-303	Rules I - VIII (Revenue)	1654
16-1-303	42.12.106, 122	1151
16-1-303	42.12.106, 122	1825
16-4-105	42.12.106	1151
16-4-105	42.12.106	1825
16-4-207	42.12.106	1151
16-4-207	42.12.106	1825

MCA	Rule or A.G.'s Opinion	Register Page No.
16-4-402	42.12.122	1151
16-4-402	42.12.122	1825
16-4-404, 405	42.12.122	1151
16-4-404, 405	42.12.122	1825
16-4-420	Rules I - VII (Revenue)	1654
16-4-420	42.12.106, 122	1151
16-4-420	42.12.106, 122	1825
16-4-423	42.12.106	1151
16-4-423	42.12.106	1825
17-2-108	Opinion No. 7	1394
17-5-402	Opinion No. 7	1394
17-5-414 - 416	Opinion No. 7	1394
17-5-423, 424	Opinion No. 7	1394
17-5-802	Opinion No. 7	1394
17-6-406	8.99.401, 402, 404, 505, 506, 510	1547
17-6-408	8.99.401, 404	1547
17-6-411	8.99.402	1547
17-7-304	Opinion No. 7	1394
18-1-114	2.5.201, 403	1107
18-1-201	2.5.502	1107
18-1-402	2.5.406	1107
18-1-402	2.5.406	1816
18-4-221	Rule I (Administration)	1107
18-4-221	2.5.201, 202, 301, 302, 402 - 404, 406, 502, 503, 505, 601 - 604	1107
18-4-221	2.5.406	1816
18-4-222	2.5.202, 301	1107
18-4-225	2.5.504	1107
18-4-241	2.5.402	1107
18-4-302	2.5.301	1107
18-4-303	2.5.503, 505, 601	1107
18-4-304	2.5.503, 505, 602	1107
18-4-305	2.5.603	1107
18-4-306	2.5.604	1107
18-4-308	2.5.402	1107
18-4-309	Rule I (Administration)	1107
18-4-312	2.5.502	1107
18-5-102, 103	2.5.607	1107
19-2-403	Rule I (Administration - PERB)	1843
19-2-403	2.43.203	1660
19-2-403	2.43.203, 406, 427	1103
19-2-1101	Rule I (Administration - PERB)	1843
Title 19, Ch. 3	2.43.427	1103
Title 19, Ch. 3, Pt. 5	2.43.406	1103
Title 19, Ch. 5	2.43.427	1103
Title 19, Ch. 5, Pt. 3	2.43.406	1103

MCA	Rule or A.G.'s Opinion	Register Page No.
19-5-901	Rule I (Administration - PERB)	1843
Title 19, Ch. 6	2.43.427	1103
Title 19, Ch. 6, Pt. 3	2.43.406	1103
19-6-710	Rule I (Administration - PERB)	1843
Title 19, Ch. 7	2.43.427	1103
Title 19, Ch. 7, Pt. 3	2.43.406	1103
Title 19, Ch. 8, Pt. 3	2.43.406, 427	1103
Title 19, Ch. 9	2.43.427	1103
Title 19, Ch. 9, Pt. 4	2.43.406	1103
19-9-1009	Rule I (Administration - PERB)	1843
Title 19, Ch. 13, Pt. 4	2.43.406, 427	1103
19-13-1010	Rule I (Administration - PERB)	1843
20-1-301	10.65.101	1966
20-1-302	10.65.201, 202	1966
20-1-304	10.65.102, 103	1966
20-2-114	10.58.527	1964
20-2-121	10.57.211	1187
20-2-121	10.57.301	1962
20-2-121	10.58.527	1964
20-2-121	10.65.101 - 103, 201, 202	1966
20-3-201	8.78.401 - 403	2016
20-4-102	10.57.211	1187
20-4-102	10.57.301	1962
22-1-101	10.101.203	1119
22-1-303, 304	Opinion No. 6	1389
22-1-313	Opinion No. 6	1389
22-1-316	Opinion No. 6	1389
22-3-804	Rules I - VIII (Commerce - Burial Preservation)	2233
22-3-805	Rules II - VI (Commerce - Burial Preservation)	2233
22-3-806	Rule VII (Commerce - Burial Preservation)	2233
22-3-807	Rule VIII (Commerce - Burial Preservation)	2233
22-3-808, 809	Rule II (Commerce - Burial Preservation)	2233
23-2-701	8.63.501, 502, 504, 516 - 518, 520	1960
23-2-711, 712	8.63.504, 517, 518	1960
23-2-713	8.63.504, 518	1960
23-2-714, 715	8.63.519	1960
23-2-721	8.63.101, 210, 303, 501 - 506, 508, 516 - 520	1960

MCA	Rule or A.G.'s Opinion	Register Page No.
23-2-722	8.63.504 - 506, 508, 516 - 520	1960
23-2-723	8.63.504, 505, 508, 516	1960
23-5-110	23.16.121, 1717	2023
23-5-112	23.16.101	2023
23-5-115	23.16.101 - 103, 120, 121, 502, 1701, 1712, 1713, 1715 - 1720, 1827, 1828, 1901, 1913 - 1916, 1918, 1925, 2001, 2004	2023
23-5-118	23.16.101, 120, 502	2023
23-5-128	23.16.1914	2023
23-5-129	23.16.1915	2023
23-5-136	23.16.1827, 1901	2023
23-5-152	23.16.2001, 2004	2023
23-5-159	23.16.121	2023
23-5-176	23.16.101, 120, 502, 1717	2023
23-5-177	23.16.102, 502	2023
23-5-501	23.16.1701, 1712, 1713, 1720	2023
23-5-502	23.16.1717 - 1719	2023
23-5-503	23.16.1701, 1712, 1713, 1715, 1720	2023
23-5-602	23.16.1901	2023
23-5-603	23.16.1913	2023
23-5-606	23.16.1901, 1911	2023
23-5-607	23.16.1911	2023
23-5-609	23.16.1901	2023
23-5-610	23.16.1827, 1901	2023
23-5-611	23.16.1828, 2001	2023
23-5-614	23.16.1828, 2001	2023
23-5-616	23.16.1925	2023
23-5-621	23.16.1901, 1911, 2001	2023
23-5-625	23.16.1828, 1916, 2001	2023
23-5-626	23.16.1828	2023
23-5-628	23.16.1827	2023
23-5-629	23.16.101	2023
23-5-631	23.16.1828, 1911, 1918, 2001	2023
30-10-105	Rule I (State Auditor)	1496
30-10-107	Rule I (State Auditor)	1496
30-10-901 - 915	Rules I, II (State Auditor)	1415
30-10-901 - 915	6.12.1202	1917
30-10-904	Rule III (State Auditor)	1415
30-10-905	Rules III - VI (State Auditor)	1415
30-10-905	6.12.1204, 1205	1917
30-10-906	Rule VI (State Auditor)	1415
30-10-909	Rule V (State Auditor)	1415
30-10-913	Rule V (State Auditor)	1415
30-10-913	6.12.1205	1917
32-1-202	Rule VII, VIII (Commerce - Banking and Financial Institutions)	1534
32-8-107	Rules I - VIII (Commerce - Banking and Financial Institutions)	1871

MCA	Rule or A.G.'s Opinion	Register Page No.
32-8-107	Rules I - XI (Commerce - State Banking)	1882
32-8-107	Rules I - IX, XI (Commerce - Banking and Financial Institutions)	1534
32-8-201	Rules I - VII, IX, XI (Commerce - State Banking)	1882
32-8-201	Rules IV - VI, IX (Commerce - Banking and Financial Institutions)	1534
32-8-202	Rules I, III, V, VII, VIII, XI (Commerce - State Banking)	1882
32-8-203	Rule XI (Commerce - State Banking)	1882
32-8-205	Rules I, II, IX - XI (Commerce - State Banking)	1882
32-8-205	Rule III (Commerce - Banking and Financial Institutions)	1871
32-8-205	Rules IX - XI (Commerce - Banking and Financial Institutions)	1534
32-8-301	Rules I, III - VIII (Commerce - Banking and Financial Institutions)	1871
32-8-301	Rules III, X, XIII - XVII (Commerce - Banking and Financial Institutions)	1534
32-8-301	Rules III, XI (Commerce - State Banking)	1882
32-8-302	Rules I, II (Commerce - Banking and Financial Institutions)	1871
32-8-303	Rule III (Commerce - Banking and Financial Institutions)	1871
32-8-303	Rule XII (Commerce - Banking and Financial Institutions)	1534
32-8-308	Rules I, VI, VIII (Commerce - Banking and Financial Institutions)	1871
32-8-308	Rules XV, XVII (Commerce - Banking and Financial Institutions)	1534
32-8-309	Rules V, VII (Commerce - Banking and Financial Institutions)	1871
32-8-309	Rules XIV, XVI (Commerce - Banking and Financial Institutions)	1534
32-8-314	Rule V (Commerce - Banking and Financial Institutions)	1871
32-8-314	Rule XIV (Commerce - Banking and Financial Institutions)	1534
32-8-315	Rule VIII (Commerce - Banking and Financial Institutions)	1871
32-8-315	Rule XVII (Commerce - Banking and Financial Institutions)	1534
32-8-501	Rule V (Commerce - Banking and Financial Institutions)	1871
32-8-501	Rule XIV (Commerce - Banking and Financial Institutions)	1534
32-15-609 - 611	42.15.507	1975

MCA	Rule or A.G.'s Opinion	Register Page No.
33-1-313	6.6.511	1421
33-1-313	6.6.4101	1623
33-1-313	6.6.4002	1502
33-1-313	6.6.5101	1500
33-2-708	6.6.4101	1623
33-2-806	6.6.4002	1502
33-3-307	Rule I (State Auditor)	1706
33-4-403	6.6.4002	1502
33-15-303	6.6.511	1421
33-16-1012	6.6.8301	1419
33-22-901 - 924	6.6.511	1421
33-22-1819	6.6.5101	1500
33-22-1822	6.6.5101	1500
35-4-209	8.6.415	2142
37-1-101	8.39.508	1330
37-1-131	Rule I (Commerce - Dentistry)	2147
37-1-131	8.6.405, 407, 409, 410, 412, 413, 415	2142
37-1-131	8.14.603, 606, 802, 803, 805, 806, 813, 815, 816, 819, 820, 1215	1709
37-1-131	8.18.402, 409	1625
37-1-131	8.34.414A	1423
37-1-131	8.39.505, 508, 514, 515	1330
37-1-131	8.42.405	2169
37-1-131	8.54.702	2172
37-1-131	8.58.411	1819
37-1-131	8.58.411, 415A	1333
37-1-131	Opinion No. 5	1292
37-1-134	8.6.413	2142
37-1-134	8.14.601, 814, 1010	1709
37-1-134	8.16.405	2157
37-1-134	8.28.420, 504, 1806	1746
37-1-134	8.40.404	1628
37-1-134	8.42.403	2169
37-1-134	8.44.412	1751
37-1-134	8.54.410	2172
37-1-134	8.58.411	1333
37-1-134	8.58.411	1819
37-1-134	8.60.413	1243
37-1-136	8.54.702	2172
37-1-136, 137	8.14.402	1709
37-1-141	8.14.813	1709
37-1-304	Rule I (Commerce - Dentistry)	2147
37-1-304	8.14.804, 805	1709
37-1-304	8.16.405	2147
37-1-304	8.20.417	1743
37-1-304	8.60.413	1243
37-1-304, 305	8.44.412	1751
37-1-305	8.6.418	2142
37-1-305	8.20.401	1743

MCA	Rule or A.G.'s Opinion	Register Page No.
37-1-305	8.42.405	2169
37-1-305	8.64.502	1633
37-1-306	8.4.405, 508	2134
37-1-306	8.14.815, 819	1709
37-1-306	8.18.409	1625
37-1-306	8.42.416	2169
37-1-307	8.18.412	1625
37-1-316	8.6.412	2142
37-1-316	8.54.702	2172
37-1-319	8.4.405, 508	2134
37-1-319	8.6.412, 418	2142
37-1-319	8.14.815, 819	1709
37-1-319	8.18.409	1625
37-1-319	8.20.401	1743
37-1-319	8.28.420	1746
37-1-319	8.39.709	1330
37-1-319	8.42.416	2169
37-1-319	8.54.702	2172
37-1-319	8.58.415A	1333
37-1-319	8.64.502	1633
37-3-203	8.28.414, 420, 504, 1804	1746
37-3-301	8.28.414, 420	1746
37-3-304	8.28.414, 420	1746
37-3-307	8.28.414, 420	1746
37-3-308, 309	8.28.420	1746
37-3-311	8.28.420	1746
37-3-313	8.28.420	1746
37-4-205	Rule I (Commerce - Dentistry)	2147
37-4-205	8.16.405	2147
37-4-301	8.16.405	2147
37-4-303	8.16.405	2147
37-4-307	8.16.405	2147
37-6-106	8.28.1702	1746
37-6-304	8.28.1702	1746
37-7-201	8.40.404, 901 - 904, 906, 1303	1628
37-7-302, 303	8.40.404	1628
37-7-307	8.40.1308	1628
37-7-308, 309	8.40.1303, 1308	1628
37-7-321	8.40.404	1628
37-7-703	8.40.404	1628
37-8-102	Petition for Declaratory Ruling (Commerce - Nursing)	1609
37-9-203	8.34.414A	1423
37-9-301	8.34.414A	1423
37-9-304	8.34.414A	1423
37-11-201	8.42.403, 405, 416	2169
37-11-304	8.42.403	2169
37-11-307, 308	8.42.403	2169
37-11-309	8.42.403, 405	2169
37-13-201	8.28.503, 504	1746
37-13-301	8.28.504	1746

MCA	Rule or A.G.'s Opinion	Register Page No.
37-31-304, 305	Rules III, IV (Commerce - Cosmetologists)	1709
37-31-305	8.14.607, 608, 611, 801, 814	1709
37-31-306	8.14.806	1709
37-31-308	8.14.801 - 805	1709
37-31-309	8.14.814	1709
37-31-311	Rules I - V (Commerce - Cosmetologists)	1709
37-31-311	8.14.401, 602 - 608, 611, 803, 807, 814, 1215	1709
37-31-312	Rules I, II, V (Commerce - Cosmetologists)	1709
37-31-312	8.14.602, 603, 605, 606, 608, 611, 814, 816	1709
37-31-321	8.14.802, 814	1709
37-31-322	8.14.814, 815	1709
37-31-323	8.14.606, 814	1709
37-31-331	8.14.401	1709
37-32-201	8.14.401, 814, 1010	1709
37-32-301, 302	8.14.814	1709
37-32-304, 305	8.14.814, 1010	1709
37-32-306	8.14.401, 814	1709
37-34-301, 302	Petition for Declaratory Ruling (Commerce - Nursing)	1609
37-40-203	8.60.413	1243
37-40-302 - 304	8.60.413	1243
37-47-101	8.39.515	1330
37-47-201	Rule I (Commerce - Outfitters)	2224
37-47-201	8.39.505, 508, 514, 515, 704, 709	1330
37-47-301	8.39.514	1330
37-47-302	Rule I (Commerce - Outfitters)	2224
37-47-302	8.39.508	1330
37-47-303	8.39.508, 515	1330
37-47-304	Rule I (Commerce - Outfitters)	2224
37-47-304	8.39.505, 508	1330
37-47-306	8.39.508	1330
37-47-307	8.39.505, 508, 514, 515	1330
37-47-312	8.39.508, 709	1330
37-47-341	8.39.709	1330
37-50-203	8.54.408, 410, 702	2172
37-50-204	8.54.410	2172
37-50-302, 303	8.54.408	2172
37-50-305	8.54.408	2172
37-50-314	8.54.410	2172
37-50-317	8.54.410	2172
37-51-202	8.58.411, 415A	1333
37-51-202 - 204	8.58.411	1819
37-51-203	Rule I (Commerce - Realty Regulation)	1333
37-51-203, 204	8.58.411, 415A	1333
37-51-207	8.58.411	1333
37-51-207	8.58.411	1819

MCA	Rule or A.G.'s Opinion	Register Page No.
37-51-303	8.58.411	1333
37-51-303	8.58.411	1819
37-51-310	Rule I (Commerce - Realty Regulation)	1333
37-51-310, 311	8.58.411	1333
37-51-310, 311	8.58.411	1819
Title 37, Ch. 65	Opinion No. 5	1292
37-65-201	8.6.413	2142
37-65-204	Rule I (Commerce - Architects)	2142
37-65-204	8.6.405, 407, 409, 410, 412, 413, 415, 416, 418	2142
37-65-301	Rule I (Commerce - Architects)	2142
37-65-302	8.6.415	2142
37-65-303	8.6.407	2142
37-65-304	8.6.405, 413	2142
37-65-306	8.6.410, 413	2142
37-65-307	8.6.413, 416	2142
37-65-308	8.6.407	2142
37-67-202	8.48.507	1504
37-67-306	8.48.507	1504
37-67-309	8.48.507	1504
37-68-103	8.18.402	1625
37-68-201	8.18.402, 403, 409, 412	1625
37-68-301	8.18.403	1625
37-68-302	8.18.402, 403	1625
37-68-304, 305	8.18.402	1625
37-68-310	8.18.402, 403	1625
37-69-102	8.44.402	1751
37-69-202	8.44.402, 412	1751
37-69-307	8.44.412	1751
37-69-401	8.44.402, 412	1751
37-72-201	8.15.103	2149
37-72-202	8.15.103, 106	2149
37-72-301	8.15.103	2149
37-72-302	8.15.103, 106	2149
37-72-303 - 306	8.15.103	2149
39-3-205	Rule IV (Administration)	1855
39-30-101	2.21.1412 - 1414, 1422 - 1425, 1427 - 1429	1845
39-30-103	2.21.1417, 1418, 1421	1845
39-30-106	2.21.1417, 1418, 1421, 1432	1845
39-30-108	2.21.1432	1845
39-71-201	24.29.901, 904, 913 - 918	1364
39-71-203	24.29.901, 904, 913 - 918, 941	1364
39-71-434	2.55.402	1697
39-71-902	24.29.941	1364
39-71-1004	24.29.941	1364
39-71-2211	2.55.324, 327	1697
39-71-2311	2.55.321, 322, 324, 325, 327, 402	1697
39-71-2315, 2316	Rule I (Administration - State Fund)	1697
39-71-2315, 2316	2.55.321, 322, 324, 325, 327, 402	1697

MCA	Rule or A.G.'s Opinion	Register Page No.
39-71-2330	Rule I (Administration - State Fund)	1697
39-71-2330	2.55.321, 322, 324, 325, 327	1697
39-71-2341	2.55.325	1697
41-3-503	11.12.413	1145
41-3-1102, 1103	11.12.101	1759
41-3-1103	Rules I - XXI (DPHHS)	1759
41-3-1103	11.7.103, 310, 37.50.101	2250
41-3-1103	11.7.313	1149
41-3-1103	11.12.115, 413, 601	1145
41-3-1122	11.7.313	1149
41-3-1142	Rules I - XXI (DPHHS)	1759
41-3-1142	11.12.101	1759
41-3-1142	11.12.115, 413, 601	1145
45-9-208	20.3.503, 508, 509	2040
45-10-108	20.3.503, 508, 509	2040
49-3-201	2.21.3704, 3708, 3718, 3719, 3723, 3726	1861
49-3-201	2.21.3726	2279
50-3-102	8.19.110, 112	2163
50-5-101	16.32.399D	1910
50-5-103	Rules I - XXI (DPHHS)	1556
50-5-103	16.32.302	1574
50-5-103	16.32.346	1556
50-5-103	16.32.399D	1910
50-5-201	16.32.302	1574
50-5-204	Rules I - XXI (DPHHS)	1556
50-5-204	16.32.302	1574
50-5-204	16.32.346	1556
50-5-204	16.32.399D	1910
50-5-404	16.32.346	1556
50-6-323	16.30.102	1201
Title 50, Ch.8	16.32.346	1556
50-32-103	8.40.404	1628
50-39-101	8.19.110, 112, 117, 119	2163
50-39-102	8.19.108, 110, 112, 117, 118	2163
50-39-103	8.19.110, 117, 118	2163
50-39-104	8.19.110, 117	2163
50-39-105	8.19.110, 117, 118	2163
50-39-106	8.19.110, 117	2163
50-39-107	8.19.108, 110, 112, 117 - 119	2163
50-39-108	8.19.117	2163
50-60-103	8.70.101, 105	1509
50-60-104	8.70.101, 105, 570	1509
50-60-108, 109	8.70.101	1509
50-60-201	Rules I - V (Commerce - Building Codes)	1509

MCA	Rule or A.G.'s Opinion	Register Page No.
50-60-201	8.70.101, 104, 105, 109, 302, 501	1509
50-60-203	Rules I - V (Commerce - Building Codes)	1509
50-60-203	8.70.101, 104, 105, 109, 110, 302, 303, 404, 501 - 505, 512, 516, 519, 520, 522, 531 - 534, 537, 540 - 544, 547 - 549, 557, 558, 561, 567 - 570, 903, 907	1509
50-60-301	8.70.110	1509
50-60-401	8.70.501 - 506, 512, 516 - 520, 522, 531 - 534, 537, 540 - 544, 547 - 549, 557, 558, 561, 567 - 570	1509
50-60-402	8.70.504, 505, 531, 534, 537, 540, 543, 544, 549, 558	1509
50-60-404	8.70.504	1509
50-60-504	8.70.302, 303	1509
50-60-508	8.70.101, 302	1509
50-60-603, 604	8.70.404	1509
50-60-607	8.70.404	1509
50-73-302	8.15.204	2149
50-74-101	Rule I (Commerce - Boilers, Blasters, and Crane Operators)	2149
50-74-101	8.15.301	2149
50-74-101	8.70.903, 907	1509
50-74-103	8.70.907	1509
50-74-305	Rule I (Commerce - Boilers, Blasters, and Crane Operators)	2149
50-74-309	8.15.301	2149
50-76-101	8.15.202	2149
50-76-102	8.15.202, 203	2149
50-76-103	8.15.202, 205	2149
50-76-104	8.15.203 - 205	2149
50-76-112	8.15.202 - 205	2149
52-1-103	11.7.103, 310 37.50.101	2250
52-1-103	11.7.313	1149
52-2-111	Rules I - XXI (DPHHS)	1759
52-2-111	11.12.101	1759
52-2-113	Rules I - XXI (DPHHS)	1759
52-2-113	11.12.101	1759
52-2-702	11.14.101, 102, 601	1427
52-2-703	11.14.102	1427
52-2-704	11.14.101, 102, 601, 602, 604, 605	1427
52-2-713	11.14.101, 102, 601, 602, 604, 605	1427
52-2-721	11.14.101, 602	1427
52-2-722, 723	11.14.602	1427
52-2-731	11.14.102, 601, 602	1427
52-2-735	16.24.414	2254
53-1-203	20.14.302	1347

MCA	Rule or A.G.'s Opinion	Register Page No.
53-2-101	46.12.5007	1350
53-2-108	46.10.410	1427
53-2-201	Rule I (DPHHS)	2241
53-2-201	11.12.413	1145
53-2-201	11.14.101, 102, 601, 602, 604, 605, 46.10.410 18.214, 314	1427
53-2-201	46.12.102	2241
53-2-201	46.8.1510	2045
53-2-201	46.12.502A, 528, 538, 2013	1269
53-2-201	46.12.539	1247
53-2-201	46.12.802, 806	2257
53-2-201	46.12.4801, 4815	1210
53-2-201	46.12.5003, 5004, 5007	1350
53-2-201	46.13.303, 304, 401, 501	1649
53-2-606	46.10.410	1427
53-4-111	11.12.115, 413	1145
53-4-113	11.12.413	1145
53-4-211	11.14.101, 102, 601, 602, 604, 605, 46.10.404, 18.214, 314, 501, 502, 505, 506	1427
53-4-212	11.14.101, 102, 601, 602, 604, 605, 46.10.404, 408 - 410, 18.214, 314, 501, 502, 505, 506	1427
53-4-231	46.10.410	1427
53-4-502	11.14.101	1427
53-4-503	11.14.101, 102, 46.10.404	1427
53-4-504	11.14.102	1427
53-4-506	16.24.414	2254
53-4-514	46.10.404	1427
53-4-601	11.14.101, 102, 601, 602, 604, 605, 46.18.214, 314, 501, 502, 505, 506	1427
53-4-603	46.18.505, 506	1427
53-4-611	11.14.101, 102, 601, 602, 604, 605	1427
53-4-612	11.14.101, 102, 601, 602, 46.18.501, 502	1427
53-4-613	46.18.214, 314	1427
53-4-701	46.10.408, 409	1427
53-4-716	46.10.404, 408, 409	1427
53-4-719	46.10.408, 409	1427
53-6-101	Rule I (DPHHS)	2241
53-6-101	46.12.102, 702, 703	2241
53-6-101	46.12.502A, 528, 538, 901, 902, 905, 911, 912, 915, 2003, 2013	1269
53-6-101	46.12.539	1247
53-6-101	46.12.802, 806	2257
53-6-101	46.12.4801, 4815	1210
53-6-106, 107	46.12.102	2241
53-6-111	Rule I (DPHHS)	2241
53-6-111	46.12.102	2241

MCA	Rule or A.G.'s Opinion	Register Page No.
53-6-111	46.12.502A, 528, 538	1269
53-6-111	46.12.539	1247
53-6-111	46.12.806	2257
53-6-113	Rule I (DPHHS)	2241
53-6-113	46.12.102, 702, 703	2241
53-6-113	46.12.502A, 528, 538, 901, 902, 905, 911, 912, 915, 2003, 2013	1269
53-6-113	46.12.539	1247
53-6-113	46.12.802, 806	2257
53-6-113	46.12.4801, 4815	1210
53-6-113	46.12.5003, 5004, 5007	1350
53-6-116	46.12.4801, 4815	1210
53-6-116	46.12.5003, 5004, 5007	1350
53-6-117	46.12.5003	1350
53-6-131	46.12.102	2241
53-6-141	46.12.102, 702, 703	2241
53-6-141	46.12.802, 806	2257
53-6-141	46.12.901, 902, 905, 911, 912, 915, 2003	1269
53-20-203, 204	46.8.1510	2045
53-20-209	46.8.1510	2045
53-21-111	20.14.302, 308	1347
53-24-105	20.3.402, 405, 409	1249
53-24-204	20.3.401 - 413, 416 - 421	1249
53-24-204	20.3.502, 503, 508, 509	2040
53-24-208	20.3.401, 403 - 406, 408 - 413, 416 - 419, 421	1249
53-24-208	20.3.502, 503, 508, 509	2040
53-24-209	20.3.503, 508, 509	2040
53-24-215	20.3.417, 418, 420	1249
53-24-217	20.3.421	1249
53-30-604	Rules I - VII (Corrections)	1895
53-30-606	Rule VI (Corrections)	1895
53-30-607	Rules III - V (Corrections)	1895
61-3-101	Rules I - VII (Justice)	1901
61-3-101	23.3.805	2292
61-3-321	42.21.106	1782
61-3-501, 502	18.8.101	1969
61-3-503	Rules I - III, V - VII (Justice)	1901
61-3-503, 504	23.3.805	2292
61-3-504	Rules I, II, V - VII (Justice)	1901
61-3-506	Rules I - VII (Justice)	1901
61-3-506	18.8.101	1969
61-3-506	23.3.805	2292
61-3-506	42.21.301 - 303, 305, 307, 308, 310	1782
61-3-529	Rules I, III - V, VII (Justice)	1901
61-3-530	Rules I, III, IV (Justice)	1901
61-3-711 - 733	18.8.101	1969
61-8-401	20.3.502, 509	2040
61-8-410	20.3.503	2040

MCA	Rule or A.G.'s Opinion	Register Page No.
61-8-714	20.3.503, 508, 509	2040
61-8-722	20.3.503, 508	2040
61-8-732	20.3.503, 508, 509	2040
61-10-107	18.8.101	1969
61-10-121	18.8.101	1969
61-10-121, 122	18.8.509, 1101	1638
61-10-124	18.8.509, 517, 1101	1638
61-10-125	18.8.101	1969
61-10-129	18.8.517	1638
61-10-155	18.8.101	1969
61-10-155	18.8.1101	1638
61-10-231	18.8.101	1969
63-3-103	Rules I - XIII (PSR)	2263
67-1-301, 302	Opinion No. 7	1394
69-1-105	Opinion No. 9	2200
69-3-102	Rules I - VI (PSR)	1259
69-3-102	38.5.3801 - 3806	2088
69-3-102, 103	Rules I - XI (PSR)	2048
69-3-105	Rule III (PSR)	2263
69-3-201	Rules I - XI (PSR)	2048
69-3-201	Rules I - VI (PSR)	1259
69-3-201	38.5.3801 - 3806	2088
69-3-207	38.5.2202, 2302, 2304	1972
69-3-822	Rules I - IX (PSR)	1253
69-3-822	38.5.2002, 2003, 2005, 2007	1921
69-3-856 - 860	38.5.2002, 2003, 2005, 2007	1921
69-3-1304	38.5.3801 - 3806	2088
69-3-1402	Rules I, II (PSR)	2263
69-3-1404	Rules I, II, IV - VI (PSR)	2263
69-3-1405	Rules I - III, VIII - XI (PSR)	2263
69-3-1408	Rules I, II, XII, XIII (PSR)	2263
69-4-201	38.5.1010	1972
Title 75, Ch. 2	17.8.102, 103, 1102	1126
75-2-111	17.8.102, 103, 202, 302, 602, 702, 802, 902, 1002, 1102, 1302	1126
75-2-111	17.8.504, 505	1142
75-2-111	17.8.514	1131
75-2-202	17.8.210	1124
75-2-202	17.8.802, 902, 1002, 1302	1126
75-2-203	17.8.202, 302, 602, 802, 902, 1002	1126
75-2-204	17.8.702, 802, 902, 1002	1126
75-2-211	17.8.504, 505	1142
75-2-211	17.8.702	1126
75-2-215	17.8.702	1126
75-2-217, 218	17.8.1201, 1210, 1213	2018
75-2-217, 218	17.8.1202	1126
75-2-220	17.8.504, 505	1142

MCA	Rule or A.G.'s Opinion	Register Page No.
75-2-220	17.8.514	1131
75-5-301	17.30.636	1122
75-5-301	17.30.636	1199
75-5-301	17.30.716	1133
75-5-301	17.30.1003	1138
75-5-303	17.30.716	1133
75-5-401	17.30.1022	1138
75-5-602	17.30.1022	1138
75-11-308	Rule I (DEQ - Petroleum Tank Release Compensation)	1755
75-11-318	17.58.342	1757
75-11-319	Rule I (DEQ - Petroleum Tank Release Compensation)	1755
76-1-108	Opinion No. 4	1288
Title 76, Ch. 2, Pt. 3	Opinion No. 4	1288
Title 76, Ch.6, Pt. 1	Opinion No. 8	1926
77-5-302	Rules I, II (DNRC)	1552
77-5-302	36.11.311, 312	1992
77-5-307	Rules I, II (DNRC)	1552
77-5-307	36.11.311, 312	1992
80-4-704	4.12.1004 - 1007	1867
80-4-704	4.12.3801, 3802	1869
80-4-704, 705	Rule I (Agriculture)	1413
80-4-709, 710	4.12.1004 - 1007	1867
81-2-102	32.3.212	1641
81-2-707	32.3.212	1641
81-20-101	32.3.212	1641
81-23-103, 104	32.24.504 - 507	1662
81-23-302	Rule I (Livestock - Milk Control)	1339
81-23-302	32.24.504 - 506	1339
82-11-111	36.22.1228, 1230, 1231, 1233, 1234, 1423	1245
82-11-111	36.22.1228, 1230, 1231, 1233, 1234, 1423	1589
82-11-111	36.22.1303, 1308, 1408	1646
82-11-121	36.22.1423	1245
82-11-121	36.22.1231, 1423	1589
82-11-121	36.22.1408	1646
82-11-123	36.22.1303, 1308, 1408	1646
82-11-123, 124	36.22.1228, 1230, 1231, 1233, 1234, 1423	1245
82-11-123, 124	36.22.1228, 1230, 1231, 1234, 1423	1589
82-11-124	36.22.1303, 1408	1646
82-11-127	36.22.1423	1245

MCA	Rule or A.G.'s Opinion	Register Page No.
82-11-127	36.22.1231, 1423	1589
82-11-127	36.22.1408	1646
82-11-137	36.22.1423	1245
82-11-137	36.22.1231, 1423	1589
82-11-137	36.22.1408	1646
85-2-113	36.12.103	1643
85-2-113	36.12.103	2084
85-2-225	36.17.601, 602, 606	1268
85-2-312	Rules I - III (DNRC)	1643
85-2-312	36.12.501, 502	2084
85-2-314	Rule III (DNRC)	1643
85-2-314	36.12.501, 502	2084
87-1-301	Rule I (FWP Commission)	1753
87-2-511	Rule I (FWP Commission)	1753
90-1-103	Rule I (Commerce - Local Government Assistance)	2230
90-1-103	8.94.3707	2230
90-6-305	8.104.203A	1337
90-6-307	8.104.203A	1337
90-6-710	Rule I (Commerce - Local Government Assistance)	2228
HB 431, Sec. 4, L. 1997	Rules I - VI (PSR)	1259
Ch. 349, Sec. 20 - 25, L. 1997	Rules I - IX (PSR)	1253
Ch. 349, Sec. 37, L. 1997	Rules I - IX (PSR)	1253
Ch. 463, Sec. 11, L. 1997	Rule V (Revenue)	1153
Ch. 463, Sec. 11, L. 1997	Rule V (Revenue)	1165
Ch. 507, Sec. 14, L. 1997	20.3.417, 421	1249
Ch. 271, L. 1995	Opinion No. 9	2200
Opinion 46-19	Opinion No. 6	1389
Opinion 42-57	Opinion No. 4	1288
Opinion 41-64	Opinion No. 4	1288
Opinion 38-98	Opinion No. 4	1288
MT Const., Art. IV, Sec. 8	Opinion No. 9	2200
MT Const., Art. V, Sec. 3	Opinion No. 9	2200
MT Const., Art. XIII, Sec. 1	Opinion No. 9	2200