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Executive Orders

EXECUTIVE ORDER BJ 14-05

Flags at Half Staff

WHEREAS, Robert “Bob” Fulton Odom, Jr., died on Saturday, May 17, 2014, at the age of 78;

WHEREAS, Bob Odom was born in Haynesville in Claiborne Parish in 1935 and was first elected Commissioner of Agriculture in 1979, where he served until 2007;

WHEREAS, while Commissioner of Agriculture, he was a champion for the Louisiana agriculture community and worked tirelessly to promote the agricultural markets of Louisiana;

WHEREAS, Bob Odom honorably served his country as a lieutenant colonel in the U.S. Marine Corps Reserve;

NOW THEREFORE I, BOBBY JINDAL, Governor of the State of Louisiana, by virtue of the authority vested by the Constitution and laws of the State of Louisiana, do hereby order and direct as follows:

SECTION 1: As an expression of respect of the citizens of the State of Louisiana for Robert “Bob” Fulton

Odom, Jr. the flags of the United States and the State of Louisiana shall be flown at half-staff over the State Capitol and all public buildings and institutions of the State of Louisiana until sunset on Friday, May 23, 2014.

SECTION 2: This Order is effective upon signature and shall continue in effect until amended, modified, terminated, or rescinded by the governor, or terminated by operation of law.

IN WITNESS WHEREOF, I have set my hand officially and caused to be affixed the Great Seal of Louisiana, at the Capitol, in the city of Baton Rouge, on this 17th day of May, 2014.

Bobby Jindal
Governor

ATTEST BY
THE GOVERNOR
Tom Schedler
Secretary of State
1406#034

Policy and Procedure Memoranda

POLICY AND PROCEDURE MEMORANDA

Office of the Governor
Division of Administration
Office of State Purchasing and Travel

General Travel—PPM-49 (LAC 4:V.Chapter 15)

The following shows the amended text in PPM-49. This supersedes all prior issues of PPM-49 published in the *Louisiana Register*. This revised PPM-49 also supersedes and replaces PPM-49 which is designated as LAC 4:V.Chapter 15.

Title 4

ADMINISTRATION

Part V. Policy and Procedure Memoranda

Chapter 15. General Travel Regulations—PPM Number 49

§1501. Authorization and Legal Basis

A. In accordance with the authority vested in the commissioner of administration by section 231 of title 39 of the Revised Statutes of 1950, and in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950-968 as amended, notice is hereby given of the revision of Policy and Procedure Memoranda No. 49, the state general travel regulations, effective July 1, 2014. These amendments are both technical and substantive in nature and are intended to clarify certain portions of the previous regulations or provide for more efficient administration of travel policies. These regulations apply to all state departments, boards and commissions created by the legislature or executive order and operating from funds appropriated, dedicated, or self-sustaining; federal funds; or funds generated from any other source.

Please note that when political subdivisions are required to follow PPM-49 for any pass through money issued by the state of Louisiana, any and all required approvals must be sent to the correct appointing authority, not to the commissioner of administration.

B. Legal Basis (R.S. 39:231(B)). The commissioner of administration, with the approval of the governor, shall, by rule or regulation, prescribe the conditions under which each of various forms of transportation may be used by state officers and employees in the discharge of the duties of their respective offices and positions in the state service and the conditions under which allowances will be granted for traveling expenses.

AUTHORITY NOTE: Promulgated in accordance with R.S. 39:231.

HISTORICAL NOTE: Written by the Office of the Governor, Division of Administration, November 1, 1972, published LR 1:179 (April 1975), amended LR 1:338 (August 1975), LR 2:312 (October 1976), LR 5:93 (May 1979), LR 6:405 (August 1980), LR 7:7 (January 1981), LR 8:406 (August 1982), LR 15:820 (October 1989), LR 16:965 (November 1990), LR 26:1252 (June 2000), LR 27:802 (June 2001), LR 28:1125 (June 2002), LR 29:822 (June 2003), LR 30:1111 (June 2004), LR 31:1183 (June 2005), LR 32:938 (June 2006), LR 33:966 (June 2007), republished LR

33:1314 (July 2007), amended LR 34:1299 (July 2008), LR 35:1192 (July 2009), LR 36:1647 (July 2010), LR 37:2048 (July 2011), LR 38:1475 (July 2012), LR 39:1659 (July 2013), LR 40:1052 (June 2014).

§1502. Definitions

A. For the purposes of this PPM, the following words have the meaning indicated.

Authorized Persons—

a. advisors, consultants, contractors and other persons who are called upon to contribute time and services to the state who are not otherwise required to be reimbursed through a contract for professional, personal, or consulting services in accordance with R.S. 39:1481 et seq.;

b. members of boards, commissions, and advisory councils required by federal or state legislation or regulation. Travel allowance levels for all such members and any staff shall be those authorized for state employees unless specific allowances are legislatively provided;

c. the department head or his/her designee is allowed to deem persons as an authorized traveler for official state business only.

NOTE: College/university students must be deemed authorized travelers to be reimbursed for state business purposes. A file must be kept containing all of these approvals.

Conference/Convention—a meeting (other than routine) for a specific purpose and/or objective. *Non-routine meetings* can be defined as a seminar, *conference*, *convention*, or training. Documentation required is a formal agenda, program, letter of invitation, or registration fee. Participation as an exhibiting vendor in an exhibit/trade show also qualifies as a *conference*. For a hotel to qualify for *conference* rate lodging, it requires that the hotel is hosting or is in "conjunction with hosting" the meeting. In the event the designated *conference* hotel(s) have no room available, a department head may approve to pay actual hotel cost not to exceed the *conference* lodging rates for other hotels located near the *conference* hotel.

Controlled Billed Account (CBA)—credit account issued in an agency's name (no plastic card issued). These accounts are direct liabilities of the state and are paid by each agency. *CBA* accounts are controlled through an authorized approver(s) to provide a means to purchase airfare, registration, lodging, rental vehicles, pre-paid shuttle service and any other allowable charges outlined in the current state of Louisiana state liability travel and *CBA* policy. Each department head determines the extent of the account's use.

Corporate Travel Card—credit cards issued in a state of Louisiana employee's name to be used for specific, higher cost official business travel expenses. *Corporate travel cards* are state liability cards, paid by each agency.

Emergency Travel—each department shall establish internal procedures for authorizing travel in emergency situations. Approval may be obtained after the fact from the commissioner of administration with appropriate documentation, under extraordinary circumstances when PPM-49 regulations cannot be followed but where the best interests of the state requires that travel be undertaken.

Extended Stays—any assignment made for a period of 31 or more consecutive days at a place other than the official domicile.

Higher Education Entities—entities listed under schedule 19, higher education of the general appropriations bill.

In-State Travel—all travel within the borders of Louisiana or travel through adjacent states between points within Louisiana when such is the most efficient route.

International Travel—all travel to destinations outside the 50 United States, District of Columbia, Puerto Rico, the Virgin Islands, American Samoa, Guam, and Saipan.

Lowest Logical Airfare—in general, these types of airfares are non-refundable, penalty tickets. Penalties could include restrictions such as advanced purchase requirements, weekend stays, etc. Prices will increase as seats are sold. When schedule changes are required for lowest logical tickets, penalty fees are added.

Official Domicile—every state officer, employee, and authorized person, except those on temporary assignment, shall be assigned an *official domicile*:

a. except where fixed by law, official domicile of an officer or employee assigned to an office shall be, at a minimum, the city limits in which the office is located. The department head or his designee should determine the extent of any surrounding area to be included, such as parish or region. As a guideline, a radius of at least 30 miles is recommended. The *official domicile* of an authorized person shall be the city in which the person resides, except when the department head has designated another location (such as the person's workplace);

b. a traveler whose residence is other than the *official domicile* of his/her office shall not receive travel and subsistence while at his/her *official domicile* nor shall he/she receive reimbursement for travel to and from his/her residence;

c. the *official domicile* of a person located in the field shall be the city or town nearest to the area where the majority of work is performed, or such city, town, or area as may be designated by the department head, provided that in all cases such designation must be in the best interest of the agency and not for the convenience of the person;

d. the department head or his/her designee may authorize approval for an employee to be reimbursed for lodging expenses within an employee's domicile with proper justification as to why this is necessary and in the best interest of the state.

Out-of-State Travel—travel to any of the other 49 states plus District of Columbia, Puerto Rico, the Virgin Islands, American Samoa, Guam, and Saipan.

Passport—a document identifying an individual as a citizen of a specific country and attesting to his or her identity and ability to travel freely.

Per Diem—a flat rate paid in lieu of travel reimbursements for people on extended stays only.

Receipts/Document Requirements—supporting documentation, including original *receipts*, must be retained according to record retention laws. It shall be at the discretion of each agency to determine where the *receipts/documents* will be maintained.

Routine Travel—travel required in the course of performing his/her job duties. This does not include non-routine meetings, conferences, and out-of-state travel.

State Employee—employees below the level of state officer.

State Officer—

a. state elected officials;

b. department head as defined by title 36 of the *Revised Statutes* (secretary, deputy secretary, undersecretary, assistant secretary, and the equivalent positions in higher education and the office of elected officials).

Suburb—an immediate or adjacent location (overflow of the city) to the higher cost areas which would be within approximately 30 miles of the highest cost area.

Temporary Assignment—any assignment made for a period of less than 31 consecutive days at a place other than the official domicile.

Travel Period—a period of time between the time of departure and the time of return.

Travel Routes—the most direct traveled route must be used by official state travelers.

Travel Scholarships—if any type of scholarship for travel is offered/received by a state employee, it is the agency/employee's responsibility to receive/comply with all ethic laws/requirements (see R.S. 42:1123).

Traveler—a state officer, state employee, or authorized person performing authorized travel.

Visa—a document, or more frequently a stamp in a passport, authorizing the bearer to visit a country for specific purposes and for a specific length of time.

AUTHORITY NOTE: Published in accordance with R.S. 39:231.

HISTORICAL NOTE: Written by the Office of the Governor, Division of Administration, November 1, 1972, published LR 1:179 (April 1975), amended LR 1:338 (August 1975), LR 2:312 (October 1976), LR 5:93 (May 1979), LR 6:405 (August 1980), LR 7:7 (January 1981), LR 8:406 (August 1982), LR 15:820 (October 1989), LR 16:965 (November 1990), LR 26:1252 (June 2000), LR 27:802 (June 2001), LR 28:1125 (June 2002), LR 29:822 (June 2003), LR 30:1111 (June 2004), LR 31:1183 (June 2005), LR 32:938 (June 2006), LR 33:966 (June 2007), republished LR 33:1314 (July 2007), amended LR 34:1299 (July 2008), LR 35:1192 (July 2009), LR 36:1647 (July 2010), LR 37:2048 (July 2011), LR 38:1475 (July 2012), LR 39:1659 (July 2013), LR 40:1052 (June 2014).

§1503. General Specifications

A. Department Policies

1. Department heads may establish travel regulations within their respective agencies, but such regulations shall not exceed the maximum limitations established by the commissioner of administration. Three copies of such regulations shall be submitted for prior review and approval by the commissioner of administration. One of the copies shall highlight any exceptions/deviations to PPM-49.

2. Department and agency heads will take whatever action necessary to minimize all travel to carry on the department mission.

3. Contracted travel services the state has contracted, for travel agency services, which use is mandatory for airfares unless exemptions have been granted by the Division of Administration, Office of State Travel, prior to purchasing airfare tickets. The contracted travel agency has

an online booking system which can and should be used by all travelers for booking airfare. Use of the online booking system can drastically reduce the cost paid per transaction and state travelers are strongly encouraged to utilize.

4. When a state agency enters into a contract with an out-of-state public entity, the out-of-state public entity may have the authority to conduct any related travel in accordance with their published travel regulations.

5. Authorization to Travel

a. All non-routine travel must be authorized with prior approvals in writing by the head of the department, board, or commission from whose funds the traveler is paid. A department head may delegate this authority in writing to one designated person. Additional persons within a department may be designated with approval from the commissioner of administration. A file shall be maintained, by the agency, on all approved travel authorizations.

b. Annual travel authorizations are no longer a mandatory requirement of PPM-49 for routine travel; however, an agency can continue to utilize this process if determined to be in your department's best interest and to obtain prior approval for annual routine travel. A prior approved travel authorization is still required for non-routine meetings, conferences and out-of-state travel.

B. Funds for Travel Expenses

1. Persons traveling on official business will provide themselves with sufficient funds for all routine travel expenses not covered by the corporate travel card, LaCarte purchasing card, if applicable, and/or agency's CBA account. Advance of funds for travel shall be made only for extraordinary travel and should be punctually repaid when submitting the travel expense form covering the related travel, no later than the fifteenth day of the month following the completion of travel.

2. Exemptions. Cash advance(s) meeting the exception requirement(s) listed below, must have an original receipt to support all expenditures in which a cash advance was given, including meals. At the agency's discretion, cash advances may be allowed for:

a. state employees whose salary is less than \$30,000/year;

b. state employees who accompany and/or are responsible for students or athletes for a group travel advance;

NOTE: In this case and in regards to meals, where there is group travel advancements, a roster with signatures of each group member along with the amount of funds received by each group member, may be substituted for individual receipts. (This exception does not apply when given for just an individual employee's travel which is over a group.)

c. state employees who accompany and/or responsible for client travel;

d. new employees who have not had time to apply for and receive the state's corporate travel card;

e. employees traveling for extended periods, defined as 30 or more consecutive days;

f. employees traveling to remote destinations in foreign countries, such as jungles of Peru or Bolivia;

g. lodging purchase, if hotel will not allow direct bill or charges to agency's CBA and whose salary is less than \$30,000/year;

h. registration for seminars, conferences, and conventions;

i. any ticket booked by a traveler 30 days or more in advance and for which the traveler has been billed, may be reimbursed by the agency to the traveler on a preliminary expense reimbursement request. The traveler should submit the request with a copy of the bill or invoice. Passenger airfare receipts are required for reimbursement;

j. employees who infrequently travel or travelers that incur significant out-of-pocket cash expenditures and whose salary is less than \$30,000/year.

3. Expenses Incurred on State Business. Traveling expenses of travelers shall be limited to those expenses necessarily incurred by them in the performance of a public purpose authorized by law to be performed by the agency and must be within the limitations prescribed herein.

4. CBA (controlled billed account) issued in an agency's name, and paid by the agency may be used for airfare, registration, rental cars, prepaid shuttle charges, lodging and any allowable lodging associated charges such as parking and internet charges. Other credit cards issued in the name of the state agency are not to be used without written approval.

5. No Reimbursement When No Cost Incurred by Traveler. This includes, but is not limited to, reimbursements for any lodging and/or meals furnished at a state institution or other state agency, or furnished by any other party at no cost to the traveler. In no case will a traveler be allowed mileage or transportation when he/she is gratuitously transported by another person.

C. Claims for Reimbursement

1. All claims for reimbursement for travel shall be submitted on the state's travel expense Form BA-12 unless exception has been granted by the commissioner of administration and shall include all details provided for on the form. It must be signed by the person claiming reimbursement and approved by his/her immediate supervisor. In all cases, the date and hour of departure from and return to domicile must be shown, along with each final destination throughout the trip clearly defined on the form. On the state's travel authorization Form GF-4, the second page must be completed with breakdown of the estimated travel expenses. This is necessary for every trip, not just when requesting a travel advance. For every travel authorization request, the "purpose of the trip" for travel must be stated in the space provided on the front of the form.

2. Except where the cost of air transportation, registration, lodging, rental vehicles, shuttle service, and all other allowable charges outlined in the current state of Louisiana state liability travel and CBA policy are invoiced directly to the agency or charged to a state liability card, any and all expenses incurred on any official trip shall be paid by the traveler and his travel expense form shall show all such expenses in detail so that the total cost of the trip shall be reflected on the travel expense form. If the cost of the expenses listed above are paid directly or charged directly to the agency/department, a notation will be indicated on the travel expense form indicating the date of travel, destination, amount, and the fact that it has been paid by the agency/department. The traveler must provide receipts for all items charged or billed direct to the agency.

3. In all cases, and under any travel status, cost of meals shall be paid by the traveler and claimed on the travel expense form for reimbursement, and not charged to the

state department, unless otherwise authorized by the department head or his designee, allowed under the state liability travel, CBA and/or LaCarte purchasing card policy or with written approval from the Office of State Purchasing and Travel. A file must be kept containing all of these special approvals.

4. Claims should be submitted within the month following the travel, but preferably held until a reimbursement of at least \$25 is due. Department heads, at their discretion, may make the 30-day submittal mandatory on a department-wide basis.

5. Any person who submits a claim pursuant to these regulations and who willfully makes and subscribes to any claim which he/she does not believe to be true and correct as to every material matter, or who willfully aids or assists in, or procures, counsels or advises the preparation or presentation of a claim, which is fraudulent or is false as to any material matter, shall be guilty of official misconduct. Whoever shall receive an allowance or reimbursement by means of a false claim shall be subject to severe disciplinary action as well as being criminally and civilly liable within the provisions of state law.

6. Agencies are required to reimburse travel in an expeditious manner. In no case shall reimbursements require more than 30 days to process from receipt of complete, proper travel documentation.

AUTHORITY NOTE: Published in accordance with R.S. 39:231.

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§1504. Methods of Transportation

A. Cost-Effective Transportation. The most cost-effective method of transportation that will accomplish the purpose of the travel shall be selected. Among the factors to be considered should be length of travel time, employee's salary, cost of operation of a vehicle, cost and availability of common carrier services, etc. Common carrier shall be used for out-of-state travel unless it is documented that utilization of another method of travel is more cost-efficient or practical and approved in accordance with these regulations.

B. Air

1. Private Owned or Charter Planes

a. Before travel by privately-owned or by chartered aircraft is authorized for individual's travel by a department head, the traveler shall certify that: at least two hours of working time will be saved by such travel; and no other form of transportation, such as commercial air travel or a state plane, will serve this same purpose.

i. Chartering a privately-owned aircraft must be in accordance with the procurement code.

ii. Reimbursement for use of a chartered or un-chartered privately owned aircraft under the above guidelines will be made on the following basis:

(a). at the rate of \$1.29 per mile; or

(b). at the lesser of coach economy airfare.

b. If there are extenuating circumstances requiring reimbursement for other than listed above, approval must be granted by the commissioner of administration.

i. When common carrier services are unavailable and time is at a premium, travel via state aircraft shall be investigated, and such investigation shall be documented and readily available in the department's travel reimbursement files. Optimum utilization will be the responsibility of the department head.

2. Commercial Airlines (receipts required). All state travelers are to purchase commercial airline tickets through the state-contracted travel agency (see front cover for contract travel agency contact numbers). This requirement is mandatory unless approval is granted from the Office of State Travel. (In the event travelers seek approval to go outside the travel agency, they shall submit their request through their agency travel program administrator, who will determine if the request should be submitted to the Office of State Travel.) While state contractors are not required to use the state's contracted travel agency when purchasing airfare, it will be the agency's responsibility to monitor cost, ensuring that the contractor(s) are purchasing the lowest, most logical airfare. The state always supports purchasing the best value ticket. Therefore once all rates are received, the traveler must compare cost and options to determine which fare would be the best value for their trip. To make this determination, the traveler must ask the question: "Is there a likelihood my itinerary could change or be cancelled?" Depending on the response, the traveler must determine if the costs associated with changing a non-refundable ticket (usually around \$200) would still be the best value. Another factor to assist having a travel agent search the lowest fare is advising the agent if traveler is flexible in either your dates or time of travel. By informing the travel agent of your window-of-time for your departure and return will assist them to search for the best price.

a. Travelers are to seek airfares allowing an ample amount of lead-time prior to departure date. The lead-time should be about 10 to 14 days in advance of travel dates to ensure the lowest fares are available.

b. Note: Cost of a preferred or premium seat is not reimbursable. To avoid these charges or to avoid being bumped, a traveler must check in as early as possible. A traveler should check in online 24 hours prior to a flight or check in at the airport several hours prior to departure to obtain a seat assignment. Please be aware that this is a strict airline policy that a traveler must check in at a minimum, prior to 30 minutes of departure. The airlines are very strict about this policy. Airline rules typically state that if you don't arrive at least 30 minutes before the schedule departure, you may forfeit your registration. The earlier you arrive at the gate increases the chances of retaining your original reservation and assurance of a seat on the flight purchased.

c. Commercial air travel will not be reimbursed in excess of lowest logical airfare when it has been determined to be the best value (receipts required). The difference between coach/economy class rates and first class or business class rates will be paid by the traveler. Upgrades at the expense of the state are not permitted without prior

approval of the commissioner of administration. If space is not available in less than first or business class air accommodations in time to carry out the purpose of the travel, the traveler will secure a certification from the airline or contracted travel agency indicating this fact. The certification is required for travel reimbursement.

d. The policy regarding airfare penalties is that the state will pay for the airfare and/or penalty incurred for a change in plans or cancellation when the change or cancellation is required by the state or other unavoidable situations approved by the agency's department head. Justification for the change or cancellation by the traveler's department head is required on the travel expense form.

e. When an international flight segment is more than 10 hours in duration, the state will allow the business class rate not to exceed 10 percent of the coach rate. The traveler's itinerary provided by the travel agency must document the flight segment as more than 10 hours and must be attached to the travel expense form.

f. A lost airline ticket is the responsibility of the person to whom the ticket was issued. The airline fee of searching and refunding lost tickets will be charged to the traveler. The difference between the prepaid amount and the amount refunded by the airlines must be paid by the employee.

g. Traveler is to use the lowest logical airfare whether the plane is a prop or a jet.

h. Employees may retain promotional items, including frequent flyer miles, earned on official state travel. However, if an employee makes travel arrangements that favor a preferred airline/supplier to receive promotional items/points and this circumvents purchasing the most economical means of travel, they are in violation of this travel policy. Costs for travel arrangements subject to this violation are non-reimbursable.

i. When making airline reservations for a conference, let the travel agent know that certain airlines have been designated as the official carrier for the conference. In many instances, the conference registration form specifies that certain airlines have been designated as the official carrier offering discount rates, if available. If so, giving this information to our contracted agency could result in them securing that rate for your travel.

j. Tickets which are unused by a traveler should always be monitored by the traveler and the agency. Traveler should ensure that any unused ticket is considered when planning future travel arrangements. Some airlines have a policy which would allow for a name change to another employee within the agency. A view of the latest airline policies regarding unused tickets are available at the state travel office's website, <http://www.doa.louisiana.gov/osp/travel/airfare.htm>.

C. Motor Vehicle. No vehicle may be operated in violation of state or local laws. No traveler may operate a vehicle without having in his/her possession a valid U.S. driver's license. Safety restraints shall be used by the driver and passengers of vehicles. All accidents, major and minor, shall be reported first to the local police department or appropriate law enforcement agency. In addition, an accident report form, available from the Office of Risk Management (ORM) of the Division of Administration, should be completed as soon as possible and must be returned to ORM,

together with names and addresses of principals and witnesses. Any questions about this should be addressed to the Office of Risk Management of the Division of Administration. These reports shall be in addition to reporting the accident to the Department of Public Safety as required by law. Operating a state-owned vehicle, state-rented vehicle, or state-leased vehicle, or operating a non-state-owned vehicle for state business, while intoxicated, as set forth in R.S. 14:98 and 14:98.1, is strictly prohibited, unauthorized, and expressly violates the terms and conditions of use of said vehicle. In the event such operation results in the employee being convicted of, pleading nolo contendere to, or pleading guilty to, driving while intoxicated under R.S. 14:98 and 14:98.1, such would constitute evidence of the employee violating the terms and conditions of use of said vehicle, violating the direction of his/her employer, and acting beyond the course and scope of his/her employment with the state of Louisiana. Personal use of a state-owned, state-rented or state-leased vehicle is not permitted. No person may be authorized to operate or travel in a state-owned or rental vehicle unless that person is a classified or unclassified employee of the state of Louisiana; any duly appointed member of a state board, commission, or advisory council; or any other person who has received specific approval and is deemed as an "authorized traveler" on behalf of the state, from the department head or his designee to operate or travel in a fleet vehicle on official state business. A file must be kept containing all of these approvals. Any persons who are not official state employees must sign a hold harmless agreement form, located at the Office of State Travel's website, <http://www.doa.louisiana.gov/osp/travel/forms.htm>, prior to riding in or driving a state-owned vehicle or rental vehicle on behalf of the state. Each agency is responsible in ensuring that this, along with any other necessary documents and requirements, are completed and made part of the travel file prior to travel dates. Students not employed by the state shall not be authorized to drive state-owned or rented vehicles for use on official state business. A student may be deemed as an authorized traveler on behalf of the state by the department head or his designee to operate or travel in a state-owned or rented vehicle on official state business. The hold harmless agreement form acknowledging the fact that the state assumes no liability for any loss, injury, or death resulting from said travel must be signed as part of the approval process. A file must be kept containing all of these approvals. Persons operating a state-owned, rental or personal vehicle on official state business will be completely responsible for all traffic, driving, and parking violations received. This does not include state-owned or rental vehicle violations (i.e. inspections sticker) as the state and/or rental company would be liable for any cost associated with these types of violations.

1. State-Owned Vehicles

a. Travelers in state-owned automobiles who purchase needed fuel, repairs and equipment while on travel status shall make use of all fleet discount allowances and state bulk purchasing contracts where applicable. Reimbursements require a receipt and only regular unleaded gasoline, or diesel when applicable, should be used. This applies for both state-owned vehicles and rental vehicles, as mid-grade, super, plus or premium gasoline is typically not

necessary. Each agency/department shall familiarize itself with the existence of the fuel/repair contract(s), terms and conditions as well as location of vendors.

b. State-owned vehicles may be used for out-of-state travel only if permission of the department head has been given prior to departure. If a state-owned vehicle is to be used to travel to a destination more than 500 miles from its usual location, documentation that this is the most cost-effective means of travel should be readily available in the department's travel reimbursement files.

c. Unauthorized persons should not be transported in state vehicles. Approval of exceptions to this policy may be made by the department head if he determines that the unauthorized person is part of the official state business and the best interest of the state will be served and the passenger (or passenger's guardian) signs a hold harmless agreement form acknowledging the fact that the state assumes no liability for any loss, injury, or death resulting from said travel.

d. If a state vehicle is needed/requested to be brought to the home of a state employee overnight, then the agency/traveler should ensure it is in accordance with requirements outlined in R.S. 39:361-364.

2. Personally-Owned Vehicles

a. When two or more persons travel in the same personally-owned vehicle, only one charge will be allowed for the expense of the vehicle. The person claiming reimbursement shall report the names of the other passengers.

b. A mileage allowance shall be authorized for travelers approved to use personally-owned vehicles while conducting official state business. Mileage may be reimbursable on the basis of no more than \$0.51 per mile and in accordance with the following.

i. For official in-state business travel:

(a). employee should utilize a state vehicle when available;

(b). employee may rent a vehicle from the state's in-state, or when renting out-of-state, the state's out-of-state rental contracts, if a state vehicle is not available and travel exceeds 100 miles; or

(c). if an employee elects to use his/her personal vehicle, reimbursement may not exceed a maximum of 99 miles per round-trip and/or day at \$0.51 cents per mile. Please note that mileage is applicable for round-trip (multiple days) and/or round-trip (one day).

Example No. 1: If someone leaves Baton Rouge, travels to New Orleans and returns that same day, they are entitled to 99 miles maximum for that day "trip" if they choose to drive their personal vehicle.

Example No. 2: If someone leaves Baton Rouge, travels to New Orleans, and returns two days later, they are entitled to 99 miles maximum for the entire "trip" if they choose to drive their personal vehicle.

Example No. 3: If someone leaves Baton Rouge, travels to New Orleans then on to Lafayette, Shreveport, Monroe and returns to the office four days later, they are entitled to 99 miles maximum for the entire "trip" if they choose to drive their personal vehicle.

c. Mileage shall be computed by one of the following options:

i. on the basis of odometer readings from point of origin to point of return;

ii. by using a website mileage calculator or a published software package for calculating mileage such as Tripmaker, How Far Is It, Mapquest, etc. Employee is to print the page indicating mileage and attach it with his/her travel expense form.

d. An employee shall never receive any benefit from not living in his/her official domicile. In computing reimbursable mileage, while the employee is on official state travel status, to an authorized travel destination from an employee's residence outside the official domicile, the employee is always to claim the lesser of the miles from their official domicile or from their residence. If an employee is leaving on a non-work day or leaving significantly before or after work hours, the department head may determine to pay the actual mileage from the employee's residence not to exceed a maximum of 99 miles per round trip and/or day at \$0.51 per mile (see example, Subparagraph C.2.b).

e. The department head or his designee may approve an authorization for routine travel for an employee who must travel in the course of performing his/her duties; this may include domicile travel if such is a regular and necessary part of the employee's duties, but not for attendance to infrequent or irregular meetings, etc., within the city limits where his/her office is located. The employee may be reimbursed for mileage only, not to exceed a maximum of 99 miles per round trip and/or day, at \$0.51 per mile (see example, Subparagraph C.2.b).

f. Reimbursements will be allowed on the basis of \$0.51 per mile, not to exceed a maximum of 99 miles per round trip and/or day, to travel between a common carrier/terminal and the employees point of departure, i.e., home, office, etc., whichever is appropriate and in the best interest of the state (see example, Subparagraph C.2.b).

g. When the use of a privately-owned vehicle has been approved by the department head for out-of-state travel for the travelers convenience, the traveler will be reimbursed for mileage on the basis of \$0.51 per mile only, not to exceed a maximum of 99 miles per round trip and/or day. If prior approval for reimbursement of actual mileage is requested and granted by the commissioner of administration, the total cost of the mileage reimbursement may never exceed the cost of a rental vehicle or the cost of travel by using the lowest logical airfare obtained at least 14 days prior to the trip departure date, whichever is the lesser of the two. The reimbursement would be limited to one lowest logical airfare quote, not the number of persons traveling in the vehicle. The traveler is personally responsible for any other expenses in-route to and from destination, which is inclusive of meals and lodging. If a traveler, at the request of the department, is asked to take his/her personally-owned vehicle out-of-state for a purpose that will benefit the agency, then the department head may, on a case-by-case basis, determine to pay a traveler for all/part of in-route travel expenses; however, mileage reimbursement over 99 miles would still require prior approval from the commissioner of administration's approval. In this case, once approval is obtained from the commissioner of administration to exceed 99 miles, then the department head may authorized actual mileage reimbursements. File should be justified accordingly.

h. When a traveler is required to regularly use his/her personally-owned vehicle for agency activities, the agency head may request prior authorization from the commissioner of administration for a lump sum allowance for transportation or reimbursement for transportation (mileage). Request for lump sum allowance must be accompanied by a detailed account of routine travel listing exact mileage for each such route and justification why a rental vehicle is not feasible. Miscellaneous travel must be justified by at least a three-month travel history to include a complete mileage log for all travel incurred, showing all points traveled to or from and the exact mileage. Request for lump sum allowance shall be granted for periods not to exceed one fiscal year. A centralized file must be kept containing all approvals.

Note: Once someone is given a monthly vehicle allowance or lump sum allowance, they are not to be reimbursed for mileage, fuel or rental vehicles.

i. In all cases, the traveler shall be required to pay all operating expenses for his/her personal vehicle including fuel, repairs, and insurance.

j. The only exemption which would not require the commissioner of administration's prior approval for exceeding 99 miles reimbursement and receiving actual mileage reimbursements is for members of boards and commissions, not administration/office personnel, and for students which are traveling on a grant, scholarship, or any other occasion where use of a personal vehicle is the best and/or only method of transportation available. Department head approval is required.

3. Rented Motor Vehicles (receipts required). Any rental vehicles not covered in the state in-state or out-of-state contracts should be bid in accordance with proper purchasing rules and regulations.

a. In-State Vehicle Rental. The state has contracted for all rentals based out of Louisiana through Enterprise Rent-A-Car's state motor pool rental contract, which use is mandatory, for business travel which applies to all state of Louisiana employees and/or authorized travelers, contractors, etc., traveling on official state business.

i. A rental vehicle should be used, if a state owned vehicle is not available, for all travel over 99 miles. All exemptions must be requested and granted by the commissioner of administration for a reimbursement which exceed 99 miles prior to the trip. Requests for exemption must be accompanied by a detailed explanation as to why a rental is not feasible. If an exemption from the program is granted by the commissioner of administration as stated above, then the employee will not be required to rent a vehicle and may receive actual mileage reimbursement up to \$0.51 per mile.

ii. All state contractors, who have entered into a contract with the state of Louisiana on or after March 1, 2013, and whose contracts are required to follow PPM-49 for travel reimbursements, are required to utilize both in-state and out-of-state mandatory contracts awarded by the state.

iii. Although exemptions may be granted, by the commissioner of administration, if exemption is approved, in any case, all must adhere to the current mileage reimbursement rate of no more than \$0.51 per mile.

(a). The only exemption which would not require the commissioner of administration's prior approval for exceeding 99 miles reimbursement and receiving actual mileage reimbursements is for members of boards and commissions, not administration/office personnel, and for students which are traveling on a grant, scholarship, or any other occasion where use of a personal vehicle is the best and/or only method of transportation available. Department head approval is required.

v. For trips of 100 miles or more, any employee and/or authorized traveler, should use a state-owned vehicle or rental from Enterprise Rent-A-Car state motor pool rental contract, when a state vehicle is not available.

vi. For trips of less than 100 miles employees should utilize a state vehicle when available, may utilize their own vehicle and receive mileage reimbursement not to exceed a maximum of 99 miles per round trip and/or day at \$0.51 per mile or may rent a vehicle from Enterprise Rent-A-Car's state motor pool rental contract.

vii. Reservations should not be made at an airport location for daily routine travel, as this will add additional unnecessary cost to your rental charges.

b. Payments for rentals through the state motor pool rental contract may be made using the LaCarte purchasing card, an agency's CBA account, an employee's state corporate travel card or by direct bill to the agency. This will be an agency decision as to the form of payment chosen. If direct bill is chosen, agency must set up account billing information with Enterprise. An account may be established by contacting Joseph Rosenfeld at (225) 445-7250, joseph.g.rosenfeld@erac.com

c. Out-of-State Vehicle Rental. The state has contracted for rental vehicles for domestic and out-of-state travel, excluding Louisiana and international travel, utilizing the state of Louisiana's out-of-state contracts, which use is mandatory. All state of Louisiana employees and/or authorized travelers, contractors are mandated to use these contracts due to exceptional pricing which includes CDW (Collision Damage Waiver) and one million dollar liability insurance. The State of Louisiana Out-of-State participating vendors include Enterprise Rent-A-Car, National Car Rental and Hertz Car Rental Corporation. It is the traveler's discretion which rental company is utilized. All state contractors who have entered into a contract with the State of Louisiana on or after March 1, 2013, and whose contracts are required to follow PPM-49 for travel reimbursements, are required to utilize both in-state and out-of-state mandatory contracts awarded by the state. Although exemptions may be granted, by the commissioner of administration, if exemption is approved, in any case, all must adhere to the current mileage reimbursement rate of no more than .51 cents per mile. The only exemption which would not require the commissioner of administration's approval for exceeding 99 miles reimbursement and receiving actual mileage reimbursements is for students which are traveling on a grant, scholarship, or any other occasion where use of a personal vehicle is the best and/or only method of transportation available. Department head approval is required.

d. Payments for rentals made through the state of Louisiana out-of-state contracts may be made using the LaCarte purchasing card, an employee's corporate travel

card or by direct bill to the agency. This will be an agency decision as to the form of payment chosen. If a direct bill account is chosen for Enterprise and National, you may contact Joseph Rosenfeld at (225) 445-7250, joseph.g.rosenfeld@erac.com, and for Hertz, you may contact Tami Vetter at (225) 303-5973, tvetter@hertz.com.

e. Approvals. Written approval of the department head or his designee prior to departure is not required for the rental of vehicles, however, if your agency chooses, approval may be made mandatory or handled on an annual basis if duties require frequent rentals. Special approval is required, from the department head or his/her designee, for rental of any vehicle in the "full size" category or above.

f. Vehicle Rental Size

i. Only the cost of a compact or intermediate model is reimbursable unless non-availability is documented or the vehicle will be used to transport more than two persons.

NOTE: When a larger vehicle is necessary as stated in 1, or a larger vehicle is necessary due to the number of persons being transported, the vehicle shall be upgraded only to the next smallest size and lowest price necessary to accommodate the number of persons traveling.

ii. A department head or his/her designee may, on a case-by-case basis, authorize a larger size vehicle provided detailed justification is made in the employee's file. Such justification could include, but is not limited to, specific medical requirements when supported by a doctor's recommendation.

g. Personal Use of Rental. Personal use of a rental vehicle, when rented for official state business, is not allowed.

h. Gasoline (receipts required). Reimbursements require an original receipt and only regular unleaded gasoline, or diesel when applicable, should be used. This applies for both state-owned vehicles and rental vehicles, as mid-grade, super, plus, or premium gasoline is typically not necessary. An employee should purchase gasoline with the state's fuel card or other approved credit card, at reasonable cost, from a local gasoline station prior to returning the rental. Pre-paid fuel options for rental vehicles are only to be allowed with prior approval from the department head when the traveler can document that the pre-purchased amount was necessary and that the amount charged by the rental company is reasonable in relation to local gasoline cost.

i. Insurance for Vehicle Rentals within the 50 United States. Insurance billed by car rental companies is not reimbursable. All insurance coverage for rental vehicles, other than the state's in-state and out-of-state mandatory contracts, is provided by the Office of Risk Management. Should a collision occur while on official state business, the accident should immediately be reported to the Office of Risk Management and rental company. Any damage involving a third party must be reported to appropriate law enforcement entity to have a police report generated.

i. CDW/damage waiver insurance and \$1,000,000 liability protection coverage is included in the state in-state and out-of-state rental contract pricing.

NOTE: Lost keys and car door unlocking services for rental vehicles are not covered under the damage waiver policy and are very costly. The agency should establish an internal procedure regarding liability of these costs.

ii. No other insurance will be reimbursed when renting, except when renting outside the 50 United States (see §1504.C.3.i). There should be no other charges added to the base price, unless the traveler reserves the vehicle at an airport location (which is not recommended for daily routine travel). Reimbursable amounts would then be submitted at the end of the trip on a travel expense form.

j. Insurance for Vehicles Rentals outside the 50 United States (receipts required). The Office of Risk Management (ORM) recommends that the appropriate insurance (liability and physical damage) provided through the car rental company be purchased when the traveler is renting a vehicle outside the 50 United States. With the approval of the department head or his/her designee, required insurance costs may be reimbursed for travel outside the 50 United States only.

4. The following are insurance packages available by rental vehicle companies which are reimbursable:

a. collision damage waiver (CDW). Should a collision occur while on official state business, the cost of the deductible should be paid by the traveler and submit a reimbursement claimed on a travel expense form. The accident should also be reported to the Office of Risk Management;

b. loss damage waiver (LDW);

c. auto tow protection (ATP) (*approval of department head);

d. supplementary liability insurance (SLI) (*if required by the rental company);

e. theft and/or super theft protection (coverage of contents lost during a theft or fire) (*if required by the car rental company);

f. vehicle coverage for attempted theft or partial damage due to fire (*if required by the car rental company).

5. The following are some of the insurance packages available by rental vehicle companies that are not reimbursable:

a. personal accident coverage insurance (PAC);

b. emergency sickness protection (ESP).

6. Navigation equipment (GPS system) rented, not purchased, from a rental car company, may only be reimbursed if an employee justifies the need for such equipment and with prior approval of the department head or his designee.

D. Public Ground Transportation. The cost of public ground transportation such as buses, subways, airport shuttle/limousines, and taxis are reimbursable when the expenses are incurred as part of approved state travel (see receipt requirements below).

1. Airport shuttle/limousines, taxi, and all other public transportation where a receipt is available, requires a receipt for reimbursements. A driver's tip for shuttle/limousines and taxis may be given and must not exceed 15 percent of total charge. Amount of tip must be included on receipt received from driver/company.

2. All other forms of public ground transportation, where a receipt is not possible and other than those listed above, are limited to \$15 per day without a receipt; claims in excess of \$15 per day requires a receipt. At the agency's discretion, the department head may implement an agency wide policy requiring receipts for all public transportation request less than \$15 per day.

3. To assist agencies with verification of taxi fares, you may contact the taxi company for an estimate or visit sites such as taxifarefinder.com. An employee should always get approval, prior to a trip, if multiple taxis will be used, as it may be in the agency's best interest to rent a vehicle versus reimbursement of multiple taxi expenses.

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§1505. State Issued Travel Credit Cards/CBA Accounts

A. Use. The state travel office contracts for an official state corporate travel card to form one source of payment for travel. If a supervisor recommends an employee be issued a state travel card, the employee should complete an application through their agency travel program administrator.

1. The employee's corporate travel card is for official state travel business purposes only. Personal use on the state travel card shall result in disciplinary action.

B. Liability

1. The corporate travel card is the liability of the state. Each monthly statement balance is due in full to the card-issuing bank. The state will have no tolerance to assist those employees who abuse their travel card privileges.

2. The department/agency is responsible for cancellation of corporate travel cards for those employees terminating/retiring from state service.

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§1506. Lodging and Meals

A. Eligibility

1. Official Domicile/Temporary Assignment. Travelers are eligible to receive reimbursement for travel only when away from official domicile or on temporary assignment unless exception is granted in accordance with these regulations. Temporary assignment will be deemed to have ceased after a period of 30 calendar days, and after such period, the place of assignment shall be deemed to be his/her official domicile. He/she shall not be allowed travel and subsistence unless permission to extend the 30-day

period has been previously secured from the commissioner of administration.

2. Extended Stays. For travel assignments approved by the commissioner of administration involving duty for extended periods (31 or more consecutive days) at a fixed location, the reimbursement rates indicated should be adjusted downward whenever possible. Claims for meals and lodging may be reported on a per diem basis supported by lodging receipt. Care should be exercised to prevent allowing rates in excess of those required to meet the necessary authorized subsistence expenses. It is the responsibility of each agency head to authorize only such travel allowances as are justified by the circumstances affecting the travel.

a. The only exemption for travel of 31 days or more which does not require the commissioner of administration's approval are students, professors, or other state employees which are traveling on a grant, scholarship, studying abroad, or any other occasion where funds utilized are other than state general funds. Department head approval is required.

3. Single-Day Travel

a. Meals are not eligible for reimbursements on single-day travel. This means that when an authorized traveler of the state is in travel status where no overnight stay is required, no meals are eligible for reimbursement. Each department head or their designees are to determine the reasonableness of when an overnight stay is justified.

b. However, the department head will be allowed to authorize single-day meal reimbursements on a case-by-case basis or by type(s) of single-day travel when it is determined to be in the best interest of the department. In those cases, the department must keep the approvals in the travel file and must be responsible to take appropriate steps to report the reimbursement as wages to the employee.

c. If a department head or his/her designee determines that single-day meals will be provided for, they must adhere the following allowances. To receive any meal reimbursement on single-day travel, an employee must be in travel status for a minimum of 12 hours.

i. The maximum allowance for meal reimbursement for single-day travel will be \$42:

(a) breakfast and lunch (\$22)—the 12-hours travel duration must begin at or before 6 a.m.;

(b) lunch (\$13)—requires 12-hours duration in travel status;

(c) lunch and dinner (\$42)—the 12-hour travel duration must end at or after 8 p.m.

4. Travel with Over Night Stay (minimum of 12 hours in travel status). Travelers may be reimbursed for meals according to the following schedule:

a. breakfast—when travel begins at/or before 6 a.m. on the first day of travel or extends at/or beyond 9 a.m. on the last day of travel, and for any intervening days;

b. lunch—when travel begins at/or before 10 a.m. on the first day of travel or extends at/or beyond 2 p.m. on the last day of travel, and for any intervening days;

c. dinner—when travel begins at/or before 4 p.m. on the first day of travel or extends at/or beyond 8 p.m. on the last day of travel, and for any intervening days.

5. Alcohol. Reimbursement for alcohol is prohibited.

B. Exceptions

1. Routine Lodging Overage Allowances (receipts required). Department head or his/her designee has the authority to approve actual costs for routine lodging provisions on a case-by-case basis, not to exceed 50 percent over PPM-49 current listed rates. (Note, this authority for increase in allowance is for lodging only and not for any other area of PPM-49.) Justification must be maintained in the file to show that attempts were made with hotels in the area to receive the state/best rate. In areas where the governor has declared an emergency, a department head or his/her designee will have the authority to approve actual routine lodging provisions on a case-by-case basis, not to exceed 75 percent over PPM-49 current listed rates. Each case must be fully documented as to necessity (e.g., proximity to meeting place) and cost-effectiveness of alternative options. Documentation must be readily available in the department's travel reimbursement files.

2. Actual Expenses for State Officers. (Itemized receipts or other supporting documents are required for each item claimed.) State officers and others so authorized by statute (see definition under *state officer*) or individual exception will be reimbursed on an actual expense basis for meals and lodging except in cases where other provisions for reimbursement have been made by statute. Request shall not be extravagant and will be reasonable in relation to the purpose of travel. State officers entitled to actual expense reimbursements are only exempt from meals and lodging rates; they are subject to the time frames and all other requirements as listed in these travel regulations.

C. Meals and Lodging Allowances. Meal rates are not a per diem, only the maximum allowed while in travel status.

1. Meal Allowance (includes tax and tips). Receipts are not required for routine meals within these allowances unless a cash advance was received (see Section 1503.B.2). Number of meals claimed must be shown on travel expense form. For meal rates, the inclusion of suburbs (see definition of *suburb*) shall be determined by the department head or his/her designee on a case-by-case basis (see tier pricing below). Partial meals, such as continental breakfast or airline meals are not considered meals. Note, if a meal is included in a conference schedule, it is part of the registration fee, therefore, an employee cannot request/receive additional reimbursement for that meal. If meals of state officials receiving actual expenses exceed these allowances, itemized receipt are required (see §1506.B.2).

2. Meals with relatives or friends may not be reimbursed unless the host can substantiate costs for providing for the traveler. The reimbursement amount will not automatically be the meal cost for that area, but rather the actual cost of the meal.

Example: The host would have to show proof of the cost of extra food, etc. Cost shall never exceed the allowed meal rate listed for that area.

3. Routine Lodging Allowance. Employees will be reimbursed lodging rate, plus tax and any mandatory surcharge (receipts are required). For lodging rates, the inclusion of suburbs (see definition of *suburb*) shall be determined by the department head on a case-by-case basis. Employees should always attempt to use the tax exempt form located on the state travel website,

<http://www.doa.louisiana.gov/osp/travel/forms/hoteltaxexemption.pdf>, when traveling in-state on official state business and must be used if hotel expenses are being charged to employee's state corporate travel card, the LaCarte card, or the agency's CBA account. When two or more employees on official state business share a lodging room, the state will reimburse the actual cost of the room, subject to a maximum amount allowed for an individual traveler times the number of employees.

4. Lodging with relatives or friends may not be reimbursed unless the host can substantiate costs for accommodating the traveler. The amount will not automatically be the lodging cost for that area, but rather the actual cost of accommodations.

Example: The host would have to show proof of the cost of extra water, electricity, etc. Cost shall never exceed the allowed routine lodging rate listed for that area.

5. Department head or his/her designee's approval must be provided to allow lodging expenses to be direct billed to an agency.

6. Conference Lodging Allowance. Employees may be reimbursed lodging rate, plus tax (other than state of Louisiana tax) and any mandatory surcharge (receipts are required). Department head or his/her designee has the authority to approve the actual cost of conference lodging for a single occupancy standard room when the traveler is staying at the designated conference hotel. If there are multiple designated conference hotels, the lower cost designated conference hotel should be utilized, if available. In the event the designated conference hotel(s) have no room availability, a department head or his/her designee may approve to pay actual hotel cost not to exceed the conference lodging rates for other hotels in the immediate vicinity of the conference hotel. This allowance does not include agency-hosted conference lodging allowances; see §1510 for these allowances. In the event a traveler chooses to stay at a hotel which is not associated with the conference, then the traveler is subject to making reservations and getting reimbursed within the hotel rates allowed in routine lodging only, as listed below.

7. No reimbursements are allowed for functions not relating to a conference (i.e., tours, dances, golf tournaments, etc.).

Tier I	
Breakfast	\$9
Lunch	\$13
Dinner	\$29
Total	\$51
Lodging Area	Routine Lodging
In-State Cities (except as listed)	\$83
Alexandria/Leesville/Natchitoches	\$84
Baton Rouge—EBR	\$97
Covington/Slidell—St.Tammany	\$91
Lake Charles—Calcasieu	\$83
Lafayette	\$83

Tier II	
Breakfast	\$10
Lunch	\$16
Dinner	\$30
Total	\$56

Tier II	
Lodging Area	Routine Lodging
New Orleans— (Orleans, St. Bernard, Jefferson and Plaquemines Parishes)	
July – September	\$108
October – December	\$140
January - June	\$151
Out-of-State (except cities listed in Tier III and IV)	\$91

Tier III	
Breakfast	\$12
Lunch	\$17
Dinner	\$32
Total	\$61
Lodging Area	Routine Lodging
Austin,TX; Atlanta, GA; Cleveland, OH; Dallas/Fort Worth, TX; Denver, CO; Ft. Lauderdale, FL; Hartford, CT; Houston, TX; Kansas City, MO; Los Angeles, CA; Miami, FL; Minneapolis/St. Paul, MN; Nashville, TN; Oakland, CA; Orlando, FL; Philadelphia, PA; Phoenix, AZ; Pittsburgh, PA; Portland, OR, Sacramento, CA; San Antonio, TX; San Diego, CA; Sedona, AZ; St. Louis, MO; Wilmington, DE; all of Alaska and Hawaii; Puerto Rico; Virgin Island; American Samoa; Guam, Saipan	\$120

Tier IV	
Breakfast	\$13
Lunch	\$19
Dinner	\$33
Total	\$65
Lodging Area	Routine Lodging
Baltimore, MD; San Francisco, CA; Seattle, WA; Chicago, IL; Boston, MA	\$175
Alexandria, VA; Arlington, VA; New York City, NY; Washington DC	\$225
International Cities	\$200

AUTHORITY NOTE: Published in accordance with R.S. 39:231.

HISTORICAL NOTE: Written by the Office of the Governor, Division of Administration, November 1, 1972, published LR 1:179 (April 1975), amended LR 1:338 (August 1975), LR 2:312 (October 1976), LR 5:93 (May 1979), LR 6:405 (August 1980), LR 7:7 (January 1981), LR 8:406 (August 1982), LR 15:820 (October 1989), LR 16:965 (November 1990), LR 26:1256 (June 2000), LR 27:807 (June 2001), republished LR 27:1495 (September 2001), LR 28:1130 (June 2002), LR 30:1116 (June 2004 LR 31:1189 (June 2005), LR 32:939 (June 2006), LR 33:967 (June 2007), republished LR 33:1320 (July 2007), amended LR 34:1305 (July 2008), LR 35:1198 (July 2009), LR 36:1654 (July 2010), LR 37:2055 (July 2011), LR 38:1482 (July 2012), LR 39:1667 (July 2013), LR 40:1060 (June 2014).

§1507. Parking and Related Parking Expenses

A. Parking at the Baton Rouge Airport. The state's current contract rate is \$3.50 per day (no receipts required) for parking in the indoor parking garage as well as the outside, fenced parking lot at the Baton Rouge airport. Documentation required to receive the contract price is the airport certificate and a state ID. If the agency does not issue a state ID, the traveler would need a business card and a driver's license, along with the certificate, to be eligible for the state contracted rate. Airport certificate may be found on state travel office's website at <http://www.doa.louisiana.gov/osp/travel/parking/brairport.pdf>. At the agency

discretion an employee may be paid actual expenses up to \$5 per day with a receipt.

B. New Orleans Airport Parking. The state's current contract is with Park-N-Fly and the rate, inclusive of all allowable and approved taxes/fees, etc., will not exceed \$7 per day and \$42 weekly (no receipts required for parking at Park-N-Fly in New Orleans). Promotional code 0050081 must be used to obtain this rate. For on-line reservations, no other documentation will be required to receive this rate. For all "pay when you exit" employees, a state-issued ID or a valid ID with a state business card along with a tax exempt form is required to receive the state contracted rate. At the agency discretion, an employee may be paid actual expenses, at another location, up to \$7 per day with a receipt.

C. Travelers using motor vehicles on official state business may be reimbursed for all other parking, including airport parking, except as listed in Subsections A and B above, ferry fares, and road and bridge tolls. For each transaction over \$5, a receipt is required.

D. Tips for valet parking not to exceed \$2 per day.

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§1508. Reimbursement for Other Expenses

NOTE: These charges are while in travel status only.

A. The following expenses incidental to travel may be reimbursed:

1. communications expenses:

a. for official state business, all business communication costs may be reimbursed (receipts required);

b. for domestic overnight travel, up to \$3 for personal calls upon arrival at each destination and up to \$3 for personal calls every second night after the first night if the travel extends several days;

c. for international travel, up to \$10 for personal calls upon arrival at each destination and up to \$10 for personal calls every second night after the first night if the travel extends several days;

d. internet access charges for official state business from hotels or other travel locations are treated the same as business telephone charges. A department may implement a stricter policy for reimbursement of internet charges. (receipts required).

B. Charges for storage and handling of state equipment (receipts required).

C. Baggage tips:

1. hotel allowances, up to \$3 tip per hotel check-in and \$3 tip per hotel checkout, if applicable;

2. airport allowances, up to \$3 tip for airport outbound departure trip and \$3 tip for inbound departure trip.

D. Luggage Allowances (receipt required). A department head or his designee may approve reimbursement to a traveler for airline charges for first checked bag for a business trip of 5 days or less and for the second checked bag for a 6-10 day business trip and/or any additional baggage which is business-related and required by the department. The traveler must present a receipt to substantiate these charges.

1. Travelers will be reimbursed for excess baggage charges (overweight baggage) only in the following circumstances:

- a. when traveling with heavy or bulky materials or equipment necessary for business;
- b. the excess baggage consists of organization records or property.

NOTE: Traveler should always consider shipping materials to final destination or splitting materials into additional pieces of luggage to avoid the excess baggage charges in order to save their agency costs.

E. Registration fees at conferences (meals that are a designated integral part of the conference may be reimbursed on an actual expense basis with prior approval by the department head).

NOTE: If a meal is included in a conference schedule, it is part of the registration fee; therefore, an employee cannot request/receive additional reimbursement for that meal.

F. Laundry Services. Employees on travel for more than seven days may be reimbursed with department head or his/her designee's approval, up to actual, but reasonable, costs incurred. Receipts are required for reimbursement.

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HISTORICAL NOTE: Written by the Office of the Governor, Division of Administration, November 1, 1972, published LR 1:179 (April 1975), amended LR 1:338 (August 1975), LR 2:312 (October 1976), LR 5:93 (May 1979), LR 6:405 (August 1980), LR 7:7 (January 1981), LR 8:406 (August 1982), LR 15:820 (October 1989), LR 16:965 (November 1990), LR 26:1258 (June 2000), LR 27:808 (June 2001), LR 28:1131 (June 2002), LR 30:1118 (June 2004), LR 31:1190 (June 2005), LR 32:941 (June 2006), republished LR 33:1322 (July 2007), amended LR 34:1307 (July 2008), LR 35:1200 (July 2009), LR 36:1656 (July 2010), LR 37:2058 (July 2011), LR 38:1485 (July 2012), LR 39:1669 (July 2013), LR 40:1062 (June 2014).

§1509. Special Meals

A. Reimbursement designed for those occasions when, as a matter of extraordinary courtesy or necessity, it is appropriate and in the best interest of the state to use public funds for provision of a meal to a person who is not otherwise eligible for such reimbursement and where reimbursement is not available from another source. Requests should be within reason and may include tax and tips. Itemized receipts are required:

1. visiting dignitaries or executive-level persons from other governmental units, and persons providing identified gratuity services to the state. This explicitly does not include normal visits, meetings, reviews, etc., by federal or local representatives;

2. *extraordinary situations* are when state employees are required by their supervisor to work more than a 12-hour weekday or six-hours on a weekend (when such are not normal working hours to meet crucial deadlines or to handle emergencies).

B. All special meals must have prior approval from the commissioner of administration or, for higher education, the

entity head or his designee in order to be reimbursed, unless specific authority for approval has been delegated to a department head for a period not to exceed one fiscal year with the exception in Subsection C, as follows.

C. A department head may authorize a special meal within allowable rates listed under meals, Tier 1, to be served in conjunction with a working meeting of departmental staff. Reasonable tip is allowed if ordered from an outside vendor. No tip should exceed 20%.

D. In such cases, the department will report on a quarterly basis to the commissioner of administration all special meal reimbursements made during the previous three months. For higher education, these reports should be sent to the respective institution of higher education management board. These reports must include, for each special meal, the name and title of the person receiving reimbursement, the name and title of each recipient, the cost of each meal, and an explanation as to why the meal was in the best interest of the state. Renewal of such delegation will depend upon a review of all special meals authorized and paid during the period. Request to the commissioner for special meal authorization must include, under signature of the department head:

1. name and position/title of the state officer or employee requesting authority to incur expenses and assuming responsibility for such;

2. clear justification of the necessity and appropriateness of the request;

3. names, official titles or affiliations of all persons for whom reimbursement of meal expenses is being requested;

4. statement that allowances for meal reimbursement according to these regulations will be followed unless specific approval is received from the commissioner of administration to exceed this reimbursement limitation;

a. all of the following must be reviewed and approved by the department head or his/her designee prior to reimbursement:

i. detailed breakdown of all expenses incurred, with appropriate receipts(s);

ii. subtraction of cost of any alcoholic beverages;

iii. copy of prior written approval from the commissioner of administration or, for higher education, the entity head or his/her designee.

AUTHORITY NOTE: Published in accordance with R.S. 39:231.

HISTORICAL NOTE: Written by the Office of the Governor, Division of Administration, November 1, 1972, published LR 1:179 (April 1975), amended LR 1:338 (August 1975), LR 2:312 (October 1976), LR 5:93 (May 1979), LR 6:405 (August 1980), LR 7:7 (January 1981), LR 8:406 (August 1982), LR 15:820 (October 1989), LR 16:965 (November 1990), LR 26:1258 (June 2000), LR 27:809 (June 2001), LR 28:1132 (June 2002), LR 30:1118 (June 2004), LR 31:1191 (June 2005), republished LR 1322 (July 2007), amended LR 34:1307 (July 2008), LR 35:1200 (July 2009), LR 36:1656 (July 2010), LR 37:2058 (July 2011), LR 38:1485 (July 2012), LR 39:1670 (July 2013), LR 40:1063 (June 2014).

§1510. Agency-Hosted Conferences (both in-state and out-of-state)

A. State-Sponsored Conferences. An agency must solicit three bona fide competitive quotes in accordance with the governor's Executive Order for small purchase.

B. Conference Lunch Allowance. Lunch direct-billed to an agency in conjunction with a state-sponsored conference is to be within the following rates plus mandated gratuity.

Lunch—In-State excluding, New Orleans	\$20
Lunch—New Orleans and Out-of-State	\$25

1. Any other meals such as breakfast and dinner require special approval in accordance with PPM-49, §1509, special meal, and must have prior approval from the commissioner of administration or, for higher education, the entity head or his/her designee.

C. Conference Refreshment Allowance. Cost for break allowances for meeting, conference, or convention are to be within the following rates.

1. Refreshments shall not exceed \$4.50 per person, per morning and/or afternoon sessions. A mandated gratuity may be added if refreshments are being catered.

D. Conference Lodging Allowances. Lodging rates may not exceed \$20 above the current listed routine lodging rates listed for the area in which the conference is being held.

AUTHORITY NOTE: Published in accordance with R.S. 39:231.

HISTORICAL NOTE: Written by the Office of the Governor, Division of Administration, November 1, 1972, published LR 1:179 (April 1975), amended LR 1:338 (August 1975), LR 2:312 (October 1976), LR 5:93 (May 1979), LR 6:405 (August 1980), LR 7:7 (January 1981), LR 8:406 (August 1982), LR 15:820 (October 1989), LR 16:965 (November 1990), LR 26:1256 (June 2000), LR 27:807 (June 2001), republished LR 27:1495 (September 2001), LR 28:1130 (June 2002), LR 30:1116 (June 2004), LR 31:1191 (June 2005), LR 32:941 (June 2006), republished LR 33:1323 (July 2007), amended LR 34:1308 (July 2008), LR 35:1201 (July 2009), LR 36:1657 (July 2010), LR 39:1670 (July 2013), LR 40:1063 (June 2014).

§1511. International Travel

A. International travel must be approved by the commissioner of administration or, for higher education, the entity head or his designee prior to departure, unless specific authority for approval has been delegated to a department head. Requests for approval must be accompanied by a detailed account of expected expenditures (such as room rate, date, meals, local transportation, etc.) and an assessment of the adequacy of this source to meet such expenditures without curtailing subsequent travel plans.

B. International travelers will be reimbursed the Tier IV area rates for meals and lodging, unless U.S. State Department rates are requested and authorized by the commissioner of administration or, for higher education, the entity head or his designee, prior to departure. Itemized receipts are required for reimbursement of meals and

lodging claimed at the U.S. State Department rates, http://aoprals.state.gov/web920/per_diem.asp.

C. It is the agency’s decision, if justification is given, to allow state employees to be reimbursed for a visa and/or immunizations when the traveler is traveling on behalf of the agency/university on official state business. However, it is not considered best practice for the state to reimburse for a passport; therefore, passport reimbursements must be submitted to the department head for approval along with detailed justification as to why this reimbursement is being requested/approved.

AUTHORITY NOTE: Published in accordance with R.S. 39:231.

HISTORICAL NOTE: Written by the Office of the Governor, Division of Administration, November 1, 1972, published LR 1:179 (April 1975), amended LR 1:338 (August 1975), LR 2:312 (October 1976), LR 5:93 (May 1979), LR 6:405 (August 1980), LR 7:7 (January 1981), LR 8:406 (August 1982), LR 15:820 (October 1989), LR 16:965 (November 1990), LR 26:1256 (June 2000), LR 27:807 (June 2001), republished LR 27:1495 (September 2001), LR 28:1130 (June 2002), LR 30:1116 (June 2004), LR 31:1191 (June 2005), LR 32:941 (June 2006), republished LR 33:1323 (July 2007), amended LR 34:1308 (July 2008), LR 35:1201 (July 2009), LR 36:1657 (July 2010), LR 37:2059 (July 2011), LR 38:1486 (July 2012), LR 39:1671 (July 2013), LR 40:1064 (June 2014).

§1512. Waivers

A. The commissioner of administration may waive, in writing, any provision in these regulations when the best interest of the state will be served. All waivers must obtain prior approval, except in emergency situations.

AUTHORITY NOTE: Published in accordance with R.S. 39:231.

HISTORICAL NOTE: Written by the Office of the Governor, Division of Administration, November 1, 1972, published LR 1:179 (April 1975), amended LR 1:338 (August 1975), LR 2:312 (October 1976), LR 5:93 (May 1979), LR 6:405 (August 1980), LR 7:7 (January 1981), LR 8:406 (August 1982), LR 15:820 (October 1989), LR 16:965 (November 1990), LR 26:1259 (June 2000), LR 27:809 (June 2001), LR 28:1132 (June 2002), LR 30:1119 (June 2004), LR 31:1192 (June 2005), republished LR 33:1323 (July 2007), amended LR 34:1308 (July 2008), republished LR 35:1202 (July 2009), amended LR 36:1657 (July 2010), LR 37:2059 (July 2011), LR 38:1487 (July 2012), LR 39:1671 (July 2013), LR 40:1064 (June 2014).

Sandra G. Gillen
Director

1406#033

Emergency Rules

DECLARATION OF EMERGENCY

Department of Children and Family Services Division of Programs Licensing Section

Licensing Class “A” and “B” Regulations
for Child Care Centers (LAC 67:III.Chapter 73)

The Department of Children and Family Services (DCFS), Division of Programs, Licensing Section in accordance with provisions of the Administrative Procedure Act, R.S. 49:953(B) proposes to amend LAC 67:III, Subpart 21, Child Care Licensing, Chapter 73, Sections 7302, 7317, 7355, and 7372. This declaration is necessary to extend the original Emergency Rule since it is effective for a maximum of 120 days and will expire before the Final Rule takes effect. This Emergency Rule extension is effective on July 9, 2014 and will remain in effect until the Final Rule becomes effective.

The department finds it necessary to adopt this emergency rule to correct the unintended consequences on the child care industry that may have resulted from the inadvertent change to the naptime supervision requirements and the implementation of a retroactive timeframe for which a fine may be imposed.

Title 67

SOCIAL SERVICES

Part III. Economic Stability

Subpart 21. Child Care Licensing

Chapter 73. Day Care Centers

Subchapter A. Licensing Class “A” Regulations for Child Care Centers

§7302. Authority

A. - I.2. ...

3. In assessing a fine, any violation of one or more of the above categories which occur during any 24 month period after the adoption of this Section shall be counted in determining whether multiple violations have occurred. For purposes of establishing a history of non-compliance, any violation of one or more of the above categories which occur during any 24 month period shall be counted in determining whether multiple violations have occurred.

I.4.a. - J.4. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:1401 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987), amended by the Department of Social Services, Office of the Secretary, Bureau of Licensing, LR 20:450 (April 1994), LR 24:2345 (December 1998), LR 29:1107 (July 2003), repromulgated by the Department of Social Services, Office of Family Support, LR 33:2755 (December 2007), amended LR 36:332 (February 2010), LR 36:847 (April 2010), amended by the Department of Children and Family Services, Division of Programs, LR 37:811 (March 2011), amended by the Department of Children and Family Services, Division of Programs, Licensing Section, LR 39:66 (January 2013), LR 40:243 (February 2014), effective March 1, 2014, LR 40:

§7317. Supervision

A. - D. ...

E. Children ages one year and above may be grouped together at rest time with one staff in each room supervising the resting children. If two rooms share a common doorway, one staff may supervise the resting children. If the view of the staff supervising the children is obstructed by an object such as a low shelving unit, children shall be checked by sight by staff continually circulating among the resting children.

F. - H. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:1401 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987), amended by the Department of Social Services, Office of the Secretary, Bureau of Licensing, LR 20:450 (April 1994), LR 24:2345 (December 1998), LR 29:1116 (July 2003), repromulgated by the Department of Social Services, Office of Family Support, LR 33:2764 (December 2007), amended by the Department of Children and Family Services, Division of Programs, Licensing Section, LR 40:252 (February 2014), effective March 1, 2014, LR 40:

Subchapter B. Licensing Class “B” Regulations for Child Care Centers

§7355. Authority

A. - I.2. ...

3. In assessing a fine, any violation of one or more of the above categories which occur during any 24 month period after the adoption of this Section shall be counted in determining whether multiple violations have occurred. For purposes of establishing a history of non-compliance, any violation of one or more of the above categories which occur during any 24 month period shall be counted in determining whether multiple violations have occurred.

I.4.a. - J.4. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:1401 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987), amended by the Department of Social Services, Office of the Secretary, LR 18:970 (September 1992), LR 26:1635 (August 2000), repromulgated by the Department of Social Services, Office of Family Support, LR 33:2770 (December 2007), amended LR 36:333 (February 2010), LR 36:849 (April 2010), amended by the Department of Children and Family Services, Division of Programs, Licensing Section, LR 39:66 (January 2013), LR 40:254 (February 2014), effective March 1, 2014, LR 40:

§7372. Supervision

A. - D. ...

E. Children ages one year and above may be grouped together at rest time with one staff in each room supervising the resting children. If two rooms share a common doorway, one staff may supervise the resting children. If the view of the staff supervising the children is obstructed by an object such as a low shelving unit, children shall be checked by sight by staff continually circulating among the resting children.

F. - H. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:1430 et seq.

HISTORICAL NOTE: Promulgated by the Department of Children and Family Services, Division of Programs, Licensing Section, LR 40:263 (February 2014), effective March 1, 2014, amended LR 40:

Suzy Sonnier
Secretary

1406#083

DECLARATION OF EMERGENCY

Department of Health and Hospitals Bureau of Health Services Financing

Disproportionate Share Hospital Payments
Louisiana Low-Income Academic Hospitals
(LAC 50:V.2903 and Chapter 31)

The Department of Health and Hospitals, Bureau of Health Services Financing repeals LAC 50:V.2903 and adopts LAC 50:V.Chapter 31 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

The Department of Health and Hospitals, Bureau of Health Services Financing promulgated Emergency Rules which amended the provisions governing disproportionate share hospital (DSH) payments to hospitals participating in public-private partnerships in the south and north Louisiana areas (*Louisiana Register*, Volume 39, Numbers 7 and 10). As a result of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services' disapproval of the corresponding State Plan Amendments, the department has now determined that it is necessary to repeal the provisions of the July 6, 2013 and October 1, 2013 Emergency Rules governing DSH payments to the hospitals participating in the south and north Louisiana area public-private partnerships.

The department now proposes to amend the provisions governing DSH payments in order to establish payments to Louisiana low-income academic hospitals. This action is being taken to promote the health and welfare of Medicaid recipients by maintaining recipient access to much needed hospital services. It is estimated that implementation of this Emergency Rule will have no fiscal impact for state fiscal year 2013-2014.

Effective May 24, 2014 the Department of Health and Hospitals, Bureau of Health Services Financing amends the provisions governing DSH payments to establish payments to participating Louisiana low-income academic hospitals.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE

Part V. Hospital Services

Subpart 3. Disproportionate Share Hospital Payments

Chapter 29. Public-Private Partnerships

§2903. Payment Methodology

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:

Chapter 31. Louisiana Low-Income Academic

Hospitals

§3101. Qualifying Criteria

A. Hospitals Located Outside of the Lake Charles Metropolitan Statistical Area

1. Effective for dates of service on or after May 24, 2014, a hospital may qualify for this category by:

a. being a private acute care general hospital that is located outside of the Lake Charles metropolitan statistical area (MSA);

b. having uninsured patient utilization, as measured by allowable uninsured inpatient and outpatient charges, greater than 20 percent. Qualification shall be based on uninsured utilization data per the prior state fiscal year date of service time period; and

c. maintaining at least 15 unweighted intern and resident full-time equivalent positions, as reported on the Medicare Cost Report Worksheet E-4, line 6.

B. Hospitals Located In the Lake Charles Metropolitan Statistical Area

1. Effective for dates of service on or after May 24, 2014, a hospital may qualify for this category by:

a. being a private acute care general hospital that is located in the Lake Charles MSA;

b. having uninsured patient utilization, as measured by allowable uninsured inpatient and outpatient charges, greater than 10 percent. To determine qualification in state fiscal year 2014, the first six month dates of service time period (July 1, 2013 through December 31, 2013) shall be used. In subsequent state fiscal years, qualification shall be based on uninsured utilization data per the prior state fiscal year date of service time period; and

c. maintaining at least 20 unweighted intern and resident full-time equivalent positions, as reported on the Medicare Cost Report Worksheet E-4, line 6.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:

§3103. Payment Methodology

A. Each qualifying hospital shall be paid DSH adjustment payments equal to 100 percent of allowable hospital specific uncompensated care costs. Costs, patient specific data, and documentation that qualifying criteria is met shall be submitted in a format specified by the department. Costs and lengths of stay shall be reviewed by

the department for reasonableness before payments are made.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Interested persons may submit written comments to J. Ruth Kennedy, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030 or by email to Medicaid.Policy@la.gov. Ms. Kennedy is responsible for responding to all inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Kathy H. Kliebert
Secretary

1406#001

DECLARATION OF EMERGENCY

Department of Health and Hospitals Bureau of Health Services Financing

Disproportionate Share Hospital Payments Public-Private Partnerships (LAC 50:V.Chapter 29)

The Department of Health and Hospitals, Bureau of Health Services Financing adopts LAC 50:V.Chapter 29 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

The Department of Health and Hospitals, Bureau of Health Services Financing promulgated an Emergency Rule which adopted provisions governing disproportionate share hospital (DSH) payments for non-state owned hospitals in order to encourage them to take over the operation and management of state-owned and operated hospitals that have terminated or reduced services (*Louisiana Register*, Volume 38, Number 11). Participating non-state owned hospitals shall enter into a cooperative endeavor agreement with the department to support this public-private partnership initiative. This Emergency Rule is being promulgated to continue the provisions of the November 1, 2012 Emergency Rule. This action is being taken to promote the health and welfare of Medicaid recipients by maintaining recipient access to much needed hospital services.

Effective June 28, 2014, the Department of Health and Hospitals, Bureau of Health Services Financing adopts provisions to establish DSH payments to non-state owned hospitals participating in public-private partnerships.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE

Part V. Hospital Services

Subpart 3. Disproportionate Share Hospital Payments

Chapter 29. Public-Private Partnerships

§2901. General Provisions

A. Qualifying Criteria. Effective for dates of service on or after November 1, 2012 a hospital may qualify for this category by being:

1. a non-state privately owned and operated hospital that enters into a cooperative endeavor agreement with the Department of Health and Hospitals to increase its provision of inpatient Medicaid and uninsured hospital services by:

a. assuming the management and operation of services at a facility where such services were previously provided by a state owned and operated facility; or

b. providing services that were previously delivered and terminated or reduced by a state owned and operated facility; or

2. a non-state publicly owned and operated hospital that enters into a cooperative endeavor agreement with the Department of Health and Hospitals to increase its provision of inpatient Medicaid and uninsured hospital services by:

a. assuming the management and operation of services at a facility where such services were previously provided by a state owned and operated facility; or

b. providing services that were previously delivered and terminated or reduced by a state owned and operated facility.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:

Interested persons may submit written comments to J. Ruth Kennedy, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030 or by email to MedicaidPolicy@la.gov. Ms. Kennedy is responsible for responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Kathy H. Kliebert
Secretary

1406#057

DECLARATION OF EMERGENCY

Department of Health and Hospitals Bureau of Health Services Financing

Early and Periodic Screening, Diagnosis and Treatment Personal Care Services Removal of Parental Availability (LAC 50:XV.7305)

The Department of Health and Hospitals, Bureau of Health Services Financing amends LAC 50:XV.7305 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Emergency Rule is promulgated in accordance with the

provisions of the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing amended the provisions governing personal care services covered in the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program in order to revise the reimbursement methodology to be consistent with current payment methodologies (*Louisiana Register*, Volume 36, Number 11).

The Department of Health and Hospitals, Bureau of Health Services Financing has now determined that it is necessary to amend the provisions governing EPSDT personal care services in order to revise the recipient qualifications to remove the criteria regarding parental/caregiver availability in the home.

This action is being taken to promote the health and well-being of children by ensuring access to EPSDT personal care services. It is estimated that implementation of this Emergency Rule will reduce expenditures in the Medicaid Program by approximately \$45,034 for state fiscal year 2013-2014.

Effective June 01, 2014, the Department of Health and Hospitals, Bureau of Health Services Financing amends the provisions governing EPSDT personal care services.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE

Part XV. Services for Special Populations

Subpart 5. Early and Periodic Screening, Diagnosis, and Treatment

Chapter 73. Personal Care Services

§7305. Recipient Qualifications

A. - A.3. ...

4. Repealed.

5. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 21:947 (September 1995), repromulgated LR 29:177 (February 2003), amended LR 30:253 (February 2004), LR 40:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Interested persons may submit written comments to J. Ruth Kennedy, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030 or by email to MedicaidPolicy@la.gov. Ms. Kennedy is responsible for responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Kathy H. Kliebert
Secretary

1406#004

DECLARATION OF EMERGENCY

Department of Health and Hospitals Bureau of Health Services Financing

Family Planning Services
(LAC 50:XV.Chapters 251-255)

The Department of Health and Hospitals, Bureau of Health Services Financing amends LAC 50:XV.Chapters 251-257 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

The Department of Health and Hospitals, Bureau of Health Services Financing adopted provisions to establish a new optional eligibility group under the Medicaid State Plan to provide coverage for family planning services and supplies (*Louisiana Register*, Volume 40, Number 6). The department now proposes to amend the provisions governing family planning services to revise and clarify the provisions of the June 20, 2014 Rule.

This action is being taken to avoid sanctions or federal penalties from the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) for noncompliance with federal requirements. It is estimated that implementation of this Emergency Rule will have no fiscal impact in the Medicaid Program for state fiscal year 2013-2014.

Effective June 20, 2014, the Department of Health and Hospitals, Bureau of Health Services Financing amends the provisions governing family planning State Plan services.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE

Part XV. Services for Special Populations

Subpart 17. Family Planning Services

Chapter 251. General Provisions

§25101. Purpose

A. Effective July 1, 2014, the Medicaid Program shall provide coverage of family planning services and supplies under the Medicaid State Plan, to a new targeted group of individuals who are otherwise ineligible for Medicaid. This new optional coverage group may also include individuals receiving family planning services through the Section 1115 demonstration waiver, Take Charge Program, if it is determined that they meet the eligibility requirements for the State Plan family planning services.

B. The primary goals of family planning services are to:

1. increase access to services which will allow improved reproductive and physical health;
2. improved perinatal outcomes; and
3. reduce the number of unintended pregnancies.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:

Chapter 253. Eligibility Criteria

§25301. Recipient Qualifications

A. Recipients who qualify for family planning services in the new categorically needy group include individuals of child bearing age who meet the following criteria:

1. women who are not pregnant and have income at or below 138 percent of the federal poverty level; and
2. men who have income at or below 138 percent of the federal poverty level.
3. Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:

Chapter 255. Services

§25501. Covered Services

A. Medicaid covered family planning services include:

1. seven office visits per year for physical examinations or necessary re-visits as it relates to family planning or family planning-related services;
2. contraceptive counseling (including natural family planning), education, follow-ups and referrals;
3. laboratory examinations and tests for the purposes of family planning and management of sexual health;
4. pharmaceutical supplies and devices to prevent conception, including all methods of contraception approved by the Federal Food and Drug Administration; and

a. Repealed.

5. male and female sterilization procedures and follow-up tests provided in accordance with 42 CFR 441, Subpart F.

c. Repealed

C. Family planning-related services include the diagnosis and treatment of sexually transmitted diseases or infections, regardless of the purpose of the visit at which the disease or infection was discovered. Medicaid covered family planning-related services include:

1. diagnostic procedures, drugs and follow-up visits to treat a sexually transmitted disease, infection or disorder identified or diagnosed at a family planning visit (other than HIV/AIDS or hepatitis);
2. annual family planning visits for individuals, both males and females of child bearing age, which may include:
 - a. a comprehensive patient history;
 - b. physical, including breast exam;
 - c. laboratory tests; and
 - d. contraceptive counseling;
3. vaccine to prevent cervical cancer;
4. treatment of major complications from certain family planning procedures; and
5. transportation services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Center for Medicaid Services (CMS) if it is determined that submission to CMS for review and approval is required.

Interested persons may submit written comments to J. Ruth Kennedy, Bureau of Health Services Financing, P.O.

Box 91030, Baton Rouge, LA 70821-9030 or by email to MedicaidPolicy@la.gov. Ms. Kennedy is responsible for responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Kathy H. Kliebert
Secretary

1406#054

DECLARATION OF EMERGENCY

Department of Health and Hospitals Bureau of Health Services Financing

Hospice Services (LAC 50:XV.Chapters 33-43)

The Department of Health and Hospitals, Bureau of Health Services Financing, amends LAC 50:XV.Chapters 33-43 under the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

As a result of a budgetary shortfall in state fiscal year 2009, the Department of Health and Hospitals, Bureau of Health Services Financing amended the provisions governing the reimbursement methodology for hospice services provided to long-term care residents to reduce the reimbursement rates (*Louisiana Register*, Volume 35, Number 9).

The Department of Health and Hospitals, Bureau of Health Services Financing promulgated an Emergency Rule which amended the provisions governing hospice services in order to bring these provisions into compliance with the requirements of the Patient Protection and Affordable Care Act (PPACA) and also amended the provisions governing prior authorization for hospice services in order to control the escalating costs associated with the Hospice Program (*Louisiana Register*, Volume 38, Number 3). The department promulgated a Notice of Intent which further revised and clarified the provisions governing hospice services (*Louisiana Register*, Volume 39, Number 11). The department subsequently promulgated an Emergency Rule which amended the provisions of the May 1, 2012 Emergency Rule to incorporate the revisions made in the Notice of Intent and to revise the formatting of these provisions in order to ensure that the provisions are promulgated in a clear and concise manner (*Louisiana Register*, Volume 39, Number 11).

The department promulgated an Emergency Rule which amended the November 20, 2013 Emergency Rule to further clarify the provisions governing prior authorization for hospice services (*Louisiana Register*, Volume 40, Number 3). This Emergency Rule is being promulgated to continue the provisions of the March 20, 2014 Emergency Rule. This action is being taken to avoid sanctions from the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services for noncompliance with PPACA requirements, and to avoid a budget deficit in the medical assistance programs.

Effective July 19, 2014, the Department of Health and Hospitals, Bureau of Health Services Financing amends the provisions governing hospice services.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE

Part XV. Services for Special Populations

Subpart 3. Hospice

Chapter 33. Provider Participation

§3301. Conditions for Participation

A. Statutory Compliance

1. Coverage of Medicaid hospice care shall be in accordance with:

a. 42 USC 1396d(o); and

b. the Medicare Hospice Program guidelines as set forth in 42 CFR Part 418.

B. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1466 (June 2002), amended LR 30:1024 (May 2004), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:

Chapter 35. Recipient Eligibility

§3501. Election of Hospice Care

A. ...

B. An election statement must be filed with a particular hospice for the individual who meets the eligibility requirements as set forth in §3501.A above.

1. The election must be filed by the eligible individual or by a person authorized by law (legal representative) to consent to medical treatment for such individual.

a. A legal representative does not have the authority to elect, revoke, or appeal the denial of hospice services if the recipient is able to and wishes to convey a contrary choice.

B.2. - F. ...

G. Election Statement Requirements. The election statement must include:

1. ...

2. the individual's or his/her legal representative's acknowledgment that he or she has been given a full understanding of the palliative rather than curative nature of hospice care, as it relates to the individual's terminal illness;

3. - 4. ...

5. the signature of the individual or his/her legal representative.

H. Duration of Election. An election to receive hospice care will be considered to continue through the initial election period and through the subsequent election periods without a break in care as long as the individual:

1. remains in the care of a hospice;

2. does not revoke the election under the provisions of §3505; and

3. is not discharged from hospice in accordance with §3505.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 19:749 (June 1993), amended LR 28:1466

(June 2002), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:

§3503. Waiver of Payment for Other Services

A. Individuals who are 21 and over, and approved to receive hospice, may not receive any other services that are related to the treatment of the terminal condition or that are equivalent to hospice care, with the exception of long-term personal care services. The hospice provider must provide services to the individual that are comparable to the services they received through Medicaid prior to their election of hospice. These services include, but are not limited to:

1. pharmaceutical and biological services;

2. durable medical equipment; and

a. - c. Repealed.

3. any other services permitted by federal law.

4. The services listed in §3503.A.1-3 are for illustrative purposes only. The hospice provider is not exempt from providing care if an item or category is not listed.

B. Individuals under age 21 who are approved for hospice may continue to receive curative treatments for their terminal illness; however, the hospice provider is responsible to coordinate all curative treatments related to the terminal illness.

1. *Curative Treatments*—medical treatment and therapies provided to a patient with the intent to improve symptoms and cure the patient's medical problem. Antibiotics, chemotherapy, a cast for a broken limb are examples of curative care.

2. Curative care has as its focus the curing of an underlying disease and the provision of medical treatments to prolong or sustain life.

3. The hospice provider is responsible to provide durable medical equipment or contract for the provision of durable medical equipment. Personal care services, extended home health, and pediatric day health care must be coordinated with hospice services pursuant to §3705.C.

C. Individuals who elect hospice services may also receive long-term personal care services (LT-PCS) concurrently. The hospice provider and the LT-PCS provider must coordinate services and develop the patient's plan of care as set forth in §3705.

D. The hospice provider is responsible for making a daily visit to all clients under age 21 and for the coordination of care to assure there is no duplication of services. The daily visit is not required if the person is not in the home due to hospitalization or inpatient respite or inpatient hospice stays.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1467 (June 2002), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:

§3505. Revoking the Election of Hospice Care/Discharge

A. - A.4.b. ...

5. Re-election of Hospice Benefits. If an election has been revoked in accordance with the provisions of this §3505, the individual or his/her representative may at any

time file an election, in accordance with §3501, for any other election period that is still available to the individual.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1467 (June 2002), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:

Chapter 37. Provider Requirements

§3701. Requirements for Coverage

A. To be covered, a certification of terminal illness must be completed as set forth in §3703, the election of hospice care form must be completed in accordance with §3501, and a plan of care must be established in accordance with §3705. A written narrative from the referring physician explaining why the patient has a prognosis of six months or less must be included in the certificate of terminal illness.

B. Prior authorization requirements stated in Chapter 41 of these provisions are applicable to all election periods.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1467 (June 2002), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:

§3703. Certification of Terminal Illness

A. ...

1. For the first 90-day period of hospice coverage, the hospice must obtain a verbal certification no later than two calendar days after hospice care is initiated. If a verbal certification is not obtained within two calendar days following the initiation of hospice care, a written certification must be made within 10 calendar days following the initiation of hospice care. The written certification and notice of election must be obtained before requesting prior authorization for hospice care. If these requirements are not met, no payment is made for the days prior to the certification. Instead, payment begins with the day certification, i.e., the date all certification forms are obtained.

a. - c. Repealed.

2. For the subsequent periods, a written certification must be included in an approved prior authorization packet before a claim may be billed.

a. - 4. Repealed.

B. Face-to-Face Encounter

1. A hospice physician or hospice nurse practitioner must have a face-to-face encounter with each hospice patient whose total stay across all hospices is anticipated to reach the third benefit period. The face-to-face encounter must occur no more than 30 calendar days prior to the third benefit period recertification, and every benefit period recertification thereafter, to gather clinical findings to determine continued eligibility for hospice care.

2. The physician or nurse practitioner who performs the face-to-face encounter with the patient must attest in writing that he or she had a face-to-face encounter with the patient, including the date of that visit. The attestation of the nurse practitioner or a non-certifying hospice physician shall state that the clinical findings of that visit were provided to the certifying physician for use in determining continued eligibility for hospice care.

C. Content of Certifications

1. Certifications shall be based on the physician's or medical director's clinical judgment regarding the normal course of the individual's illness.

2. The certification must specify that the individual's prognosis is for a life expectancy of six months or less if the terminal illness runs its normal course.

3. Written clinical information and other documentation that support the medical prognosis must accompany the certification of terminal illness and must be based on the physician's clinical judgment regarding the normal course of the individual's illness filed in the medical record with the written certification, as set forth in §3703.C.

4. The physician must include a brief written narrative explanation of the clinical findings that support a life expectancy of six months or less as part of the certification and recertification forms, or as an addendum to the certification/recertification forms:

a. if the physician includes an addendum to the certification and recertification forms, it shall include, at a minimum:

- i. the patient's name;
- ii. physician's name;
- iii. terminal diagnosis(es);
- iv. prognosis; and
- v. the name and signature of the IDG member making the referral;

b. the narrative must reflect the patient's individual clinical circumstances and cannot contain check boxes or standard language used for all patients;

c. the narrative associated with the third benefit period recertification and every subsequent recertification must include an explanation of why the clinical findings of the face-to-face encounter support a life expectancy of six months or less, and shall not be the same narrative as previously submitted;

d. prognosis; and

e. the name and signature of the IDG member taking the referral.

5. All certifications and recertifications must be signed and dated by the physician(s), and must include the benefit period dates to which the certification or recertification applies.

D. Sources of Certification

1. For the initial 90-day period, the hospice must obtain written certification statements as provided in §3703.A.1 from:

a. the hospice's medical director or physician member of the hospice's interdisciplinary group; and

b. the individual's referring physician.

i. The referring physician is a doctor of medicine or osteopathy and is identified by the individual, at the time he or she elects to receive hospice care, as having the most significant role in the determination and delivery of the individual's medical care.

ii. The referring physician is the physician identified within the Medicaid system as the provider to which claims have been paid for services prior to the time of the election of hospice benefits.

2. For subsequent periods, the only requirement is certification by either the medical director of the hospice or the physician member of the hospice interdisciplinary group.

E. Maintenance of Records. Hospice staff must make an appropriate entry in the patient's clinical record as soon as they receive an oral certification and file written certifications in the clinical record.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 19:749 (June 1993), amended LR 28:1468 (June 2002), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:

§3705. Plan of Care

A. - B. ...

C. When developing the plan of care (POC), the hospice provider must consult with, and collaborate with the recipient, his/her caregiver, and his/her long-term personal care services provider, and if the recipient is under age 21, his/her extended home nursing provider and/or pediatric day health care provider. If the recipient is receiving any of these services at the time of admission to hospice, the hospice provider must ensure that the POC clearly and specifically details the services and tasks, along with the frequency, to be performed by the non-hospice provider(s), as well as the services and tasks, along with the frequency, that are to be performed by the hospice provider to ensure that services are non-duplicative and that the recipient's needs are being met.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1468 (June 2002), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:

Chapter 39. Covered Services

§3901. Medical and Support Services

A. - A.11.b.iv. ...

c. Inpatient Respite Care Day. An inpatient respite care day is a day on which the individual receives care in an approved facility on a short-term basis, not to exceed five days in any one election period, to relieve the family members or other persons caring for the individual at home. An approved facility is one that meets the standards as provided in 42 CFR §418.98(b). This service cannot be delivered to individuals already residing in a nursing facility.

d. General Inpatient Care Day. A general inpatient care day is a day on which an individual receives general inpatient care in an inpatient facility that meets the standards as provided in 42 CFR §418.98(a) and for the purpose of pain control or acute or chronic symptom management which cannot be managed in other settings.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1468 (June 2002), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:

Chapter 41. Prior Authorization

§4101. Prior Authorization of Hospice Services

A. Prior authorization is required for all election periods as specified in §3501.C of this Subpart. The prognosis of terminal illness will be reviewed. A patient must have a terminal prognosis and not just certification of terminal illness. Authorization will be made on the basis that a patient

is terminally ill as defined in federal regulations. These regulations require certification of the patient's prognosis, rather than diagnosis. Authorization will be based on objective clinical evidence contained in the clinical record which supports the medical prognosis that the patient's life expectancy is six months or less if the illness runs its normal course and not simply on the patient's diagnosis.

1. The Medicare criteria found in local coverage determination (LCD) hospice determining terminal status (L32015) will be used in analyzing information provided by the hospice to determine if the patient meets clinical requirements for this program.

2. Providers shall submit the appropriate forms and documentation required for prior authorization of hospice services as designated by the department in the Medicaid Program's service and provider manuals, memorandums, etc.

B. Written Notice of Denial. In the case of a denial, a written notice of denial shall be submitted to the hospice, recipient, recipient's legal representative, and nursing facility, if appropriate.

C. Reconsideration. Claims will only be paid from the date of the Hospice notice of election if the prior authorization request is received within 10 days from the date of election and is approved. If the prior authorization request is received 10 days or more after the date on the Hospice notice of election, the approved begin date for hospice services is the date the completed prior authorization packet is received.

D. Appeals. If the recipient does not agree with the denial of a hospice prior authorization request, the recipient, the recipient's legal representative, or the hospice on behalf of the recipient, can request an appeal of the prior authorization decision. The appeal request must be filed with the Division of Administrative Law within 30 days from the date of the postmark on the denial letter. The appeal proceedings will be conducted in accordance with the Administrative Procedure Act.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1470 (June 2002), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:

Chapter 43. Reimbursement

§4303. Levels of Care for Payment

A. - B.3. ...

C. Inpatient Respite Care. The inpatient respite care rate is paid for each day the recipient is in an approved inpatient facility and is receiving respite care (see §3901.A.11.c). Respite care may be provided only on an occasional basis and payment for respite care may be made for a maximum of five days at a time including the date of admission but not counting the date of discharge. Payment for the day of discharge in a respite setting shall be at the routine home level-of-care discharged alive rate.

1. ...

2. Respite care may not be provided when the hospice patient is a nursing home resident, regardless of the setting, i.e., long-term acute care setting.

D. General Inpatient Care. Payment at the inpatient rate is made when an individual receives general inpatient care in an inpatient facility for pain control or acute or chronic

symptom management which cannot be managed in other settings. General inpatient care is a short-term level of care and is not intended to be a permanent solution to a negligent or absent caregiver. A lower level of care must be used once symptoms are under control. General inpatient care and nursing facility or intermediate care facility for persons with intellectual disabilities room and board cannot be reimbursed for the same recipient on the same covered days of service. Payment for the day of discharge in a general inpatient setting shall be at the routine home level-of-care discharged alive rate.

1. - 2. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1470 (June 2002), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:

§4305. Hospice Payment Rates

A. - A.2. ...

a. The hospice is paid for other physicians' services, such as direct patient care services, furnished to individual patients by hospice employees and for physician services furnished under arrangements made by the hospice unless the patient care services were furnished on a volunteer basis. The physician visit for the face-to-face encounter will not be reimbursed by the Medicaid Program.

b. - d.ii. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1470 (June 2002), LR 34:441 (March 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:

§4307. Payment for Long Term Care Residents

A. ...

1. who is residing in a nursing facility or intermediate care facility for persons with intellectual disabilities (ICF/ID);

2. who would be eligible under the state plan for nursing facility services or ICF/ID services if he or she had not elected to receive hospice care;

3. ...

4. for whom the hospice agency and the nursing facility or ICF/ID have entered into a written agreement in accordance with the provisions set forth in the licensing standards for hospice agencies (LAC 48:I.Chapter 82), under which the hospice agency takes full responsibility for the professional management of the individual's hospice care and the facility agrees to provide room and board to the individual.

B. - D. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 19:749 (June 1993), amended LR 28:1471 (June 2002), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:1894 (September 2009), LR 40:

§4309. Limitation on Payments for Inpatient Care

A. ...

1. During the 12-month period beginning November 1 of each year and ending October 31, the number of inpatient respite care days for any one hospice recipient may not exceed five days per occurrence.

2. - 2.b. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1472 (June 2002), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:

Interested persons may submit written comments to J. Ruth Kennedy, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030 or by email to Medicaid.Policy@la.gov. Ms. Kennedy is responsible for responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Kathy H. Kliebert
Secretary

1406#058

DECLARATION OF EMERGENCY

Department of Health and Hospitals Bureau of Health Services Financing

Inpatient Hospital Services
Major Teaching Hospitals
Qualifying Criteria
(LAC 50:V.Chapter 13)

The Department of Health and Hospitals, Bureau of Health Services Financing amends LAC 50:V.1301-1309 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

Act 347 of the 2009 Regular Session of the Louisiana Legislature revised the qualifying criteria for major teaching hospitals. In compliance with Act 347, the department amended the provisions governing the qualifying criteria for major teaching hospitals and repromulgated the provisions of the March 20, 2000 Rule governing teaching hospitals in a codified format for inclusion in the *Louisiana Administrative Code (Louisiana Register, Volume 39, Number 2)*. The department promulgated an Emergency Rule which amended the provisions of the February 20, 2013 Rule governing the qualifying criteria for teaching hospitals in order to correlate with Medicare guidelines, and to clarify deadlines for submissions of qualifying documentation and provisions for conversion to private ownership (*Louisiana Register, Volume 39, Number 6*). This Emergency Rule is being promulgated to continue the

provisions of the July 1, 2013 Emergency Rule. This action is being taken to promote the health and welfare of Medicaid recipients by encouraging provider participation in the Medicaid Program to assure sufficient access to hospital services.

Effective June 29, 2014 the Department of Health and Hospitals, Bureau of Health Services Financing amends the provisions governing inpatient hospital services rendered by non-rural, non-state hospitals designated as teaching hospitals.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE

Part V. Hospital Services

Subpart 1. Inpatient Hospital Services

Chapter 13. Teaching Hospitals

Subchapter A. General Provisions

§1301. Major Teaching Hospitals

A. The Louisiana Medical Assistance Program's recognition of a major teaching hospital is limited to facilities having a documented affiliation agreement with a Louisiana medical school accredited by the Liaison Committee on Medical Education (LCME). A major teaching hospital shall meet one of the following criteria:

1. be a major participant in at least four approved medical residency programs and maintain at least 15 intern and resident un-weighted full time equivalent positions. For purposes of this rule full time equivalent positions will be calculated as defined in 42 CFR 413.78. At least two of the programs must be in medicine, surgery, obstetrics/gynecology, pediatrics, family practice, emergency medicine or psychiatry; or

2. maintain at least 20 intern and resident un-weighted full time equivalent positions, with an approved medical residency program in family practice located more than 150 miles from the medical school accredited by the LCME. For purposes of this rule full time equivalent positions will be calculated as defined in 42 CFR 413.78.

B. For the purposes of recognition as a major teaching hospital, a facility shall be considered a "major participant" in a graduate medical education program if it meets the following criteria. The facility must participate in residency programs that:

1. require residents to rotate for a required experience;
a. - c. Repealed.

2. require explicit approval by the appropriate Residency Review Committee (RRC) of the medical school with which the facility is affiliated prior to utilization of the facility; or

a. - c. Repealed.

3. provide residency rotations of more than one sixth of the program length or more than a total of six months at the facility and are listed as part of an accredited program in the *Graduate Medical Education Directory* of the Accreditation Council for Graduate Medical Education (ACGME).

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 39:324 (February 2013), amended LR 40:

§1303. Minor Teaching Hospitals

A. The Louisiana Medical Assistance Program's recognition of a minor teaching hospital is limited to facilities having a documented affiliation agreement with a Louisiana medical school accredited by the LCME. A minor teaching hospital shall meet the following criteria:

1. ...

2. maintain at least six intern and resident un-weighted full time equivalent positions. For purposes of this rule full time equivalent positions will be calculated as defined in 42 CFR 413.78.

B. For the purposes of recognition as a minor teaching hospital, a facility is considered to "participate significantly" in a graduate medical education program if it meets the following criteria. The facility must participate in residency programs that:

1. require residents to rotate for a required experience;
a. - c. Repealed.

2. require explicit approval by the appropriate Residency Review Committee of the medical school with which the facility is affiliated prior to utilization of the facility; or

a. - c.i. Repealed.

3. provide residency rotations of more than one sixth of the program length or more than a total of six months at the facility and are listed as part of an accredited program in the *Graduate Medical Education Directory* of the Accreditation Council for Graduate Medical Education.

a. If not listed, the sponsoring institution must have notified the ACGME, in writing, that the residents rotate through the facility and spend more than one sixth of the program length or more than a total of six months at the facility.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 39:324 (February 2013), amended LR 40:

§1305. Approved Medical Residency Program

A. An approved medical residency program is one that meets one of the following criteria:

1. is approved by one of the national organizations listed in 42 CFR 415.152;

2. may count towards certification of the participant in a specialty or subspecialty listed in the current edition of either of the following publications:

a. The *Directory of Graduate Medical Education Programs* published by the American Medical Association, and available from American Medical Association, Department of Directories and Publications; or

b. The *Annual Report and Reference Handbook* published by the American Board of Medical Specialties, and available from American Board of Medical Specialties;

3. is approved by the Accreditation Council for Graduate Medical Education (ACGME) as a fellowship program in geriatric medicine; or

4. is a program that would be accredited except for the accrediting agency's reliance upon an accreditation standard that requires an entity to perform an induced abortion or require, provide, or refer for training in the performance of

induced abortions, or make arrangements for such training, regardless of whether the standard provides exceptions or exemptions.

B. - B.2. Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 39:324 (February 2013), amended LR 40:

§1307. Graduate Medical Education

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 39:325 (February 2013), repealed LR 40:

§1309. Requirements for Reimbursement

A. Qualification for teaching hospital status shall be re-established at the beginning of each fiscal year.

B. To be reimbursed as a teaching hospital, a facility shall submit a signed "Certification For Teaching Hospital Recognition" form to the Bureau of Health Services, Supplemental Payments Section at least 30 days prior to the beginning of each state fiscal year or at least 30 days prior to the effective date of the conversion of a state owned and operated teaching hospital to private ownership in accordance with a Public/Private Partnership Cooperative Endeavor Agreement that was instituted to preserve graduate medical education training and access to healthcare services for indigent patients.

1. - 3. Repealed.

C. Each hospital which is reimbursed as a teaching hospital shall submit the following documentation with their Medicaid cost report filing:

1. - 2. ...

D. Copies of all affiliation agreements, contracts, payroll records and time allocations related to graduate medical education must be maintained by the hospital and available for review by the state and federal agencies or their agents upon request.

E. If it is subsequently discovered that a hospital has been reimbursed as a major or minor teaching hospital and did not qualify for that peer group for any reimbursement period, retroactive adjustment shall be made to reflect the correct peer group to which the facility should have been assigned. The resulting overpayment will be recovered through either immediate repayment by the hospital or recoupment from any funds due to the hospital from the department.

F. - G. Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 39:325 (February 2013), amended LR 40:

Interested persons may submit written comments to J. Ruth Kennedy, Bureau of Health Service Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030 or by email to MedicaidPolicy@la.gov. Ms. Kennedy is responsible for responding to all inquiries regarding this Emergency Rule. A

copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Kathy H. Kliebert
Secretary

1406#059

DECLARATION OF EMERGENCY

Department of Health and Hospitals Bureau of Health Services Financing

Inpatient Hospital Services
Non-Rural, Non-State Hospitals
Supplemental Payments
(LAC 50:V.953)

The Department of Health and Hospitals, Bureau of Health Services Financing amends LAC 50:V.953 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act and as directed by Act 14 of the 2013 Regular Session of the Louisiana Legislature which states: "The secretary is directed to utilize various cost containment measures to ensure expenditures remain at the level appropriated in this Schedule, including but not limited to precertification, preadmission screening, diversion, fraud control, utilization review and management, prior authorization, service limitations, drug therapy management, disease management, cost sharing, and other measures as permitted under federal law." This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

As a result of a budgetary shortfall in state fiscal year (SFY) 2011, the Department of Health and Hospitals, Bureau of Health Services Financing amended the provisions governing the reimbursement methodology for inpatient hospital services to reduce the reimbursement rates for inpatient hospital services rendered by non-rural, non-state hospitals (*Louisiana Register*, Volume 37, Number 7).

The department promulgated an Emergency Rule which amended the provisions governing the reimbursement methodology for inpatient hospital services to revise the participation requirements for the Low Income and Needy Care Collaboration (*Louisiana Register*, Volume 37, Number 1). The department promulgated an Emergency Rule which amended the provisions governing the reimbursement methodology for inpatient hospital services to adjust the reimbursement rates paid for NICU and PICU services rendered by non-rural, non-state hospitals and to revise the outlier payment methodology (*Louisiana Register*, Volume 37, Number 3). The department promulgated an Emergency Rule which amended the March 1, 2011 Emergency Rule governing the reimbursement methodology for inpatient hospital services to revise the formatting of these provisions in order to ensure that the provisions were promulgated in a clear and concise manner (*Louisiana Register*, Volume 38, Number 8).

In anticipation of a budgetary shortfall in state fiscal year 2013 as a result of the reduction in the state's disaster recovery Federal Medical Assistance Percentage (FMAP) rate, the department promulgated an Emergency Rule which amended the provisions governing the reimbursement methodology for inpatient hospital services to reduce the reimbursement rates paid to non-rural, non-state hospitals (*Louisiana Register*, Volume 38, Number 8). Due to a continuing budgetary shortfall in SFY 2013, the department promulgated an Emergency Rule which amended the provisions governing the reimbursement methodology for inpatient hospital services to further reduce the reimbursement rates paid to non-rural, non-state hospitals (*Louisiana Register*, Volume 39, Number 1).

Due to a continuing budgetary shortfall in SFY 2014, the department promulgated an Emergency Rule which amended the provisions governing the reimbursement methodology for inpatient hospital services to reduce the total supplemental payments pool for non-rural, non-state hospitals and to change the frequency of payments (*Louisiana Register*, Volume 39, Number 11). This Emergency Rule is being promulgated to continue the provisions of the November 20, 2013 Emergency Rule. This action is being taken to avoid a budget deficit in the medical assistance programs.

Effective July 20, 2014, the Department of Health and Hospitals, Bureau of Health Services Financing amends the provisions governing the reimbursement methodology for inpatient hospital services to reduce the supplemental payments pool for non-rural, non-state hospitals.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE

Part V. Hospital Services

Subpart 1. Inpatient Hospital Services

Chapter 9. Non-Rural, Non-State Hospitals

Subchapter B. Reimbursement Methodology

§953. Acute Care Hospitals

A. - H.2. ...

3. - 5. Reserved.

I. - I.2. ...

3. - 5. Reserved

J. - N.2.b. ...

3. - 6. Reserved.

O. - Q.1. ...

R. - S. Reserved.

T. Effective for dates of service on or after November 20, 2013, supplemental payments to non-rural, non-state acute care hospitals that qualify as a high Medicaid hospital shall be annual. The amount appropriated for annual supplemental payments shall be reduced to \$1,000,000. Each qualifying hospital's annual supplemental payment shall be calculated based on the pro rata share of the reduced appropriation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:876 (May 2008), amended LR 34:877 (May 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:1895 (September 2009), LR 35:1896 (September 2009), repromulgated LR 35:2182 (October 2009), amended LR 36:1552 (July 2010), LR 36:2561 (November 2010), LR 37:2161 (July 2011), LR: 40:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Interested persons may submit written comments to J. Ruth Kennedy, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821—9030 or by email to MedicaidPolicy@la.gov. Ms. Kennedy is responsible for responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Kathy H. Kliebert
Secretary

1406#060

DECLARATION OF EMERGENCY

Department of Health and Hospitals Bureau of Health Services Financing

Inpatient Hospital Services
Public-Private Partnerships
Reimbursement Methodology
(LAC 50:V.1703)

The Department of Health and Hospitals, Bureau of Health Services Financing amends LAC 50:V.1703 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

The Department of Health and Hospitals, Bureau of Health Services Financing promulgated an Emergency Rule which amended the provisions governing inpatient hospital services to establish supplemental Medicaid payments to non-state owned hospitals in order to encourage them to take over the operation and management of state-owned and operated hospitals that have terminated or reduced services. Participating non-state owned hospitals shall enter into a cooperative endeavor agreement with the department to support this public-provider partnership initiative (*Louisiana Register*, Volume 39, Number 11). The department promulgated an Emergency Rule which amended the provisions governing the reimbursement methodology for inpatient psychiatric hospital services provided by non-state owned hospitals participating in public-private partnerships (*Louisiana Register*, Volume 39, Number 1). In April 2013, the department promulgated an Emergency Rule to continue the provisions of the January 2, 2013 Emergency Rule (*Louisiana Register*, Volume 39, Number 4).

The department amended the provisions governing the reimbursement methodology for inpatient services provided by non-state owned major teaching hospitals participating in public-private partnerships which assume the provision of services that were previously delivered and terminated or reduced by a state-owned and operated facility to establish an interim per diem reimbursement (*Louisiana Register*, Volume 39, Number 4). In June 2013, the department

determined that it was necessary to rescind the January 2, 2013 and the May 3, 2013 Emergency Rules governing Medicaid payments to non-state owned hospitals for inpatient psychiatric hospital services (*Louisiana Register*, Volume 39, Number 6). The department promulgated an Emergency Rule which amended the provisions of the April 15, 2013 Emergency Rule in order to revise the formatting of these provisions as a result of the promulgation of the June 1, 2013 Emergency Rule to assure that these provisions are promulgated in a clear and concise manner in the *Louisiana Administrative Code* (LAC) (*Louisiana Register*, Volume 39, Number 7). This Emergency Rule is being promulgated to continue the provisions of the July 20, 2013 Emergency Rule. This action is being taken to promote the health and welfare of Medicaid recipients by maintaining recipient access to much needed hospital services.

Effective July 18, 2014, the Department of Health and Hospitals, Bureau of Health Services Financing amends the provisions governing Medicaid payments for inpatient hospital services provided by non-state owned hospitals participating in public-private partnerships.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE

Part V. Hospital Services

Subpart 1. Inpatient Hospital Services

Chapter 17. Public-Private Partnerships

§1703. Reimbursement Methodology

A. Reserved.

B. Effective for dates of service on or after April 15, 2013, a major teaching hospital that enters into a cooperative endeavor agreement with the Department of Health and Hospitals to provide acute care hospital services to Medicaid and uninsured patients and which assumes providing services that were previously delivered and terminated or reduced by a state owned and operated facility shall be reimbursed as follows:

1. The inpatient reimbursement shall be reimbursed at 95 percent of allowable Medicaid costs. The interim per diem reimbursement may be adjusted not to exceed the final reimbursement of 95 percent of allowable Medicaid costs.

C. - E.3. Reserved.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:

Interested persons may submit written comments to J. Ruth Kennedy, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030 or by email to MedicaidPolicy@la.gov. Ms. Kennedy is responsible for responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Kathy H. Kliebert
Secretary

1406#061

DECLARATION OF EMERGENCY

Department of Health and Hospitals Bureau of Health Services Financing

Inpatient Hospital Services
Public-Private Partnerships
South Louisiana Area
(LAC 50:V.1703)

The Department of Health and Hospitals, Bureau of Health Services Financing amends LAC 50:V.1703 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

The Department of Health and Hospitals, Bureau of Health Services Financing promulgated an Emergency Rule which amended the provisions governing inpatient hospital services to establish supplemental Medicaid payments to non-state owned hospitals in order to encourage them to take over the operation and management of state-owned and operated hospitals that have terminated or reduced services. Participating non-state owned hospitals shall enter into a cooperative endeavor agreement with the department to support this public-provider partnership initiative (*Louisiana Register*, Volume 38, Number 11). The department promulgated an Emergency Rule which amended the provisions governing reimbursement for Medicaid payments for inpatient services provided by non-state owned major teaching hospitals participating in public-private partnerships which assume the provision of services that were previously delivered and terminated or reduced by a state owned and operated facility (*Louisiana Register*, Volume 39, Number 4). The department subsequently promulgated an Emergency Rule which amended the provisions governing the reimbursement methodology for inpatient services provided by non-state owned hospitals participating in public-private partnerships to establish payments for hospitals located in the Lafayette and New Orleans areas (*Louisiana Register*, Volume 39, Number 7).

The department now proposes to amend the provisions of the June 24, 2013 Emergency Rule governing inpatient hospital services to remove the provisions governing the cooperative endeavor agreements for Lafayette and New Orleans area hospitals as a result of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services' disapproval of the corresponding State Plan Amendments. This action is being taken to promote the health and welfare of Medicaid recipients by maintaining recipient access to much needed hospital services.

Effective June 20, 2014, the Department of Health and Hospitals, Bureau of Health Services Financing amends the provisions of the June 24, 2013 Emergency Rule governing

the reimbursement methodology for inpatient hospital services provided by non-state owned hospitals participating in public-private partnerships.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE

Part V. Hospital Services

Subpart 1. Inpatient Hospital Services

Chapter 17. Public-Private Partnerships

§1703. Reimbursement Methodology

A. Reserved.

B. Effective for dates of service on or after April 15, 2013, a major teaching hospital that enters into a cooperative endeavor agreement with the Department of Health and Hospitals to provide acute care hospital services to Medicaid and uninsured patients and which assumes providing services that were previously delivered and terminated or reduced by a state owned and operated facility shall be reimbursed as follows:

1. The inpatient reimbursement shall be reimbursed at 95 percent of allowable Medicaid costs. The interim per diem reimbursement may be adjusted not to exceed the final reimbursement of 95 percent of allowable Medicaid costs.

C. Baton Rouge Area Cooperative Endeavor Agreement

1. The Department of Health and Hospitals (DHH) shall enter into a cooperative endeavor agreement (CEA) with a non-state owned and operated hospital to increase its provision of inpatient Medicaid hospital services by providing services that were previously delivered and terminated by the state-owned and operated facility in Baton Rouge.

2. A quarterly supplemental payment shall be made to this qualifying hospital for inpatient services based on dates of service on or after April 15, 2013. Payments shall be made quarterly based on the annual upper payment limit calculation per state fiscal year. Payments shall not exceed the allowable Medicaid charge differential. The Medicaid inpatient charge differential is the Medicaid inpatient charges less the Medicaid inpatient payments (which includes both the base payments and supplemental payments).

3. The qualifying hospital shall provide quarterly reports to DHH that will demonstrate that, upon implementation, the annual Medicaid inpatient quarterly payments do not exceed the annual Medicaid inpatient charges per 42 CFR 447.271. Before the final quarterly payment for each state fiscal year the quarterly reports will be reviewed and verified with Medicaid claims data. The final quarterly payment for each state fiscal year will be reconciled and will be adjusted to assure that the annual payment does not exceed the allowable Medicaid inpatient charge differential.

4. Inpatient services shall be reimbursed at 95 percent of allowable Medicaid costs. The interim per diem reimbursement may be adjusted not to exceed the final reimbursement of 95 percent of allowable Medicaid costs.

D. - E.3. Repealed.

F. - K. Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 39:

Interested persons may submit written comments to J. Ruth Kennedy, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030 or by email to MedicaidPolicy@la.gov. Ms. Kennedy is responsible for responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Kathy H. Kliebert
Secretary

1406#055

DECLARATION OF EMERGENCY

**Department of Health and Hospitals
Bureau of Health Services Financing**

Inpatient Hospital Services
Public-Private Partnerships
Supplemental Payments
(LAC 50:V.Chapter 17)

The Department of Health and Hospitals, Bureau of Health Services Financing adopts LAC 50:V.Chapter 17 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

The Department of Health and Hospitals, Bureau of Health Services Financing promulgated an Emergency Rule which amended the provisions governing inpatient hospital services to establish supplemental Medicaid payments to non-state owned hospitals in order to encourage them to take over the operation and management of state-owned and operated hospitals that have terminated or reduced services (*Louisiana Register*, Volume 38, Number 11). Participating non-state owned hospitals shall enter into a cooperative endeavor agreement with the department to support this public-provider partnership initiative. This Emergency Rule is being promulgated to continue the provisions of the November 1, 2012 Emergency Rule. This action is being taken to promote the health and welfare of Medicaid recipients by maintaining recipient access to much needed hospital services.

Effective June 29, 2014, the Department of Health and Hospitals, Bureau of Health Services Financing adopts provisions to establish supplemental Medicaid payments for inpatient hospital services provided by non-state owned hospitals participating in public-private partnerships.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE

Part V. Hospital Services

Subpart 1. Inpatient Hospital Services

Chapter 17. Public-Private Partnerships

§1701. Qualifying Hospitals

A. Non-State Privately Owned Hospitals. Effective for dates of service on or after November 1, 2012, the department shall provide supplemental Medicaid payments

for inpatient hospital services rendered by non-state privately owned hospitals that meet the following conditions.

1. Qualifying Criteria. The hospital must be a non-state privately owned and operated hospital that enters into a cooperative endeavor agreement with the Department of Health and Hospitals to increase its provision of inpatient Medicaid and uninsured hospital services by:

a. assuming the management and operation of services at a facility where such services were previously provided by a state owned and operated facility; or

b. providing services that were previously delivered and terminated or reduced by a state owned and operated facility.

B. Non-State Publicly Owned Hospitals. Effective for dates of service on or after November 1, 2012, the department shall make supplemental Medicaid payments for inpatient hospital services rendered by non-state publicly owned hospitals that meet the following conditions.

1. Qualifying Criteria. The hospital must be a non-state publicly owned and operated hospital that enters into a cooperative endeavor agreement with the Department of Health and Hospitals to increase its provision of inpatient Medicaid and uninsured hospital services by:

a. assuming the management and operation of services at a facility where such services were previously provided by a state owned and operated facility; or

b. providing services that were previously delivered and terminated or reduced by a state owned and operated facility.

C. Non-State Free-Standing Psychiatric Hospitals. Effective for dates of service on or after November 1, 2012, the department shall make supplemental Medicaid payments for inpatient psychiatric hospital services rendered by non-state privately or publicly owned hospitals that meet the following conditions.

1. Qualifying Criteria. The hospital must be a non-state privately or publicly owned and operated hospital that enters into a cooperative endeavor agreement with the Department of Health and Hospitals to increase its provision of inpatient Medicaid and uninsured psychiatric hospital services by:

a. assuming the management and operation of services at a facility where such services were previously provided by a state owned and operated facility; or

b. providing services that were previously delivered and terminated or reduced by a state owned and operated facility.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40: **§1703. Reimbursement Methodology**

A. Payments to qualifying hospitals shall be made on a quarterly basis in accordance with 42 CFR 447.272.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:

Interested persons may submit written comments to J. Ruth Kennedy, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030 or by email to MedicaidPolicy@la.gov. Ms. Kennedy is responsible for responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Kathy H. Kliebert
Secretary

1406#062

DECLARATION OF EMERGENCY

Department of Health and Hospitals Bureau of Health Services Financing

Intermediate Care Facilities for Persons with
Developmental Disabilities—Public Facilities
Reimbursement Methodology
(LAC 50:VII.32969)

The Department of Health and Hospitals, Bureau of Health Services Financing amends LAC 50:VII.32969 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

The Department of Health and Hospitals, Bureau of Health Services Financing amended the provisions governing the reimbursement methodology for public intermediate care facilities for persons with developmental disabilities (ICFs/DD) to establish a transitional Medicaid reimbursement rate for community homes that are being privatized (*Louisiana Register*, Volume 39, Number 2). This Rule also adopted all of the provisions governing reimbursements to state-owned and operated facilities and quasi-public facilities in a codified format for inclusion in the *Louisiana Administrative Code*.

The department amended the provisions governing the transitional rates for public facilities in order to redefine the period of transition (*Louisiana Register*, Volume 39, Number 10). The department subsequently promulgated an Emergency Rule to assure compliance with the technical requirements of R.S. 49:53, and to continue the provisions of the October 1, 2013 Emergency Rule governing transitional rates for public facilities which redefined the period of transition (*Louisiana Register*, Volume 40, Number 3). This Emergency Rule is being promulgated to continue the provisions of the February 22, 2014 Emergency Rule. This action is being taken to protect the health and welfare of Medicaid recipients transitioning from public ICFs/DD.

Effective June 23, 2014, the Department of Health and Hospitals, Bureau of Health Services Financing amends the provisions governing the reimbursement methodology for public intermediate care facilities for persons with developmental disabilities.

Title 50
PUBLIC HEALTH—MEDICAL ASSISTANCE
Part VII. Long Term Care
Subpart 3. Intermediate Care Facilities for Persons with
Developmental Disabilities
Chapter 329. Reimbursement Methodology
Subchapter C. Public Facilities
§32969. Transitional Rates for Public Facilities

A. - A.4.a. ...

B. The transitional Medicaid reimbursement rate shall only be for the period of transition, which is defined as the term of the CEA or a period of four years, whichever is shorter.

C. - F.4. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 39:326 (February 2013), LR 40:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Interested persons may submit written comments to J. Ruth Kennedy, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030 or by email to MedicaidPolicy@la.gov. Ms. Kennedy is responsible for responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Kathy H. Kliebert
Secretary

1406#063

DECLARATION OF EMERGENCY

Department of Health and Hospitals
Bureau of Health Services Financing

Medical Transportation Program
Emergency Ambulance Services
Supplemental Payments
(LAC 50:XXVII.327 and 355)

The Department of Health and Hospitals, Bureau of Health Services Financing amends LAC 50:XXVII.327 and §355 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

The Department of Health and Hospitals, Bureau of Health Services Financing provides reimbursement for emergency ambulance transportation services. The department promulgated an Emergency Rule which established supplemental payments for governmental ambulance providers who render emergency medical transportation services to low income and needy patients in the state of Louisiana (*Louisiana Register*, Volume 37,

Number 6). The department promulgated an Emergency Rule which amended the provisions of the July 1, 2011 Emergency Rule to allow supplemental payments for all ambulance providers who render emergency medical transportation services to low income and needy patients (*Louisiana Register*, Volume 37, Number 7). The July 20, 2011 Emergency Rule was amended to allow supplemental payments to providers of air ambulance transportation services (*Louisiana Register*, Volume 37, Number 8). The department promulgated an Emergency Rule which rescinded and replaced the July 1, 2011, the July 20, 2011, and the August 20, 2011 Emergency Rules in order to promulgate clear and concise provisions governing supplemental payments for emergency ambulance services (*Louisiana Register*, Volume 37, Number 9). The department promulgated an Emergency Rule which amended the September 20, 2011 Emergency Rule to clarify the provisions governing supplemental payments for emergency ambulance services (*Louisiana Register*, Volume 37, Number 12). The department promulgated an Emergency Rule which amended the December 20, 2011 Emergency Rule to further clarify the provisions governing supplemental payments for emergency ambulance services (*Louisiana Register*, Volume 38, Number 3). After consulting with the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services to secure approval of the corresponding State Plan Amendment, the department promulgated an Emergency Rule which amended the March 20, 2012 Emergency Rule to further clarify the provisions governing supplemental payments for emergency medical transportation services in order to ensure that the administrative Rule is consistent with the approved Medicaid State Plan (*Louisiana Register*, Volume 39, Number 4). This Emergency Rule is being promulgated to continue the provisions of the March 20, 2013 Emergency Rule. This action is being taken to promote the health and welfare of Medicaid recipients by ensuring continued access to emergency ambulance services.

Effective July 17, 2014, the Department of Health and Hospitals, Bureau of Health Services Financing amends the provisions governing supplemental payments for emergency medical transportation services rendered by ambulance providers.

Title 50
PUBLIC HEALTH—MEDICAL ASSISTANCE
Part XXVII. Medical Transportation Program
Chapter 3. Emergency Medical Transportation
Subchapter B. Ground Transportation
§327. Supplemental Payments for Ambulance
Providers

A. Effective for dates of service on or after September 20, 2011, quarterly supplemental payments shall be issued to qualifying ambulance providers for emergency medical transportation services rendered during the quarter.

B. Qualifying Criteria. Ambulance service providers must meet the following requirements in order to qualify to receive supplemental payments. The ambulance service provider must be:

1. licensed by the state of Louisiana;
2. enrolled as a Louisiana Medicaid provider; and
3. a provider of emergency medical transportation or air ambulance services pursuant to 42 CFR 440.170 and a

provider of the corresponding medical and remedial care and services in the approved Medicaid state plan.

4. Repealed.

C. Payment Methodology. The supplemental payment to each qualifying ambulance service provider will not exceed the sum of the difference between the Medicaid payments otherwise made to these qualifying providers for emergency medical transportation and air ambulance services and the average amount that would have been paid at the equivalent community rate.

D. The supplemental payment will be determined in a manner to bring payments for these services up to the community rate level. The community rate is defined as the average amount payable by commercial insurers for the same services.

E. Supplemental Payment Calculation. The following methodology shall be used to establish the quarterly supplemental payment for ambulance providers.

1. The department shall identify Medicaid ambulance service providers that were qualified to receive supplemental Medicaid reimbursement for emergency medical transportation services and air ambulance services during the quarter.

2. For each Medicaid ambulance service provider identified to receive supplemental payments, the department shall identify the emergency medical transportation and air ambulance services for which the Medicaid ambulance service providers were eligible to be reimbursed.

3. For each Medicaid ambulance service provider described in E.1, the department shall calculate the reimbursement paid to the Medicaid ambulance service providers for the emergency medical transportation and air ambulance services identified under E.2.

4. For each Medicaid ambulance service provider described in E.1, the department shall calculate the Medicaid ambulance service provider's equivalent community rate for each of the Medicaid ambulance service provider's services identified under E.2.

5. For each Medicaid ambulance service provider described in E.1, the department shall subtract an amount equal to the reimbursement calculation for each of the emergency medical transportation and air ambulance services under E.3 from an amount equal to the amount calculated for each of the emergency medical transportation and air ambulance services under E.4.

6. For each Medicaid ambulance service provider described in E.1, the department shall calculate the sum of each of the amounts calculated for emergency medical transportation and air ambulance services under E.5.

7. For each Medicaid ambulance service provider described in E.1, the department shall calculate each emergency ambulance service provider's upper payment limit by totaling the provider's total Medicaid payment differential from E.6.

8. The department will reimburse providers based on the following criteria.

a. For ambulance service providers identified in E.1 located in large urban areas and owned by governmental entities, reimbursement will be up to 100 percent of the provider's average commercial rate calculated in E.7.

b. For all other ambulance service providers identified in E.1., reimbursement will be up to 80 percent of the provider's average commercial rate calculated in E.7.

9. - 17. Repealed.

F. Calculation of Average Commercial Rate. The supplemental payment will be determined in a manner to bring payments for these services up to the average commercial rate level.

1. For purposes of these provisions, the average community rate level is defined as the average amount payable by the commercial payers for the same services.

2. The state will align the paid Medicaid claims with the Medicare fees for each HCPCS or CPT code for the ambulance provider and calculate the Medicare payment for those claims. The state will then calculate an overall Medicare to commercial conversion factor for each ambulance provider by dividing the total amount of the average commercial payments for the claims by the total Medicare payments for the claims. The commercial to Medicare ratio for each provider will be re-determined at least every three years.

G. The supplemental payment will be made effective for emergency medical transportation provided on or after September 20, 2011. This payment is based on the average amount that would have been paid at the equivalent community rate. After the initial calculation for fiscal year 2011-2012, the department will rebase the equivalent community rate using adjudicated claims data for services from the most recently completed fiscal year. This calculation may be made annually, but shall be made no less than every three years.

H. The total amount to be paid by the state to qualified Medicaid ambulance service providers for supplemental Medicaid payments shall not exceed the total of the Medicaid payment differentials calculated under §327.E.6 for all qualified Medicaid ambulance service providers.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:

Subchapter C. Air Transportation

§355. Supplemental Payments for Ambulance Providers

A. Effective for dates of service on or after September 20, 2011, quarterly supplemental payments shall be issued to qualifying ambulance providers for emergency medical air transportation services rendered during the quarter.

B. Qualifying Criteria. Ambulance service providers must meet the following requirements in order to qualify to receive supplemental payments. The ambulance service provider must be:

1. licensed by the state of Louisiana;
2. enrolled as a Louisiana Medicaid provider; and
3. a provider of emergency medical transportation or air ambulance services pursuant to 42 CFR 440.170 and a provider of the corresponding medical and remedial care and services in the approved Medicaid state plan.
4. Repealed.

C. Payment Methodology. The supplemental payment to each qualifying ambulance service provider will not exceed the sum of the difference between the Medicaid payments

otherwise made to these qualifying providers for emergency medical transportation and air ambulance services and the average amount that would have been paid at the equivalent community rate.

D. The supplemental payment will be determined in a manner to bring payments for these services up to the community rate level. The community rate is defined as the average amount payable by commercial insurers for the same services.

E. Supplemental Payment Calculation. The following methodology shall be used to establish the quarterly supplemental payment for ambulance providers:

1. The department shall identify Medicaid ambulance service providers that were qualified to receive supplemental Medicaid reimbursement for emergency medical transportation services and air ambulance services during the quarter.

2. For each Medicaid ambulance service provider identified to receive supplemental payments, the department shall identify the emergency medical transportation and air ambulance services for which the Medicaid ambulance service providers were eligible to be reimbursed.

3. For each Medicaid ambulance service provider described in E.1, the department shall calculate the reimbursement paid to the Medicaid ambulance service providers for the emergency medical transportation and air ambulance services identified under E.2.

4. For each Medicaid ambulance service provider described in E.1, the department shall calculate the Medicaid ambulance service provider's equivalent community rate for each of the Medicaid ambulance service provider's services identified under E.2.

5. For each Medicaid ambulance service provider described in E.1, the department shall subtract an amount equal to the reimbursement calculation for each of the emergency medical transportation and air ambulance services under E.3 from an amount equal to the amount calculated for each of the emergency medical transportation and air ambulance services under E.4.

6. For each Medicaid ambulance service provider described in E.1, the department shall calculate the sum of each of the amounts calculated for emergency medical transportation and air ambulance services under E.5.

7. For each Medicaid ambulance service provider described in E.1, the Department shall calculate each emergency ambulance service provider's upper payment limit by totaling the provider's total Medicaid payment differential from B.6.

8. The department will reimburse providers based on the following criteria.

a. For ambulance service providers identified in E.1. located in large urban areas and owned by governmental entities, reimbursement will be up to 100 percent of the provider's average commercial rate calculated in E.7.

b. For all other ambulance service providers identified in E.1., reimbursement will be up to 80 percent of the provider's average commercial rate calculated in E.7.

9. - 17. Repealed.

F. Calculation of Average Commercial Rate. The supplemental payment will be determined in a manner to bring payments for these services up to the average commercial rate level.

1. For purposes of these provisions, the average commercial rate level is defined as the average amount payable by the commercial payers for the same services.

2. The state will align the paid Medicaid claims with the Medicare fees for each HCPCS or CPT code for the ambulance provider and calculate the Medicare payment for those claims. The state will then calculate an overall Medicare to commercial conversion factor for each ambulance provider by dividing the total amount of the average commercial payments for the claims by the total Medicare payments for the claims. The commercial to Medicare ratio for each provider will be re-determined at least every three years.

G. The supplemental payment will be made effective for air ambulance services provided on or after September 20, 2011. This payment is based on the average amount that would have been paid at the equivalent community rate. After the initial calculation for fiscal year 2011-2012, the department will rebase the equivalent community rate using adjudicated claims data for services from the most recently completed fiscal year. This calculation may be made annually, but shall not be made less often than every three years.

H. The total amount to be paid by the state to qualified Medicaid ambulance service providers for supplemental Medicaid payments shall not exceed the total of the Medicaid payment differentials calculated under §327.E.6 for all qualified Medicaid ambulance service providers.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:

Interested persons may submit written comments to J. Ruth Kennedy, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030 or by email to MedicaidPolicy@la.gov. Ms. Kennedy is responsible for responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Kathy H. Kliebert
Secretary

1406#064

DECLARATION OF EMERGENCY

Department of Health and Hospitals Bureau of Health Services Financing

Nursing Facilities
Leave of Absence Days
Reimbursement Reduction
(LAC 50:II.20021)

The Department of Health and Hospitals, Bureau of Health Services Financing amends LAC 50:II.20021 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

The Department of Health and Hospitals, Bureau of Health Services Financing amended the provisions governing reimbursement to nursing facilities to reduce the reimbursement paid to nursing facilities for leave of absence days (*Louisiana Register*, Volume 35, Number 9). The department promulgated an Emergency Rule which amended the provisions governing the reimbursement methodology for nursing facilities to further reduce the reimbursement rates for leave of absence days (*Louisiana Register*, Volume 39, Number 7). This Emergency Rule is being promulgated to continue the provisions of the July 1, 2013 Emergency Rule. This action is being taken to avoid a budget deficit in the medical assistance programs.

Effective June 29, 2014, the Department of Health and Hospitals, Bureau of Health Services Financing amends the provisions governing the reimbursement methodology for nursing facilities to reduce the reimbursement rates for leave of absence days.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE

Part II. Nursing Facilities

Subpart 5. Reimbursement

Chapter 200. Reimbursement Methodology

§20021. Leave of Absence Days

[Formerly LAC:VII.1321]

A. - E. ...

F. Effective for dates of service on or after July 1, 2013, the reimbursement paid for leave of absence days shall be 10 percent of the applicable per diem rate in addition to the provider fee amount.

1. The provider fee amount shall be excluded from the calculations when determining the leave of absence days payment amount.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:1899 (September 2009), amended LR 40:

Interested persons may submit written comments to J. Ruth Kennedy, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030 or by email to MedicaidPolicy@la.gov. Ms. Kennedy is responsible for responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Kathy H. Kliebert
Secretary

1406#065

DECLARATION OF EMERGENCY

Department of Health and Hospitals Bureau of Health Services Financing

Nursing Facilities
Per Diem Rate Reduction
(LAC 50:II.20005)

The Department of Health and Hospitals, Bureau of Health Services Financing amends LAC 50:II.20005 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This

Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

The Department of Health and Hospitals, Bureau of Health Services Financing amended the provisions governing the reimbursement methodology for nursing facilities to reduce the per diem rates paid to non-state nursing facilities in order to remove the rebased amount and sunset the state fiscal year (SFY) 2012-13 nursing facility rate rebasing (*Louisiana Register*, Volume 39, Number 5).

For SFY 2013-14, state general funds are required to continue nursing facility rates at the rebased level. Because of the fiscal crisis facing the state, the state general funds will not be available to sustain the increased rates. Consequently, the department promulgated an Emergency Rule which amended the provisions governing the reimbursement methodology for nursing facilities to further reduce the reimbursement rates for non-state nursing facilities (*Louisiana Register*, Volume 39, Number 7). This Emergency Rule is being promulgated to continue the provisions of the July 1, 2013 Emergency Rule. This action is being taken to avoid a budget deficit in the medical assistance programs.

Effective June 29, 2014, the Department of Health and Hospitals, Bureau of Health Services Financing amends the provisions governing the reimbursement methodology for nursing facilities to reduce the reimbursement rates for non-state nursing facilities.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE

Part II. Nursing Facilities

Subpart 5. Reimbursement

Chapter 200. Reimbursement Methodology

§20005. Rate Determination

[Formerly LAC 50:VII.1305]

A. - I. ...

J. - N. Reserved.

O. ...

P. Effective for dates of service on or after July 1, 2013, the per diem rate paid to non-state nursing facilities, excluding the provider fee, shall be reduced by \$18.90 of the rate in effect on June 30, 2013 until such time that the rate is rebased.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1791 (August 2002), amended LR 31:1596 (July 2005), LR 32:2263 (December 2006), LR 33:2203 (October 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:325 (February 2010), repromulgated LR 36:520 (March 2010), amended LR 36:1556 (July 2010), LR 36:1782 (August 2010), LR 36:2566 (November 2010), LR 37:092 (March 2011), LR 37:1174 (April 2011), LR 37:2631 (September 2011), LR 38:1241 (May 2012), LR 39:1286 (May 2013), LR 40:

Interested persons may submit written comments to J. Ruth Kennedy, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030 or by email to MedicaidPolicy@la.gov. Ms. Kennedy is responsible for responding to inquiries regarding this Emergency Rule. A

copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Kathy H. Kliebert
Secretary

1406#066

DECLARATION OF EMERGENCY

Department of Health and Hospitals Bureau of Health Services Financing

Outpatient Hospital Services
Public-Private Partnerships
Supplemental Payments
(LAC 50:V.Chapter 67)

The Department of Health and Hospitals, Bureau of Health Services Financing adopts LAC 50:V.Chapter 67 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

The Department of Health and Hospitals, Bureau of Health Services Financing promulgated an Emergency Rule which amended the provisions governing outpatient hospital services to establish supplemental Medicaid payments to non-state owned hospitals in order to encourage them to take over the operation and management of state-owned hospitals that have terminated or reduced services (*Louisiana Register*, Volume 38, Number 11). Participating non-state owned hospitals shall enter into a cooperative endeavor agreement with the department to support this public-private partnership initiative. The department promulgated an Emergency Rule which amended the provisions of the November 1, 2012 Emergency Rule to revise the reimbursement methodology in order to correct the federal citation (*Louisiana Register*, Volume 39, Number 3). This Emergency Rule continues the provisions of the March 2, 2013 Emergency Rule. This action is being taken to promote the health and welfare of Medicaid recipients by maintaining recipient access to much needed hospital services.

Effective June 29, 2014, the Department of Health and Hospitals, Bureau of Health Services Financing amends the provisions governing supplemental Medicaid payments for outpatient hospital services provided by non-state owned hospitals participating in public-private partnerships.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE

Part V. Hospital Services

Subpart 5. Outpatient Hospital Services

Chapter 67. Public-Private Partnerships

§6701. Qualifying Hospitals

A. Non-State Privately Owned Hospitals. Effective for dates of service on or after November 1, 2012, the department shall provide supplemental Medicaid payments for outpatient hospital services rendered by non-state privately owned hospitals that meet the following conditions.

1. Qualifying Criteria. The hospital must be a non-state privately owned and operated hospital that enters into a cooperative endeavor agreement with the Department of Health and Hospitals to increase its provision of outpatient Medicaid and uninsured hospital services by:

a. assuming the management and operation of services at a facility where such services were previously provided by a state owned and operated facility; or

b. providing services that were previously delivered and terminated or reduced by a state owned and operated facility.

B. Non-State Publicly Owned Hospitals. Effective for dates of service on or after November 1, 2012, the department shall make supplemental Medicaid payments for outpatient hospital services rendered by non-state publicly owned hospitals that meet the following conditions.

1. Qualifying Criteria. The hospital must be a non-state publicly owned and operated hospital that enters into a cooperative endeavor agreement with the Department of Health and Hospitals to increase its provision of outpatient Medicaid and uninsured hospital services by:

a. assuming the management and operation of services at a facility where such services were previously provided by a state owned and operated facility; or

b. providing services that were previously delivered and terminated or reduced by a state owned and operated facility.

C. Non-State Free-Standing Psychiatric Hospitals. Effective for dates of service on or after November 1, 2012, the department shall make supplemental Medicaid payments for outpatient psychiatric hospital services rendered by non-state privately or publicly owned hospitals that meet the following conditions.

1. Qualifying Criteria. The hospital must be a non-state privately or publicly owned and operated hospital that enters into a cooperative endeavor agreement with the Department of Health and Hospitals to increase its provision of outpatient Medicaid and uninsured psychiatric hospital services by:

a. assuming the management and operation of services at a facility where such services were previously provided by a state owned and operated facility; or

b. providing services that were previously delivered and terminated or reduced by a state owned and operated facility.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:

§6703. Reimbursement Methodology

A. Payments to qualifying hospitals shall be made on a quarterly basis in accordance with 42 CFR 447.321.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:

Interested persons may submit written comments to J. Ruth Kennedy, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030 or by email to MedicaidPolicy@la.gov. Ms. Kennedy is responsible for responding to inquiries regarding this Emergency Rule. A

copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Kathy H. Kliebert
Secretary

1406#067

DECLARATION OF EMERGENCY

Department of Health and Hospitals Bureau of Health Services Financing

Pharmacy Benefits Management Program
Methods of Payment
(LAC 50:XXIX.105 and Chapter 9)

The Department of Health and Hospitals, Bureau of Health Services Financing amends LAC 50:XXIX.105 and Chapter 9 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

The Department of Health and Hospitals, Bureau of Health Services Financing provides coverage and reimbursement for prescription drugs to Medicaid eligible recipients enrolled in the Medicaid Program. Act 10 of the 2009 Regular Session of the Louisiana Legislature provided that the department may redefine the reimbursement methodology for multiple source drugs in establishing the state maximum allowable cost (MAC) in order to control expenditures to the level of appropriations for the Medicaid Program. In accordance with the provisions of Act 10, the department promulgated an Emergency Rule to redefine the Louisiana maximum allowable cost (LMAC) (*Louisiana Register*, Volume 36, Number 1). In addition, the dispensing fee was increased for drugs with an LMAC.

The department subsequently determined that it was necessary to repeal the January 1, 2010 Emergency Rule in its entirety and amend the provisions governing the methods of payment for prescription drugs to redefine the LMAC (*Louisiana Register*, Volume 36, Number 2). The department promulgated an Emergency Rule to amend the February 1, 2010 Emergency Rule to revise the provisions governing the methods of payment for prescription drugs to further redefine the LMAC and increase the dispensing fee (*Louisiana Register*, Volume 36, Number 3). The department determined that it was necessary to repeal the March 1, 2010 Emergency Rule in its entirety and promulgated an Emergency Rule to amend the provisions governing the methods of payment for prescription drugs to revise the LMAC provisions (*Louisiana Register*, Volume 36, Number 3). The department subsequently promulgated an Emergency Rule to repeal the March 20, 2010 Emergency Rule in its entirety in order to revise the provisions governing the methods of payment for prescription drugs and the dispensing fee (*Louisiana Register*, Volume 38, Number 9).

The department promulgated an Emergency Rule which amended the provisions of the September 5, 2012 Emergency Rule to further revise the provisions governing the methods of payment for prescription drugs and the

dispensing fee (*Louisiana Register*, Volume 38, Number 11). This Emergency Rule is being promulgated to continue the provisions of the November 1, 2012 Emergency Rule. This action is being taken to avoid a budget deficit in the medical assistance programs.

Effective June 29, 2014, the Department of Health and Hospitals, Bureau of Health Services Financing amends the provisions governing the methods of payment for prescription drugs covered under the Pharmacy Benefits Management Program.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE

Part XXIX. Pharmacy

Chapter 1. General Provisions

§105. Medicaid Pharmacy Benefits Management

System Point of Sale—Prospective Drug Utilization Program

A. - B. ...

C. Formulary Management. The formulary is managed through the use of federal upper limits (FUL). Federal upper limits provide for dispensing of multiple source drugs at established limitations unless the prescribing physician specifies that the brand product is medically necessary for a patient. Establishment of co-payments also provides for formulary management. The Medicaid Program has established a broad formulary with limited exceptions.

D. Reimbursement Management. The cost of pharmaceutical care is managed through estimated acquisition cost (EAC) of drug ingredient costs through average acquisition cost (AAC) or through wholesale acquisition cost (WAC) when no AAC is assigned; and compliance with federal upper limits regulations, and the establishment of the dispensing fee, drug rebates, and copayments.

E. - H.

I. POS-PRO-DUR Requirements Provider Participation

1. - 5. ...

6. Pharmacy providers and physicians may obtain assistance with clinical questions from the University of Louisiana at Monroe, School of Pharmacy.

I.7. - L. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153, Title XIX of the Social Security Act, and the 1995-96 General Appropriate Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 32:1053 (June 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:

Chapter 9. Methods of Payment

Subchapter A. General Provisions

§901. Definitions

Average Acquisition Cost (AAC)—the average of payments that pharmacists made to purchase a drug product, as determined through the collection and review of pharmacy invoices and other information deemed necessary by the Medicaid Program, and in accordance with applicable state and Federal law.

Average Wholesale Price—Repealed.

* * *

Dispensing Fee—the fee paid by the Medicaid Program to reimburse for the professional services provided by a pharmacist when dispensing a prescription, including the

provider fee assessed for each prescription filled in the state of Louisiana or shipped into the state of Louisiana per legislative mandate.

* * *

Single Source Drug—a drug mandated or sold by one manufacturer or labeler.

Usual and Customary Charge—a pharmacy's charge to the general public that reflects all advertised savings, discounts, special promotions, or other programs, including membership-based discounts initiated to reduce prices for product costs available to the general public, a special population, or an inclusive category of customers.

Wholesale Acquisition Cost (WAC)—the manufacturer's published catalog price for a drug product to wholesalers as reported to Medicaid by one or more national compendia on a weekly basis.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 32:1061 (June 2006), amended LR 34:87 (January 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:1558 (July 2010), LR 40:

Subchapter B. Dispensing Fee

§915. General Provisions

A. The dispensing fee shall be set by the Department and reviewed periodically for reasonableness and, when deemed appropriate by the Medicaid Program, may be adjusted considering such factors as fee studies or surveys.

Adjustment Factors—Repealed.

a. - d. Repealed.

Base Rate—Repealed.

Base Rate Components—Repealed.

Table. Repealed.

a. - d. Repealed.

Maximum Allowable Overhead Cost—Repealed.

Overhead Year—Repealed.

B. Provider participation in the Louisiana Dispensing Fee Survey shall be mandatory. Failure to cooperate in the Louisiana Dispensing Fee Survey by a provider shall result in removal from participation as a provider of pharmacy services in the Medicaid Program. Any provider removed from participation shall not be allowed to re-enroll until a dispensing fee survey document is properly completed and submitted to the bureau.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:1558 (July 2010), amended LR 40:

§917. Maximum Allowable Overhead Cost Calculation

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:1559 (July 2010), repealed LR 40:

§919. Parameters and Limitations

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:1560 (July 2010), repealed LR 40:

§921. Interim Adjustment to Overhead Cost

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:1560 (July 2010), repealed LR 40:

§923. Cost Survey

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:1560 (July 2010), repealed LR 40:

§925. Dispensing Fee

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 32:1064 (June 2006), amended LR 34:88 (January 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:1561 (July 2010), repealed LR 40:

Subchapter C. Estimated Acquisition Cost

§935. Estimated Acquisition Cost Formula

A. *Estimated acquisition cost (EAC)* is the average acquisition cost of the drug dispensed adjusted by a multiplier of 1.1 for multiple source drugs and a multiplier of 1.01 for single-source drugs. If there is not an AAC available, the EAC is equal to the wholesale acquisition cost, as reported in the drug pricing compendia utilized by the department's fiscal intermediary. For department-defined specialty therapeutic classes, the EAC is the Wholesale Acquisition Cost adjusted by a multiplier of 1.05.

B. - B.4c. Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 32:1064 (June 2006), amended LR 34:88 (January 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:1561 (July 2010), LR 40:

Subchapter D. Maximum Allowable Costs

§945. Reimbursement Methodology

A. Maximum Pharmaceutical Price Schedule

1. ...

2. Repealed.

B. Payment will be made for medications in accordance with the payment procedures for any eligible person who has identified himself to the provider by presenting his identification card which shows his eligibility. The department advises participating pharmacists regarding payable medication.

C. - F. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 32:1064 (June 2006), amended LR 34:88

(January 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:1561 (July 2010), LR 40:

§949. Cost Limits

A. - A.3.c. ...

B. The department shall make payments for single source drugs based on the lower of:

- 1. estimated acquisition cost (EAC) plus the dispensing fee; or
- 2. the provider’s usual and customary charges to the general public not to exceed the department’s “maximum pharmaceutical price schedule.” *General public* is defined here as all other non-Medicaid prescriptions including:
 - a. third party insurance;
 - b. pharmacy benefit management; or
 - c. cash.
- 3. Repealed.

C. The department shall make payments for multiple source drugs other than drugs subject to “physician certifications” based on the lower of:

- 1. estimated acquisition cost plus the dispensing fee;
- 2. federal upper limits plus the dispensing fee; or
- 3. the provider’s usual and customary charges to the general public not to exceed the department’s “maximum pharmaceutical price schedule.” *General public* is defined here as all other non-Medicaid prescriptions including:
 - a. third party insurance;
 - b. pharmacy benefit management; or
 - c. cash.
- 4. Repealed.

D. - E.2. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 32:1065 (June 2006), amended LR 34:88 (January 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:1561 (July 2010), LR 40:

Subchapter E. 340B Program

§961. Definitions

Estimated Acquisition Cost (EAC)—the average acquisition cost of the drug dispensed adjusted by a multiplier of 1.1 for multiple source drugs and a multiplier of 1.01 for single-source drugs. If there is not an AAC available, the EAC is equal to the wholesale acquisition cost, as reported in the drug pricing compendia utilized by the department’s fiscal intermediary. For department-defined specialty therapeutic classes, the EAC is the wholesale acquisition cost adjusted by a multiplier of 1.05.

Wholesale Acquisition Cost (WAC)—the manufacturer’s published catalog price for a drug product to wholesalers as reported to Medicaid by one or more national compendia on a weekly basis.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 32:1066 (June 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:

§963. Reimbursement

A. - B. ...

C. Dispensing Fees. The covered entity shall be paid a dispensing fee of \$10.51 for each prescription dispensed to a Medicaid patient. With respect to contract pharmacy arrangements in which the contract pharmacy also serves as the covered entity's billing agent, the contract pharmacy shall be paid the \$10.51 dispensing fee on behalf of the covered entity.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 32:1066 (June 2006), amended LR 34:88 (January 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:1561 (July 2010), LR 40:

Subchapter F. Antihemophilia Drugs

§971. Reimbursement

A. Anti-hemophilia drugs purchased by a covered entity through the 340B Program and dispensed to Medicaid recipients shall be billed to Medicaid at actual 340B acquisition cost plus 10 percent and the dispensing fee unless the covered entity has implemented the Medicaid carve-out option. If the covered entity has implemented the Medicaid carve-out option, such drugs shall be reimbursed at EAC plus the dispensing fee or the billed charges, whichever is less.

B. Anti-hemophilia drugs purchased by a non-340B covered entity shall be reimbursed at EAC plus the dispensing fee.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 23:1066 (June 2006), repealed LR 33:101 (January 2007), amended LR 34:881 (May 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Interested persons may submit written comments to J. Ruth Kennedy, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030 or by email to MedicaidPolicy@la.gov. Ms. Kennedy is responsible for responding to all inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Kathy H. Kliebert
Secretary

1406#068

DECLARATION OF EMERGENCY

Department of Health and Hospitals Bureau of Health Services Financing

Pharmacy Benefits Management Program
State Supplemental Rebate Agreement Program
(LAC 50:XXIX.Chapter 11)

The Department of Health and Hospitals, Bureau of Health Services Financing adopts LAC 50:XXIX.Chapter 11 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

The Department of Health and Hospitals, Bureau of Health Services Financing provides Medicaid coverage of prescription drugs through its Pharmacy Benefits Management Program. The department amended the provisions governing the Pharmacy Benefits Management Program in order to establish provisions for the Medicaid Program's participation in The Optimal PDL Solution (TOP\$) State Supplemental Rebate Agreement Program which is a multi-state Medicaid state supplemental drug rebate pooling initiative (*Louisiana Register*, Volume 39, Number 10). This program allows states to leverage their pharmaceutical purchasing power as a group to achieve more supplemental rebates than could be achieved independently. It is anticipated that this program will lower the net cost of brand drugs and the overall dollars spent on pharmacy benefits. The department promulgated an Emergency Rule to assure compliance with the technical requirements of R.S. 49:953, and to continue the provisions of the October 1, 2013 Emergency Rule governing the Pharmacy Benefits Management Program which established provisions for the Medicaid Program's participation in The Optimal PDL Solution (TOP\$) State Supplemental Rebate Agreement Program (*Louisiana Register*, Volume 40, Number 3). This Emergency Rule is being promulgated to continue the provisions of the February 22, 2014 Emergency Rule. This action is being taken to avoid a budget deficit in the medical assistance programs.

Effective June 23, 2014, the Department of Health and Hospitals, Bureau of Health Services Financing amends the provisions governing the Medicaid coverage of prescription drugs to establish provisions for participation in TOP\$ State Supplemental Rebate Agreement Program.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE

Part XXIX. Pharmacy

Chapter 11. State Supplemental Rebate Agreement Program

§1101. General Provisions

A. Effective October 1, 2013, the Department of Health and Hospitals, Bureau of Health Services Financing hereby establishes provisions for participation in The Optimal PDL Solution (TOP\$) State Supplemental Rebate Agreement (SRA) Program. TOP\$ is a multi-state Medicaid state supplemental drug rebate pooling initiative approved by the U.S. Department of Health and Human Services, Centers for

Medicare and Medicaid Services and administered by Provider Synergies, L.L.C/Magellan Medicaid Administration. The purpose of this program is to allow states the opportunity to leverage their pharmaceutical purchasing power as a group to achieve more supplemental rebates and discounts from prescription drug companies than could be achieved independently.

B. Pursuant to R.S. 46:153.3, the department shall enter into a contractual agreement with Provider Synergies to participate in TOP\$. Provider Synergies/Magellan Medicaid Administration will act on the department's behalf to provide the necessary administration services relative to this agreement for the provision of state supplemental drug rebate contracting and preferred drug list administration services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:

Interested persons may submit written comments to J. Ruth Kennedy, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030 or by email to MedicaidPolicy@la.gov. Ms. Kennedy is responsible for responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Kathy H. Kliebert
Secretary

1406#069

DECLARATION OF EMERGENCY

Department of Health and Hospitals Bureau of Health Services Financing

Prohibition of Provider Steering of
Medicaid Recipients (LAC 50:I.Chapter 13)

The Department of Health and Hospitals, Bureau of Health Services Financing adopts LAC 50:I.Chapter 13 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

The Department of Health and Hospitals, Bureau of Health Services Financing administers the Medicaid Program which provides health care coverage to eligible recipients through Medicaid contracted managed care entities and/or through Medicaid fee-for-service.

The department promulgated an Emergency Rule which adopted provisions prohibiting Medicaid providers and contracted managed care entities from engaging in provider steering in order to ensure the integrity of Medicaid recipients' freedom of choice in choosing a particular health plan in which to enroll and, when eligible, the freedom of choice in deciding whether or not to receive care through Medicaid fee-for-service (*Louisiana Register*, Volume 39, Number 12). This Emergency Rule also established criteria for the sanctioning of providers and managed care entities

who engage in provider steering of Medicaid recipients. The department promulgated an Emergency Rule which amended the December 1, 2013 Emergency Rule in order to clarify these provisions and to incorporate provisions governing provider appeals (*Louisiana Register*, Volume 40, Number 3). This Emergency Rule is being promulgated to continue the provisions of the March 20, 2014 Emergency Rule.

This action is being taken to avoid federal sanctions from the Centers for Medicare and Medicaid Services (CMS) by ensuring the integrity of Medicaid recipients' freedom of choice in choosing a health care provider, and to ensure compliance with the federal regulations which apply to contract requirements contained in 42 CFR §438.104.

Effective July 19, 2014, the Department of Health and Hospitals, Bureau of Health Services Financing amends the provisions governing the prohibition of provider steering of Medicaid Recipients.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE

Part I. Administration

Subpart 1. General Provisions

Chapter 13. Prohibition of Provider Steering

§1301. General Provisions

A. Definitions

Health Plan—any managed care organization (MCO), prepaid inpatient *health plan* (PIHP), prepaid ambulatory *health plan* (PAHP), or primary care case management (PCCM) entity contracted with the Medicaid Program.

Provider—any Medicaid service *provider* contracted with a health plan and/or enrolled in the Medicaid Program.

Provider Steering—unsolicited advice or mass-marketing directed at Medicaid recipients by health plans including any of the entity's employees, affiliated providers, agents, or contractors, that is intended to influence or can reasonably be concluded to influence the Medicaid recipient to enroll in, not enroll in, or disenroll from a particular health plan(s).

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:

§1303. Provider Sanctions

A. First Offense. If the department determines that a provider has participated in provider steering, the department will notify the provider in writing and, at its sole discretion, may impose any of the following sanctions as applicable.

1. If a provider has steered a Medicaid recipient to enroll in a particular managed care health plan, payments to the provider for services rendered to the Medicaid recipient for the time period the recipient's care was coordinated by the health plan may be recouped.

2. If a provider has steered a Medicaid recipient to participate in Medicaid fee-for-service, payments to the provider for services rendered to the recipient for the time period the recipient's care was paid for through Medicaid fee-for-service may be recouped.

3. A provider may be assessed a monetary sanction of up to \$1,000 for each recipient steered to join a particular managed care health plan or to participate in Medicaid fee-for-service. The maximum total penalty per incident shall not exceed \$10,000.

4. A provider may be required to submit a letter to the particular Medicaid recipient notifying him/her of the imposed sanction and his/her right to freely choose another participating managed care health plan or, if eligible, participate in Medicaid fee-for-service.

B. Second Offense

1. If a provider continues to participate in provider steering after having been cited once for provider steering, and receiving one of the above sanctions, that provider may then be subject to disenrollment from the Medicaid program.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:

§1305. Provider Appeal Rights

A. Informal Hearing

1. A provider who has received a notice of sanction shall be provided with an informal hearing if the provider makes a written request for an informal hearing within 15 days of the mailing of the notice of sanction. The request for an informal hearing must be made in writing and sent in accordance with the instructions contained in the notice of sanction. The time and place for the informal hearing will be provided in the notice scheduling the informal hearing.

2. Following the informal hearing, the department shall inform the provider, by written notice, of the results of the informal hearing. The provider has the right to request an administrative appeal within 30 days of the date on the notice of the informal hearing results that is mailed to the provider.

B. Administrative Appeals

1. The provider may seek an administrative appeal of the department's decision to impose sanctions.

2. The request for an administrative appeal must be filed with the Division of Administrative Law within 30 days of the date the written sanction notice is mailed to the provider.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:

§1307. Health Plan Sanctions

A. If the department determines the Health Plan or its subcontractors has participated in provider steering, the department, at its sole discretion, may impose the following sanctions.

1. The member(s) may be disenrolled from the health plan at the earliest effective date allowed.

2. Up to 100 percent of the monthly capitation payment or care management fee for the month(s) the member(s) was enrolled in the health plan may be recouped.

3. The health plan may be assessed a monetary penalty of up to \$5,000 per member.

4. The health plan may be required to submit a letter to each member notifying he member of their imposed sanction and of their right to choose another health plan.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and

Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Interested persons may submit written comments to J. Ruth Kennedy, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030 or by email to MedicaidPolicy@la.gov. Ms. Kennedy is responsible for responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Kathy H. Kliebert
Secretary

1406#070

DECLARATION OF EMERGENCY

Department of Health and Hospitals Bureau of Health Services Financing

Rehabilitation Clinics

Termination of Coverage for Recipients 21 and Older (LAC 50:XI.103 and 301)

The Department of Health and Hospitals, Bureau of Health Services Financing amends LAC 50:XIII.103 and §301 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act and as directed by Act 13 of the 2012 Regular Session of the Louisiana Legislature which states: "The secretary is directed to utilize various cost containment measures to ensure expenditures remain at the level appropriated in this Schedule, including but not limited to precertification, preadmission screening, diversion, fraud control, utilization review and management, prior authorization, service limitations, drug therapy management, disease management, cost sharing, and other measures as permitted under federal law." This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R. S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing repromulgated the provisions governing the covered services and reimbursement paid to rehabilitation clinics in a codified format for inclusion in the *Louisiana Administrative Code* (*Louisiana Register*, Volume 30, Number 5).

Due to a budgetary shortfall in state fiscal year 2013, the Department of Health and Hospitals, Bureau of Health Services Financing promulgated an Emergency Rule which amended the provisions governing rehabilitation clinics in order to terminate the coverage and Medicaid reimbursement of services rendered to recipients 21 years of age and older (*Louisiana Register*, Volume 39, Number 1). In compliance with a court order from the *Melanie Chisholm, et al vs. Kathy Kliebert* class action litigation, the Department of Health and Hospitals, Bureau of Health Services Financing promulgated an Emergency Rule which amended the reimbursement methodology for rehabilitation clinics in order to increase the reimbursement rates for physical and occupational therapy services rendered to recipients under

the age of 21 (*Louisiana Register*, Volume 40, Number 2). The department promulgated an Emergency Rule which amended the provisions of the February 1, 2013 Emergency Rule in order to revise the formatting as a result of the publication of the February 1, 2014 Emergency Rule (*Louisiana Register*, Volume 40, Number 2). This Emergency Rule is being promulgated to continue the provisions of the February 20, 2014 Emergency Rule. This action is being taken to avoid a budget deficit in the medical assistance programs and to ensure that these provisions are published in a clear and concise manner in the *Louisiana Administrative Code*.

Effective June 21, 2014, the Department of Health and Hospitals, Bureau of Health Services Financing amends the provisions governing rehabilitation clinic services rendered to recipients 21 years of age and older in order to terminate coverage of these services.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE

Part XI. Clinic Services

Subpart 1. Rehabilitation Clinics

Chapter 1. General Provisions

§103. Services

A. ...

B. Effective for dates of service on or after February 1, 2013, the department terminates the coverage of all rehabilitation services to recipients 21 years of age and older.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 9:13 (January 1983), repromulgated for inclusion in LAC, LR 30:1021 (May 2004), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:

Chapter 3. Reimbursement

§301. Reimbursement Methodology

A. ...

B. Effective for dates of service on or after February 1, 2013, reimbursement shall not be made for services rendered to recipients 21 years of age and older.

C. - D. Reserved.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 22:109 (February 1996), amended LR 23:731 (June 1997), repromulgated for inclusion in LAC, LR 30:1021 (May 2004), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:

Interested persons may submit written comments to J. Ruth Kennedy, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030 or by email to MedicaidPolicy@la.gov. Ms. Kennedy is responsible for responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Kathy H. Kliebert
Secretary

1406#071

DECLARATION OF EMERGENCY

Department of Health and Hospitals Bureau of Health Services Financing

Targeted Case Management Reimbursement Methodology (LAC 50:XV.10701)

The Department of Health and Hospitals, Bureau of Health Services Financing amends LAC 50:XV.10701 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

As a result of a budgetary shortfall in state fiscal year 2013, the Department of Health and Hospitals, Bureau of Health Services Financing amended the provisions governing the reimbursement methodology for targeted case management (TCM) services to reduce the reimbursement rates and to revise these provisions as a result of the promulgation of the January 2013 Emergency Rules which terminated Medicaid reimbursement of TCM services provided to first-time mothers in the Nurse Family Partnership Program and TCM services rendered to HIV disabled individuals (*Louisiana Register*, Volume 39, Number 12).

The department has now determined that it is necessary to amend the provisions governing the reimbursement methodology for TCM services provided to New Opportunities Waiver (NOW) recipients in order to adopt a payment methodology based on a flat monthly rate rather than 15-minute increments. This action is being taken to promote the health and welfare of NOW participants by ensuring continued access to Medicaid covered services. It is estimated that implementation of this Emergency Rule will have no fiscal impact on expenditures in the Medicaid Program for state fiscal year 2014-2015.

Effective July 1, 2014, the Department of Health and Hospitals, Bureau of Health Services Financing amends the provisions governing reimbursement methodology for TCM for NOW services.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE

Part XV. Services for Special Populations

Subpart 7. Targeted Case Management

Chapter 107. Reimbursement

§10701. Reimbursement

A. - H.3.a. ...

I. - J. Reserved

K. Effective for dates of service on or after July 1, 2014, reimbursement for case management services provided to participants in the New Opportunities Waiver shall be reimbursed at a flat rate for each approved unit of service.

1. The standard unit of service is equivalent to one month and covers both service provision and administrative costs.

- a. Service provision includes the core elements in:
 - i. §10301 of this Chapter;
 - ii. the case management manual; and

iii. contracted performance agreements.

2. All services must be prior authorized.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:1040 (May 2004), amended LR 31:2032 (August 2005), amended LR 35:73 (January 2009), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:1903 (September 2009), amended LR 36:1783 (August 2010), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Public Health, LR 39:97 (January 2013), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 39:3302 (December 2013), LR 40:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Interested persons may submit written comments to J. Ruth Kennedy, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821—9030 or by email to MedicaidPolicy@la.gov. Ms. Kennedy is responsible for responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Kathy H. Kliebert
Secretary

1406#056

DECLARATION OF EMERGENCY

Department of Wildlife and Fisheries Wildlife and Fisheries Commission

2014-15 Resident Honorably Discharged Veterans Deer Season on Private Lands

In accordance with the emergency provisions of R.S. 49:953 of the Administrative Procedure Act, and under the authority of R.S. 56:115 and 116, the Wildlife and Fisheries Commission hereby adopts the following Emergency Rule:

Currently, special open deer seasons are provided for youth and physically challenged hunters. These seasons are set prior to the opening weekend of regular firearms season. In response to HB 1284 of the 2014 Regular Legislative Session, an additional special season will be provided for Louisiana residents who are honorably discharged veterans of the U.S. Armed Forces. This season shall run concurrently with the open Youth Season in all zones, and shall be restricted to hunting on private lands.

Therefore, the Wildlife and Fisheries Commission hereby adopts adding the following dates for a special Resident Honorably Discharged Veterans Deer Season on private lands:

Areas 1, 4, 5, 6, and 9: Oct. 25-31

Area 2: Oct. 11-17

Areas 3, 7, 8, and 10: Sept. 27-Oct. 3.

This action is being taken pursuant to the Administrative Procedure Act, R.S. 49:953(H), which allows for the

Louisiana Wildlife and Fisheries Commission to employ the timetables and provisions utilized for a Declaration of Emergency when promulgating rules and regulations relative to hunting seasons.

Billy Broussard
Chairman

1406#037

DECLARATION OF EMERGENCY

Department of Wildlife and Fisheries Wildlife and Fisheries Commission

Large Shark Closure

In accordance with the emergency provisions of R.S. 49:953, the Administrative Procedure Act, R.S. 49:967 which allows the Department of Wildlife and Fisheries and the Wildlife and Fisheries Commission to use emergency procedures to set finfish seasons, R.S. 56:326.3 which provides that the Wildlife and Fisheries Commission may set seasons for saltwater finfish, and the authority given to the secretary of the department by the commission in its rule LAC 76:VII.357.M.2 which allows the secretary authority to modify seasons to maintain consistency with the adjacent federal waters, and that such closure order shall close the season until the date projected for the re-opening of that fishery in the adjacent federal waters, the Secretary of the Department of Wildlife and Fisheries hereby declares:

Effective 11:30 p.m., June 30, 2014, the commercial fishery for Large Coastal Sharks in Louisiana waters, as described in LAC 76:VII.357.B.2, (great hammerhead, scalloped hammerhead, smooth hammerhead, nurse shark, blacktip shark, bull shark, lemon shark, sandbar shark, silky shark, spinner shark and tiger shark) will close and remain closed until January 1, 2015, at which time the season is scheduled to reopen. This closure will not pertain to persons holding a federal shark research permit issued by NOAA Fisheries Service, when those persons are legally fishing under the regulations promulgated for that permit including that a NMFS-approved observer is aboard the vessel. Nothing herein shall preclude the legal harvest of large coastal sharks by legally licensed recreational fishermen during the open season for recreational harvest. Effective with this closure, no person shall commercially harvest, possess, purchase, exchange, barter, trade, sell or attempt to purchase, exchange, barter, trade or sell large coastal sharks, whether taken from within or without Louisiana waters, except for a federal shark research permit holder, when legally operating under that permit. Also effective with the closure, no person shall possess large coastal sharks in excess of a daily bag limit whether taken from within or without Louisiana waters, which may only be in possession during the open recreational season. Nothing shall prohibit the possession or sale of fish legally taken prior to the closure, or from federal shark research permit holders, provided that all commercial dealers possessing large coastal sharks taken legally prior to the closure shall maintain appropriate records in accordance with R.S. 56:306.5 and R.S. 56:306.6.

The secretary has been notified by NOAA Fisheries Service that the harvest of large coastal sharks in the federal

waters of the Gulf of Mexico closed at 11:30 p.m. local time on May 20, 2014, and will be closed until January 1, 2015, at which time the season is scheduled to reopen. Establishing this closure is necessary to ensure that compatible regulations are in effect, and to increase effectiveness of enforcement operations.

Robert Barham
Secretary

1406#003

DECLARATION OF EMERGENCY

Department of Wildlife and Fisheries Wildlife and Fisheries Commission

Recreational and Commercial Fisheries Closure

In accordance with the emergency provisions of R.S. 49:953 of the Administrative Procedure Act, and under the authority of R.S. 56:6.1, the Wildlife and Fisheries Commission hereby closes all commercial fishing, effective immediately June 5, 2014 in the following areas:

Those waters north of 28 degrees 56 minutes 30 seconds north latitude and south of 28 degrees 59 minutes 30 seconds north latitude from the eastern shore of Southwest Pass of the Mississippi River eastward to a line beginning at 28 degrees 59 minutes 30 seconds west longitude and -89 degrees 19 minutes 50 seconds west longitude and ending at 28 degrees 56 minutes 30 seconds north latitude and -89 degrees 23 minutes 00 seconds west longitude; and, those waters north of 29 degrees 02 minutes 00 seconds north latitude and south of 29 degrees 02 minutes 20 seconds north latitude from the western shore of South Pass of the Mississippi River westward to -89 degrees 15 minutes 25 seconds west longitude; and, those waters north of 28 degrees 59 minutes 40 seconds north latitude and south of 29 degrees 02 minutes 00 seconds north latitude from the western shore of South Pass of the Mississippi River westward to -89 degrees 15 minutes 25 seconds west longitude and southeastward along a line beginning at 29 degrees 02 minutes 00 seconds north latitude and -89 degrees 15 minutes 25 seconds west longitude and ending at 28 degrees 59 minutes 40 seconds north latitude and -89 degrees 10 minutes 15 seconds west longitude; and, those waters west of the western shore of South Pass of the Mississippi River south of 28 degrees 59 minutes 40 seconds north latitude bounded by the following coordinates: 1) 28 degrees 59 minutes 15 seconds north latitude and -89 degrees 08 minutes 15 seconds west longitude, 2) 28 degrees 58 minutes 20 seconds north latitude and -89 degrees 10 minutes 00 seconds west longitude, 3) 28 degrees 59 minutes 01 seconds north latitude and -89 degrees 11 minutes 00 seconds west longitude, 4) 28 degrees 59 minutes 40 seconds north latitude and -89 degrees 10 minutes 15 seconds west longitude; and, those waters east of the eastern shore of South Pass of the Mississippi River and south of 29 degrees 01 minutes 50 seconds north latitude eastward to a line beginning at 29 degrees 01 minutes 50 seconds north latitude and -89 degrees 07 minutes 20 seconds west longitude and ending at 28 degrees 59 minutes 35 seconds north latitude and -89 degrees 08 minutes 00 seconds west longitude; and, those waters adjacent to but not

including Northeast Pass and Southeast Pass of the Mississippi River and bounded by the following coordinates: 1) 29 degrees 08 minutes 35 seconds north latitude and -89 degrees 04 minutes 20 seconds west longitude, 2) 29 degrees 08 minutes 15 seconds north latitude and -89 degrees 02 minutes 10 seconds west longitude, 3) 29 degrees 04 minutes 50 seconds north latitude and -89 degrees 04 minutes 10 seconds west longitude, 4) 29 degrees 05 minutes 30 seconds north latitude and -89 degrees 05 minutes 10 seconds west longitude; and, those waters south and west of Pass a Loutre of the Mississippi River and east of -89 degrees 05 minutes 35 seconds west longitude bounded by the following coordinates: 1) 29 degrees 11 minutes 25 seconds north latitude and -89 degrees 03 minutes 30 seconds west longitude, 2) 29 degrees 11 minutes 00 seconds north latitude and -89 degrees 02 minutes 25 seconds west longitude, 3) 29 degrees 09 minutes 00 seconds north latitude and -89 degrees 05 minutes 35 seconds west longitude, 4) 29 degrees 11 minutes 00 seconds north latitude and -89 degrees 05 minutes 35 seconds west longitude; and, those waters south of North Pass of the Mississippi River bounded by the following coordinates: 1) 29 degrees 11 minutes 35 seconds north latitude and -89 degrees 02 minutes 55 seconds west longitude, 2) 29 degrees 12 minutes 35 seconds north latitude and -89 degrees 01 minutes 05 seconds west longitude, 3) 29 degrees 11 minutes 35 seconds north latitude and -89 degrees 01 minutes 10 seconds west longitude, 4) 29 degrees 11 minutes 10 seconds north latitude and -89 degrees 02 minutes 00 seconds west longitude; and, those state inside and outside waters adjacent to Grand Terre Island bounded by the following coordinates: 1) 29 degrees 18 minutes 20 seconds north latitude and -89 degrees 54 minutes 50 seconds west longitude, 2) 29 degrees 17 minutes 10 seconds north latitude and -89 degrees 53 minutes 50 seconds west longitude, 3) 29 degrees 15 minutes 40 seconds north latitude and -89 degrees 56 minutes 00 seconds west longitude, 4) 29 degrees 17 minutes 00 seconds north latitude and -89 degrees 57 minutes 20 seconds west longitude; and, those state inside waters in the upper Barataria Basin north of 29 degrees 26 minutes 00 seconds north latitude and south of 29 degrees 29 minutes 00 seconds north latitude from -89 degrees 50 minutes 00 seconds west longitude westward to -89 degrees 57 minutes 00 seconds west longitude; and, that portion of state outside waters seaward a distance of one-half mile from the inside/outside shrimp line from the western shore of Caminada Pass at -90 degrees 02 minutes 46.597 seconds west longitude westward to the eastern shore of Belle Pass at -90 degrees 13 minutes 30 seconds west longitude; and that portion of state outside waters seaward a distance of one-half mile from the shoreline from the southwestern shore of Grand Terre Island 2 at -89 degrees 54 minutes 04 seconds west longitude; thence eastward along the shoreline to the southeastern shore of Grand Terre Island 2 at -89 degrees 51 minutes 39 seconds west longitude; thence eastward along

29 degrees 18 minutes 46 seconds north latitude to -89 degrees 51 minutes 19 seconds west longitude.

Recreational fishing is open in all state inside and outside territorial waters, except in the following areas, where only recreational angling, charter boat angling and the harvest of bait by wholesale/retail seafood dealers who hold a special bait dealers permit and who harvest bait for sale to recreational fishermen exclusively, pursuant to the provisions of LAC 76:VII.329 is allowed: those state inside and outside waters adjacent to Grand Terre Island bounded by the following coordinates: 1) 29 degrees 18 minutes 20 seconds north latitude and -89 degrees 54 minutes 50 seconds west longitude, 2) 29 degrees 17 minutes 10 seconds north latitude and -89 degrees 53 minutes 50 seconds west longitude, 3) 29 degrees 15 minutes 40 seconds north latitude and -89 degrees 56 minutes 00 seconds west longitude, 4) 29 degrees 17 minutes 00 seconds north latitude and -89 degrees 57 minutes 20 seconds west longitude; and, those state inside waters in the upper Barataria Basin north of 29 degrees 26 minutes 00 seconds north latitude and south of 29 degrees 29 minutes 00 seconds north latitude from -89 degrees 50 minutes 00 seconds west longitude westward to -89 degrees 57 minutes 00 seconds west longitude; and, that portion of state outside waters seaward a distance of one-half mile from the inside/outside shrimp line from the western shore of Caminada Pass at -90 degrees 02 minutes 46.597 seconds west longitude westward to the eastern shore of Belle Pass at -90 degrees 13 minutes 30 seconds west longitude; and, those state outside waters seaward a distance of one-half mile from the shoreline from the southwestern shore of Grand Terre Island 2 at -89 degrees 54 minutes 04 seconds west longitude; thence eastward along the shoreline to the southeastern shore of Grand Terre Island 2 at -89 degrees 51 minutes 39 seconds west longitude; thence eastward along 29 degrees 18 minutes 46 seconds north latitude to -89 degrees 51 minutes 19 seconds west longitude.

The Deepwater Horizon drilling rig accident has resulted in a significant release of hydrocarbon pollutants into the waters offshore of southeast Louisiana and these pollutants have the potential to impact fish and other aquatic life in portions of these coastal waters. Efforts have been made and are continuing to be made to minimize the potential threats to fish and other aquatic life.

The commission hereby grants authority to the Secretary of the Department of Wildlife and Fisheries to open, close, reopen-reclose, broaden or otherwise modify the areas closed and opened to fishing if biological, environmental and technical data indicate the need to do so, or as needed to effectively implement the provisions herein.

Billy Broussard
Chairman

1406#038

Rules

RULE

Department of Health and Hospitals Board of Dentistry

Moderate Sedation, Minimal Education Requirements,
Facilities, Personnel and Equipment
(LAC 46:XXXIII.Chapter 15)

In accordance with the applicable provisions of the Administrative Procedure Act, R.S. 49:950 et seq., the Dental Practice Act, R.S. 37:751 et seq., and particularly R.S. 37:760 (8), the Department of Health and Hospitals, Board of Dentistry has amended LAC 46:XXXIII.1505, 1509, and 1511.

Title 46

PROFESSIONAL AND OCCUPATIONAL STANDARDS

Part XXXIII. Dental Health Profession

Chapter 15. Anesthesia/Analgesia Administration

§1505. Moderate Sedation with Parenteral Drugs

A. In order to receive a permit to administer moderate sedation with parenteral drugs the dentist shall:

1. meet all of the minimal educational requirements specified in LAC 46:XXXIII.1509; and

2. successfully complete a personally attended advanced training program beyond the pre-doctoral dental school level accredited by the Commission on Dental Accreditation of the American Dental Association which includes anesthesiology and related academic subjects as required in §1505 of this Chapter; or

3. utilize the services of a third-party medical doctor or doctor of osteopathy, who specializes in anesthesiology, third-party certified registered nurse anesthetist, or an oral and maxillofacial surgeon who is permitted by the board to administer moderate sedation, deep sedation, and general anesthesia provided that the third-party anesthetist must remain on the premises of the dental facility until any patient given parenteral drugs is sufficiently recovered; or

4. successfully complete a board-approved personally attended continuing education course as described in part III of the American Dental Association guidelines for teaching the comprehensive control of pain and anxiety in dentistry provided the applicant has held a license to practice dentistry for a minimum of three years. The board has determined that 80 hours of clinical airway management would be a minimum to achieve competency as described in part III of the previously mentioned guidelines.

B. In addition to the requirements of Subsection A of this Section, the dentist must provide proof of current certification in cardiopulmonary resuscitation, course "advanced cardiac life support" (ACLS) as defined by the American Heart Association, or its equivalent. The board will only accept an ACLS course which includes a practical component which is personally attended.

C. In addition to the requirements of Subsections A and B, the dentist shall provide proof of current certification in pediatric advanced life support (PALS) when administering sedation to patients under the age of 13. The board will only accept a PALS course which includes a practical component which is personally attended.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:760(8).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Dentistry, LR 20:659 (June 1994), amended LR 22:1216 (December 1996), LR 33:2653 (December 2007), LR 38:1958 (August 2012), LR 39:90 (January 2013), LR 40:1094 (June 2014).

§1509. Minimal Educational Requirements for the Granting of Permits to Administer Nitrous Oxide Inhalation Analgesia, Moderate Sedation with Parenteral Drugs and General Anesthesia/Deep Sedation

A. - A.3. ...

B. Moderate Sedation with Parenteral Drugs

1. To be granted a moderate sedation with parenteral drugs permit, the applicant's training must be personally attended. Online or correspondence courses are not acceptable; and the applicant must submit verification of successful completion of formal post-doctoral training in the use of parenteral drugs via the intramuscular (IM), submucosal (SM), intranasal (IN), subcutaneous (SC), and moderate IV sedation routes of administration and competency to handle all emergencies relating to parenteral sedation providing such program consists of a minimum of 60 hours of instruction and 100 hours of clinical experience which includes at least 20 documented cases of parenteral sedation.

C. - D. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:760(8).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Dentistry, LR 20:659 (June 1994), amended LR 22:1216 (December 1996), LR 32:244 (February 2006), LR 37:590 (February 2011), LR 37:2151 (July 2011), LR 38:1958 (August 2012), LR 39:90 (January 2013), LR 40:1094 (June 2014).

§1511. Required Facilities, Personnel and Equipment for Sedation Procedures

A. - A.7.d. ...

e. pulse oximeter when parenteral or enteral moderate sedation on a patient is performed;

f. ...

g. working electrocardiograph and defibrillator when general anesthesia or deep sedation is utilized.

8. - 8.i. ...

j. oxygen; and

k. 50 percent dextrose or other antihypoglycemic.

B. - B.5. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:760(8).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Dentistry, LR 20:659 (June 1994), amended LR 32:244 (February 2006), LR 37:1407 (May 2011), 39:91 (January 2013), LR 39:2753 (October 2013), LR 40:1094 (June 2014).

Peyton B. Burkhalter
Executive Director

1406#089

RULE

Department of Health and Hospitals Board of Pharmacy

Prescription Monitoring Program Delegates (LAC 46:LIII.Chapter 29)

In accordance with the provisions of the Administrative Procedure Act (R.S. 49:950 et seq.) and the Pharmacy Practice Act (R.S. 37:1161 et seq.), and pursuant to the provisions of Act 110 of the 2013 Legislature, the Louisiana Board of Pharmacy has amended several Sections within Chapter 29, Prescription Monitoring Program, of its rules, to allow prescribers and dispensers to appoint delegates for the purpose of accessing and retrieving information from the prescription monitoring program database.

Title 46

PROFESSIONAL AND OCCUPATIONAL STANDARDS

Part LIII. Pharmacists

Chapter 29. Prescription Monitoring Program

Subchapter A. General Operations

§2901. Definitions

A. As used in this Chapter, the following terms shall have the meaning ascribed to them unless the context clearly indicates otherwise.

* * *

Delegate—a person authorized by a prescriber or dispenser who is also an authorized user (as described in §2917 of this Chapter) to access and retrieve program data for the purpose of assisting the prescriber or dispenser, and for whose actions the authorizing prescriber or dispenser retains accountability.

* * *

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1011.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Pharmacy, LR 33:1345 (July 2007), amended LR 36:755 (April 2010), effective September 1, 2010, LR 39:314 (February 2013), LR 40:1095 (June 2014).

Subchapter C. Access to Prescription Monitoring Information

§2917. Authorized Direct Access Users of Prescription Monitoring Information

A. The following persons may access prescription monitoring information in the same or similar manner, and for the same or similar purposes, as those persons are authorized to access similar protected health information under federal and state law and regulation:

1. persons authorized to prescribe or dispense controlled substances or drugs of concern, and their delegates, for the purpose of providing medical or pharmaceutical care for their patients, or for verifying their prescription records;

2. - 5. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1011

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Pharmacy, LR 33:1347 (July 2007), amended LR 39:315 (February 2013), LR 40:1095 (June 2014).

§2919. Registration Procedures for Authorized Direct Access Users

A. Authorized users of prescription monitoring information, and their delegates, shall comply with the following requirements to register with the board, in order to receive the appropriate credentials to access prescription monitoring information.

1. - 5. ...

6. Prescribers and dispensers approved for access shall be responsible for the enabling and/or disabling of access privileges for their delegates, as well as the supervision of their activities.

AUTHORITY NOTE: Promulgated by R.S. 40:1011.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Pharmacy, LR 33:1347 (July 2007), amended LR 40:1095 (June 2014).

§2921. Methods of Access to Prescription Monitoring Information

A. Prescribers and dispensers as well as their delegates, once properly registered, may solicit prescription monitoring information from the program concerning their patients, or for verifying their prescription records. The program may require such users to certify the legitimacy of their inquiry prior to furnishing the requested information.

B. - H. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1011.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Pharmacy, LR 33:1347 (July 2007), amended LR 39:315 (February 2013), LR 40:1095 (June 2014).

§2923. Unlawful Use or Disclosure of Prescription Monitoring Information

A. If the program receives evidence of inappropriate or unlawful use or disclosure of prescription monitoring information by an authorized user or his delegate, the program shall refer that user to the appropriate professional licensing, certification, or regulatory agency for administrative sanctions as deemed appropriate by that agency.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1011.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Pharmacy, LR 33:1348 (July 2007), amended LR 40:1095 (June 2014).

Malcolm J Broussard
Executive Director

1406#023

RULE

**Department of Health and Hospitals
Board of Pharmacy**

**Veterinarian Exclusion from Prescription Monitoring
Program (LAC 46:LIII.Chapter 29)**

In accordance with the provisions of the Administrative Procedure Act (R.S. 49:950 et seq.) and the Pharmacy Practice Act (R.S. 37:1161 et seq.), and pursuant to the provisions of Act 27 of the 2013 Legislature, the Louisiana Board of Pharmacy has amended two Sections within Chapter 29, Prescription Monitoring Program, of its rules, to exclude veterinarians from any participation in the program and to exempt them from any reporting or other requirements from the program.

Title 46

**PROFESSIONAL AND OCCUPATIONAL
STANDARDS**

Part LIII. Pharmacists

Chapter 29. Prescription Monitoring Program

Subchapter A. General Operations

§2901. Definitions

A. As used in this Chapter, the following terms shall have the meaning ascribed to them unless the context clearly indicates otherwise.

* * *

Dispenser—a person authorized by this state to dispense or distribute to the ultimate user any controlled substance or drug monitored by the program, but shall not include any of the following:

- a. - d. ...
- e. Repealed.

* * *

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1011.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Pharmacy, LR 33:1345 (July 2007), amended LR 36:755 (April 2010), effective September 1, 2010, LR 39:314 (February 2013), LR 40:1096 (June 2014).

§2909. Advisory Council

A. The advisory council shall consist of the following members, each of whom may appoint a designee:

- 1. - 4. ...
- 5. Repealed;
- 6. - 25. ...
- 26. Repealed.

B. - C.6. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1005.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Pharmacy, LR 33:1346 (July 2007), amended LR 39:314 (February 2013), LR 40:1096 (June 2014).

Malcolm J Broussard
Executive Director

1406#022

RULE

**Department of Health and Hospitals
Bureau of Health Services Financing**

**Coordinated Care Network
Recipient Participation
(LAC 50:I.3103 and 3105)**

The Department of Health and Hospitals, Bureau of Health Services Financing has amended LAC 50:I.3103 and §3105 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE

Part I. Administration

Subpart 3. Medicaid Coordinated Care

Chapter 31. Coordinated Care Network

§3103. Recipient Participation

A. The following Medicaid recipients shall be mandatory participants in coordinated care networks:

1. - 1.c. ...

d. uninsured women under the age of 65 who have been screened through the Centers for Disease Control National Breast and Cervical Cancer Early Detection Program and identified as being in need of treatment for breast and/or cervical cancer, including pre-cancerous conditions and early stage cancer, and are not otherwise eligible for Medicaid;

e. ...

f. Reserved.

2. ...

a. individuals and families who have more income than is allowed for Medicaid eligibility, but who meet the standards for the Regular Medically Needy Program; and

3. individuals receiving hospice services who are not otherwise excluded because of their status as a Medicare dual eligible recipient, or a resident of a long-term care facility (nursing facility or intermediate care facility for persons with intellectual disabilities).

B. Voluntary Participants

1. Participation in a CCN is voluntary for:

a. - a.i. ...

ii. an Indian health program or urban Indian program operated by a tribe or tribal organization under a contract, grant, cooperative agreement or compact with the Indian Health Service;

b. - b.iv. ...

v. enrolled in the Family Opportunity Act Medicaid Buy-In Program;

c. individuals who receive home and community-based waiver services; and

d. children under the age of 21 who are listed on the new opportunities waiver request for services registry. These children are identified as Chisholm class members.

i. For purposes of these provisions, Chisholm class members shall be defined as those children identified in the *Melanie Chisholm, et al vs. Kathy Kliebert* (or her successor) class action litigation.

2. Chisholm class members and home and community-based waiver recipients shall be exempt from the auto-assignment process and must proactively seek enrollment into an available health plan.

C. ...

D. Participation Exclusion

1. The following Medicaid and/or CHIP recipients are excluded from participation in a CCN and cannot voluntarily enroll in a CCN. Individuals who:

- a. are both Medicare and Medicaid recipients;
- b. reside in a long-term care facility (nursing facility or intermediate care facility for persons with intellectual disabilities);
- c. receive services through the Program of All-Inclusive Care for the Elderly (PACE);
- d. have a limited period of eligibility such as eligibility through the Spend-down Medically Needy Program or emergency services only;
- e. are participants in the Take Charge Family Planning Waiver Program;
- f. are eligible through the Tuberculosis Infected Individual Program; or
- g. are enrolled in the Louisiana Health Insurance Premium Payment (LaHIPP) Program.
- h. - j. Repealed.

E. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:1573 (June 2011), amended LR 40:310 (February 2014), LR 40:1096 (June 2014).

§3105. Enrollment Process

A. - D.2. ...

E. Selection of a CCN

1. - 2. ...

a. Recipients who fail to choose a CCN shall be automatically assigned to a CCN by the enrollment broker and the CCN shall be responsible to assign the member to a PCP if a PCP is not selected at the time of enrollment into the CCN.

i. Recipients of home and community-based services and Chisholm class members shall be exempt from automatic assignment to a CCN.

3. - 4.b. ...

c. Recipients who fail to make a selection will be automatically assigned to a participating CCN in their area, with the exception of recipients of home and community-based services and Chisholm class members.

d. ...

F. Automatic Assignment Process

1. ...

a. mandatory CCN participants that fail to select CCN and voluntary participants that do not exercise their option not to participate in the CCN program within the minimum 30 day window, with the exception of recipients of home and community-based services and Chisholm class members;

F.1.b. - I.3. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:1574 (June 2011), amended LR 40:310 (February 2014), LR 40:1097 (June 2014).

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Kathy H. Kliebert
Secretary

1406#077

RULE

**Department of Health and Hospitals
Bureau of Health Services Financing**

Family Planning Services
(LAC 50:XV.Chapters 251-257)

The Department of Health and Hospitals, Bureau of Health Services Financing has adopted LAC 50:XV.Chapters 251-257 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE

Part XV. Services for Special Populations

Subpart 17. Family Planning Services

Chapter 251. General Provisions

§25101. Purpose

A. Effective July 1, 2014, the Medicaid Program shall provide coverage of family planning services and supplies under the Medicaid state plan, to a new targeted group of individuals who are otherwise ineligible for Medicaid. This new optional coverage group will also include individuals currently receiving family planning services through the section 1115 demonstration waiver, Take Charge Program, at the time the new family planning state plan option becomes effective.

B. The primary goals of family planning services are to:

- 1. increase access to services which will allow management of reproductive health;
- 2. reduce the number of unintended pregnancies; and
- 3. reduce Medicaid expenditures for prenatal and delivery related services for women in the targeted population.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:1097 (June 2014).

Chapter 253. Eligibility Criteria

§25301. Recipient Qualifications

A. Recipients who qualify for family planning services in the new categorically needy group include men and women of any age who meet the following criteria:

- 1. women who are not pregnant; and

2. have income at or below 214 percent of the federal poverty level; or

3. women who would have been eligible for the approved section 1115 family planning demonstration waiver, Take Charge Program.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:1097 (June 2014).

Chapter 255. Services

§25501. Covered Services

A. Family planning services are services and supplies that prevent or delay pregnancy. Medicaid covered family planning services include:

1. four office visits per year for physical examinations or necessary re-visits as it relates to family planning and birth control;

2. counseling, education, follow-ups and referrals;

3. laboratory examinations and tests for the purposes of family planning; and

4. pharmaceutical supplies and devices to prevent conception, including:

a. all methods of contraception approved by the federal Food and Drug Administration;

b. male and female sterilization procedures provided in accordance with 42 CFR 441, Subpart F; and

c. natural family planning.

C. Family planning-related services may be provided when conducted as part of a visit for the purpose of delivering family planning services or as a follow-up to a visit for the purpose of delivering family planning services. Medicaid-covered family planning-related services include:

1. diagnostic procedures and treatment of sexually-transmitted diseases and infections;

2. annual family planning visits for women of child bearing age, men and teens, which may include:

a. a comprehensive patient history;

b. physical;

c. laboratory tests; and

d. contraceptive counseling; and

3. transportation services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:1098 (June 2014).

§25503. Service Delivery

A. Family planning services may be delivered through any enrolled Medicaid provider whose scope of practice includes family planning services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:1098 (June 2014).

Chapter 257. Reimbursement

§25701. Reimbursement Methodology

A. All Medicaid providers, including federally qualified health centers, rural health clinics and tribal 638 facilities, shall be reimbursed according to the established fee-for-service rates published in the Medicaid fee schedule for family planning services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:1098 (June 2014).

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Center for Medicaid Services (CMS) if it is determined that submission to CMS for review and approval is required.

Kathy H. Kliebert
Secretary

1406#078

RULE

Department of Health and Hospitals Bureau of Health Services Financing and Office of Aging and Adult Services

Home and Community-Based Services Waivers
Freedom of Choice (LAC 50:XXI.Chapter 1)

The Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services have adopted LAC 50:XXI.Chapter 1 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE Part XXI. Home and Community Based Services Waivers

Subpart 1. General Provisions

Chapter 1. Freedom of Choice

§101. General Provisions

A. The Department of Health and Hospitals may remove a service provider from the waiver provider freedom of choice list and offer freedom of choice to waiver participants when:

1. one or more of the following departmental proceedings are pending against a waiver participant's service provider:

a. revocation of the provider's home and community-based services license;

b. exclusion from the Medicaid Program;

c. termination from the Medicaid Program; or

d. withholding of Medicaid reimbursement as authorized by the department's surveillance and utilization review (SURS) Rule (LAC 50:I.Chapter 41);

2. the service provider fails to timely renew its home and community-based services license as required by the home and community-based services providers licensing standards Rule (LAC 48:I.Chapter 50); or

3. the Louisiana Attorney General's Office has seized the assets of the service provider.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 40:1098 (June 2014).

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Kathy H. Kliebert
Secretary

1406#079

RULE

Department of Health and Hospitals Bureau of Health Services Financing

Hospital Licensing Standards
Alternative Birthing Units
(LAC 48:I.9551-9567)

The Department of Health and Hospitals, Bureau of Health Services Financing has adopted LAC 48:I.9551-9567 in the Medical Assistance Program as authorized by R.S. 36:254 and 40:2100-2115. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

Title 48

PUBLIC HEALTH—GENERAL

Part I. General Administration

Subpart 3. Licensing and Certification

Chapter 95. Hospitals

Subchapter U. Alternative Birthing Units

§9551. General Provisions

A. An alternative birthing unit (ABU) is a unit that is housed within a licensed hospital that provides both obstetrical and neonatal intensive care unit (NICU) level one status at that location. The ABU shall be its own designated unit, separate and apart from any other unit within the hospital.

B. An ABU shall be in compliance with the:

1. American Midwifery Certification Board;
2. American Academy of Pediatrics; and
3. American College of Obstetrics and Gynecology guidelines.

C. An ABU shall be in compliance with all federal, state and local statutes, laws, rules, regulations and ordinances as applicable.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:1099 (June 2014).

§9553. Definitions

Active Labor—contractions resulting in progressive effacement and dilation of the cervix.

Alternative Birthing Unit (ABU)—a unit located within a hospital in which delivery is expected following a low risk, normal, and uncomplicated pregnancy. Care and services provided prior to, during, and following childbirth are under the direction of a certified nurse midwife.

Antepartum Care (Prenatal Care)—occurring or existing before birth. The prenatal period (also known as antenatal care) refers to the regular medical and nursing care recommended for women during pregnancy. Prenatal care is

a type of preventative care with the goal of providing regular check-ups that allow doctors or certified nurse midwives to treat and prevent potential health problems throughout the course of the pregnancy.

Certified Nurse Midwife (CNM)—an advanced practice registered nurse educated in the disciplines of nursing and midwifery and certified according to a nationally recognized certifying body, such as the American College of Nurse Midwives Certification Council, as approved by the Board, and who is authorized to manage the nurse midwifery care of newborns and women in the antepartum, intrapartum, postpartum and/or gynecological periods pursuant to Title 46, Part XLVII, Chapter 45, §4503.B.1 et seq.

Complications—any condition as defined by the medical staff/governing body that contraindicates continued care in the alternative birthing center.

Doula—a nonmedical person, certified by Doula of North America (DONA) who assists a woman before, during or after childbirth, as well as her partner and/or family, by providing information, physical assistance and emotional support.

Family—individuals selected by the pregnant woman to be present and/or in attendance during her admission to the ABU.

Intrapartum—the period beginning with active labor to the expulsion of the placenta.

Licensed Practitioner—for purposes of this Rule refers to a licensed physician and/or a certified nurse midwife.

Low Risk Pregnancy—a normal uncomplicated term pregnancy as determined by a generally accepted course of prenatal care. The expectation of a normal uncomplicated birth as shall be defined by the medical staff/governing body.

Medical Director—a physician licensed to practice medicine by the Louisiana State Board of Medical Examiners (LSBME), who is board certified as an obstetrician and gynecologist (OB/GYN) and credentialed and privileged for the hospital's obstetrical/gynecological services.

Postmature—gestational age of greater than 42 weeks.

Postpartum—the period beginning immediately after childbirth.

Preterm—prior to the thirty-seventh week of gestation.

Term—gestational age of greater or equal to 37 weeks.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:1099 (June 2014).

§9555. Program Requirements

A. An ABU shall have policies/procedures and written criteria for the evaluation of risk status, admission, transfer, discharge, and complications requiring medical or surgical intervention. The policies/procedures and written criteria shall be developed, implemented, enforced, monitored, and reviewed annually by the clinical staff and approved by the governing body.

1. In order for a pregnant woman to be admitted to an ABU, the following admission requirements must be met.

a. The pregnancy shall be deemed low-risk by the licensed practitioner with the expectation of a singleton, vertex, and spontaneous vaginal birth at term without complication.

b. The pregnant woman shall have had consistent prenatal care which began no later than 28 weeks gestation with consistent prenatal screening.

c. A maternal/fetal assessment performed by the CNM shall be completed and documented within one hour of admission to the ABU.

2. The facility shall have policies and procedures readily available in the event the condition of the mother and/or newborn require transfer to an acute care unit within the hospital or emergent transfer to another hospital.

3. The facility shall have policies and procedures for discharge planning of the mother and newborn.

B. A patient who meets any of the following criteria/conditions shall not be admitted for delivery in an ABU:

1. females below 18 years of age;

2. a patient with any of the below documented condition(s) in the maternal medical history, based on an assessment by a licensed practitioner:

a. cardiovascular disease;

b. pulmonary disease and/or history of pulmonary embolus;

c. renal disease;

d. insulin-dependent diabetes;

e. bleeding disorder or hemolytic disease;

f. fetal malpresentation;

g. placenta previa;

h. preeclampsia;

i. oligohydramnios;

j. polyhydramnios;

k. ruptured membranes greater than 18 hours prior to onset of labor;

l. previous Rh sensitization;

m. vaginal birth following C-section (VBAC);

n. multiple births;

o. preterm labor;

p. post-maturity; or

q. fetal abnormality; or

3. a patient with a high risk pregnancy as determined by a licensed practitioner.

C. The following services shall be prohibited in the ABU:

1. general, intravenous, and/or conductive analgesia/anesthesia to include spinal and epidural analgesia/anesthesia;

2. conscious sedation;

3. caesarean sections and operative obstetrics to include tubal ligations;

4. stimulation or augmentation with chemical agents, e.g., oxytocin during the first and second stages of labor; and

5. vacuum extractors and/or forceps.

D. Prenatal Screening Requirements

1. Pregnant women shall be screened by either/or an OB/GYN, a certified nurse midwife (CNM), or an advanced practice registered nurse (APRN). Documentation of the screening shall include, but not be limited to:

a. social, family, medical, reproductive, nutritional, drug and alcohol use;

b. violence screen, depression screen and mental health history;

c. physical examination to include Papanicolaou smear and assessment for sexually transmitted diseases as determined by a licensed practitioner;

d. a prenatal laboratory profile to include a:

i. complete blood count, blood type and Rh antibody screen;

ii. glucose tolerance test;

iii. urinalysis; and

iv. other diagnostic testing as medically indicated; and

e. a repeat evaluation of the hemoglobin or hematocrit between 28 and 36 weeks gestation.

E. Newborn Requirements. The ABU shall be in compliance with current state laws, rules and regulations for screening of newborn health conditions.

F. Patient and/or Patient's Family Educational Requirements. The following educational programs are required to be completed by the patient and/or patient's family as determined by the policy and procedures of the ABU prior to discharge:

1. anticipated physiological and psychological changes during pregnancy;

2. fetal development;

3. normal nutrition;

4. warning signs of pregnancy complications;

5. self-care to include:

a. information on the dangers of smoking, alcohol and substance abuse; and

b. the need for dental care;

6. stages of labor;

7. non-pharmacologic techniques to promote comfort and relaxation during labor;

8. delivery process;

9. newborn care;

10. normal postpartum;

11. bonding;

12. breast-feeding;

13. importance of immunization;

14. criteria for discharge from the center;

15. child safety to include the use of car seats and safe sleeping practices;

16. directions for obtaining laboratory tests for newborns as required by the Department of Health and Hospitals;

17. instruction as to the clothing/supplies needed at the time of discharge from the center; and

18. a family instructional program.

G. In order for the family to participate in the birth process in the ABU, the following requirements shall be met.

1. The number of individuals/family members present at the time of birth shall be determined by the ABU's policy which takes into account room size and the need for infection control.

2. Individuals/family members shall abide by the facility's infection control policies.

3. An adult not involved in the birthing process shall be in charge of all minor children.

4. Only service animals shall be allowed in the ABU.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:1099 (June 2014).

§9557. Policies and Procedures

A. An ABU shall develop, implement, enforce, monitor, and review annually the policies and procedures specific to the care and services of the mother and newborn. The policies and procedures shall be jointly developed by the medical director and professional staff and adopted by the governing body. These policies and procedures shall include, but are not limited to:

1. staffing;
2. admission criteria;
3. educational services;
4. consent for medical treatment and care;
5. initial and continuing risk assessment by the CNM;
6. criteria for consultation with collaborative physicians;
7. water birth;
8. external fetal monitoring (EFM);
9. nursing assessments;
10. medication administration;
11. laboratory and diagnostic services;
12. dietary services;
13. obstetric and pediatric consultation services;
14. newborn care, including:
 - a. pulse oximetry heart disease screening; and
 - b. circumcision of a male newborn by a licensed OB/GYN or other qualified physician as determined by the governing body;
15. emergency procedures for the mother and/or newborn, including:
 - a. maternal emergent care policy;
 - b. newborn emergent care policy;
 - c. maternal transfer to an acute care unit within the hospital or transfer to another hospital;
 - d. newborn transfer to an acute care unit within the hospital or transfer to another hospital;
 - e. precipitous delivery; and
 - f. newborn abduction;
16. family support and participation, including:
 - a. criteria for labor and delivery attendance; and
 - b. doula;
17. unique identification for mother and newborn;
18. delivery log;
19. mother/baby couplet aftercare, including:
 - a. lactation support services;
 - b. social services; and
 - c. home health care services, if applicable;
20. maternal and newborn discharge, including:
 - a. length of stay; and
 - b. child passenger restraint system;
21. follow-up postpartum and newborn care; and
22. hospital staff on call policy and procedure.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:1101 (June 2014).

§9559. Physical Environment

A. An ABU shall submit, meet, and obtain approval for facility plan review from the Office of State Fire Marshall prior to construction.

1. An ABU shall:
 - a. consist of a minimum of two birthing rooms and one examination room;
 - b. be located to ensure privacy;
 - c. be located out of the path of unrelated traffic; and
 - d. be under the direct supervision of the unit staff.
2. Birthing rooms shall:
 - a. be single occupancy;
 - b. have a minimum clear floor area of 200 square feet, including the newborn care area and a minimum clear dimension of 12 feet;
 - c. have an outside window;
 - d. have windows or doors within a normal sightline that would permit observation into the room and shall be arranged or draped as necessary for mother and newborn privacy;
 - e. have a hands-free hand-washing station; and
 - f. have direct access to a private bathroom that includes a:
 - i. hand-washing station;
 - ii. toilet; and
 - iii. shower or tub.
- B. The newborn care area shall be a separately located area within the birthing room.
- C. The reception and administration area shall be located as to control and monitor traffic flow/access to the ABU.
- D. The staff work area shall:
 1. be provided for the ABU staff;
 2. have space for counters and storage; and
 3. have convenient access to hand-washing facilities.
- E. Hand-washing stations shall be readily accessible to families, visitors, and staff.
- F. Medication Preparation Location
 1. Provisions shall be made for the distribution of medications from a medicine preparation room or area, from a self-contained medicine dispensing unit, or by another approved system.
 2. The medication preparation room or area shall:
 - a. be under the visual control of the staff; and
 - b. contain the following:
 - i. a work counter;
 - ii. a hand-washing station;
 - iii. a lockable refrigerator; and
 - iv. a locked storage for controlled drugs.
 3. When a medication preparation room or area is to be used to store self-contained medication dispensing units, the room shall be designed with adequate space to prepare medicines with the self-contained medicine-dispensing units present.
- G. Self-Contained Medication-Dispensing Unit
 1. The location of a self-contained medicine-dispensing unit shall be permitted in the clean workroom or in an alcove, provided the ABU has adequate security for medications and adequate lighting to easily identify drugs.
 2. The self-contained medicine-dispensing unit shall provide convenient access to hand-washing stations.
- H. Nourishment Area
 1. A nourishment area shall have the following:
 - a. a sink;
 - b. a work counter;
 - c. a refrigerator;
 - d. storage cabinets;

- e. equipment for hot and cold nourishment;
- f. provisions and space for separate temporary storage of unused and soiled dietary trays not picked up during meal time; and
- g. immediate accessible hand-washing stations in or near the nourishment area.

2. Ice-making equipment shall:

- a. be provided for treatments and nourishment;
- b. be permitted in the clean workroom or the nourishment room; and
- c. ice intended for human consumption shall be provided in the nourishment station and shall be served from self-dispensing ice-makers.

I. A clean workroom shall be separate from and have no direct connection with soiled workrooms or soiled holding rooms.

1. If the room is used for preparing care items for mothers and newborns, it shall contain:

- a. a work counter;
- b. a hand-washing station; and
- c. storage facilities for clean and sterile supplies and equipment.

2. Storage for hazardous cleaning solutions, compounds, and substances shall be labeled and kept in an enclosed storage area or approved cabinet separate from other cleaning materials.

J. A soiled workroom or soiled holding room shall be separate from and have no direct connection with clean work rooms or clean supply rooms.

1. A soiled workroom or soiled holding room shall contain:

- a. a clinical sink (or equivalent flushing rim fixture) and a hand-washing station; and
- b. a work counter and space for separate covered container for soiled linen and a variety of waste types.

2. Omission of the clinical sink and work counter shall be permitted in rooms used only for temporary holding of soiled material. If the flushing-rim clinical sink is not provided, the facilities for cleaning bedpans shall be provided in the mothers' toilet rooms.

K. Environmental Services Room. An environmental services room shall be provided for the exclusive use of the ABU and include:

- 1. a service sink or floor receptor; and
- 2. a space for storage of supplies, housekeeping equipment, and housekeeping carts.

L. Examination Rooms. An examination room shall:

- 1. preserve patient privacy from outside observation;
- 2. be located convenient to nursing the station;
- 3. have a bathroom immediately accessible that includes:
 - a. ventilation with a minimum of 10 air changes per hour; and
 - b. have an exhaust;
- 4. have a hand-washing station;
- 5. have the following space requirements:
 - a. a minimum clear floor area of 80 square feet;
 - b. a minimum continuous clearance of 2 feet 8 inches at each side of the examination table; and
 - c. have counter and shelf space;
- 6. have ventilation with a minimum of six air changes per hour;

- 7. have lighting with fixed and portable features; and
- 8. have an examination table with access to at least two duplex receptacles.

M. Support areas provided for staff shall include:

- 1. a changing room;
- 2. a lounge;
- 3. a bathroom; and
- 4. securable lockers, closets and cabinet compartments.

N. Engineering and maintenance services shall have sufficient space for mechanical and electrical equipment and for the proper maintenance of equipment.

O. Building Codes and Architectural Details

1. The facility shall meet the business occupancy provisions of applicable life safety and building codes.

2. Corridors shall have a minimum corridor width of 5 feet and minimum height of 7 feet 8 inches.

3. Ceilings shall have a minimum height of 7 feet 10 inches with the following exceptions:

- a. ceilings heights for storage rooms, toilet rooms, etc. shall not be less than 7 feet 8 inches; and
- b. rooms containing ceiling mounted equipment/light fixtures shall be of sufficient height to accommodate the equipment or fixtures and normal movement.

4. Birthing Room Surfaces. Birthing room surfaces shall have:

- a. finishes selected to facilitate cleaning and to resist strong detergents; and
- b. finishes in the dietary area to ensure the ability to be cleaned and disinfected.

P. Building Systems

1. Heating, ventilation and air-conditioning, electrical, plumbing and related systems shall meet state and local building codes.

2. Heating, ventilation and air-conditioning systems in the environmental services (housekeeping) room shall be exhausted at a rate consistent with approved infection control guidelines.

Q. Electrical Systems

- 1. Lighting shall:
 - a. provide both subdued indirect lighting and special lighting capable of providing at least 70 foot-candles in the delivery and newborn care area(s); and
 - b. have emergency lighting available.

R. Oxygen and vacuum outlets shall be available.

1. Use of portable equipment shall be permitted.

S. Security systems shall be designed for active and passive security systems. Locking arrangements, security alarms, and monitoring devices shall be placed not to interfere with the life safety feature necessary to operate and maintain a healthy and functional environment.

T. Elevators shall be equipped with a cab with minimum dimensions of 5 feet 8 inches wide by 7 feet 6 inches deep.

U. Corridors, attics, and passageways shall be free of storage. Exits shall not be blocked by storage of furniture or equipment at any time.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:1101 (June 2014).

§9561. Equipment

A. The governing body and medical staff shall specify the types of equipment that is required for an ABU. This shall include at a minimum:

1. emergency equipment including:
 - a. an adult emergent care cart labeled and stocked accordingly; and
 - b. a neonatal emergent care cart labeled and stocked accordingly;
2. equipment and supplies used for labor and delivery including:
 - a. fetal heart rate doppler, fetoscope, and/or external fetal monitor;
 - b. a birthing tub; and
 - c. a bed;
3. equipment and supplies used for the newborn including:
 - a. a newborn crib, bassinet or newborn examination unit; and
 - b. calibrated newborn scales;
4. oxygen and supplies;
5. pulse oximetry supplies;
6. suction and supplies for mother and newborn;
7. maternal and newborn airways;
8. a wall clock synchronized with hospital system;
9. supplies for unique identification of mother and newborn;
10. a secure medication dispensing system;
11. emergency call and lighting systems; and
12. ancillary support equipment as needed.

B. The facility shall have a newborn abduction emergency alert system.

C. All hand-washing facilities shall be equipped with hands-free handles, disposable soap dispenser, paper towel dispenser and trash receptacle.

D. Vertical and horizontal transport systems shall be operated and maintained in a manner to provide for safe transport.

E. The facility shall have functional emergency communication, including:

1. telephone;
2. nurse call; and
3. internal/external paging system.

F. An ABU shall have storage for hazardous cleaning solutions, compounds, and substances.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:1103 (June 2014).

§9563. Services

A. The ABU shall have patient care services policies that delineate the organization of the unit, qualifications of the staff and requirements for staff to patient ratio.

B. Unit Organization

1. Care in an ABU shall be under the direction of a CNM.
 - a. A CNM and a registered nurse shall be available per hospital on call policy to ensure 24-hour coverage for patient care.
 - b. Qualified professional clinical staff shall monitor the patient's progress in labor with ongoing assessments of

maternal/fetal reactions to the process of labor, within accepted professional standards.

2. Authority and responsibilities of all patient care staff shall be clearly defined in written policies.

3. The functions of the ABU shall be under the direction of perinatal services. These functions shall include, but are not limited to:

- a. the development, implementation, enforcement, monitoring, and annual review of policies and procedures related to patient care;
- b. the orientation and training of qualified staff for provision of care; and
- c. provisions for current educational and reference materials.

C. Staff Qualifications

1. The CNM shall provide documentation of current licensure and certification, as required by the Louisiana State Board of Nursing (LSBN). The documentation shall be maintained as part of the credential file for each CNM.

2. Licensed nursing personnel shall practice in accordance with the Louisiana State Nurse Practice Act and demonstrate current licensure by LSBN.

3. All clinical staff of the ABU shall be required to provide documentation of training and continued competence in Adult Basic Cardiopulmonary Life Support (BCLS) and Neonatal Resuscitation Program (NRP) or its equivalent.

4. Documented, dated, and signed demonstration of skills competencies shall be maintained in the personnel file for each staff member.

D. Requirements for Staff to Patient Ratio

1. A CNM must be present at all times while a laboring patient is in the ABU.

2. A registered nurse (RN) shall provide 1:1 maternal care during labor, delivery and post-delivery.

3. There shall be sufficient professional and support staff on duty and on call to meet the following patient's needs:

- a. for services routinely provided;
- b. to assure patient safety and satisfaction; and
- c. to ensure that no patient in active labor is left unattended.

4. During the second stage of labor, 2:1 patient care is required, with one of the clinical staff being a CNM and one other RN.

5. Staffing per shift shall be based on acuity and census of the ABU.

6. Each RN shall be responsible for 1:1 labor care and/or 1:2 couplet care.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:1103 (June 2014).

§9565. Medical Records Requirements

A. The medical record of the mother and newborn shall include, but not be limited to, the following documentation:

1. informed consent signed by the patient and the CNM;
2. demographic and patient information;
3. family, medical, social, reproductive, nutrition and behavioral history;

4. initial maternal assessment and examination;
5. evaluation of maternal/fetal risk factors;
6. written orders for maternal/fetal and newborn care;
7. laboratory and/or diagnostic test results;
8. documentation of maternal/fetal and newborn monitoring;
9. postpartum assessments;
10. physical assessment of newborn, e.g., Apgar score, weights, measurements;
11. labor and discharge summaries; and
12. educational instructions for postpartum and newborn home care, follow ups, and referrals.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:1103 (June 2014).

§9567. Pharmaceutical Services

A. The ABU shall follow hospital policies and procedures for pharmaceutical services regarding the procurement, storage, distribution and control of all medications. The ABU shall be in compliance with all local, state, and federal regulations.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:1104 (June 2014).

Kathy H. Kliebert
Secretary

1406#080

RULE

**Department of Health and Hospitals
Bureau of Health Services Financing**

Inpatient Hospital Services
Coverage of Long-Acting Reversible Contraceptives
(LAC 50:V.113)

The Department of Health and Hospitals, Bureau of Health Services Financing has adopted LAC 50:V.113 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE

Part V. Hospital Services

Subpart 1. Inpatient Hospitals

Chapter 1. General Provisions

§113. Coverage of Long-Acting Reversible Contraceptives

A. The Medicaid Program shall provide reimbursement to acute care hospitals for long-acting reversible contraceptives (LARCs) provided to women immediately following childbirth and during the hospital stay.

B. Reimbursement. Hospitals shall be reimbursed for LARCs as an add-on service in addition to their daily per diem rate for the inpatient hospital stay.

1. Physicians/professional practitioners who insert the device will also be reimbursed an insertion fee in accordance with the reimbursement rates established for this service in the Professional Services Program.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:1104 (June 2014).

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) if it is determined that submission to CMS for review and approval is required.

Kathy H. Kliebert
Secretary

1406#081

RULE

**Department of Public Safety and Corrections
Corrections Services**

Disciplinary Rules and Procedures for Adult Offenders
(LAC 22:I.341)

Editor's Note: The following Rule is being repromulgated to correct a codification error. The original Rule can be viewed in its entirety in the May 20, 2014 edition of the *Louisiana Register* on pages 1010-1011.

In accordance with the provisions of the Administrative Procedure Act (R.S. 49:950), the Department of Public Safety and Corrections, Corrections Services, has amended the contents of Section 341, Disciplinary Rules and Procedures for Adult Offenders.

Title 22

**CORRECTIONS, CRIMINAL JUSTICE AND LAW
ENFORCEMENT**

Part I. Corrections

Chapter 3. Adult Services

Subchapter B. Disciplinary Rules and Procedures for Adult Offenders

§341. Disciplinary Rules and Procedures for Adult Offenders

* * *

A. - F.1.a.i.(a).(iii).[a].[iii]. ...

[a].[iv]. the date and approximate time of the offense; and

(a).(iii).[a].[v]. - (c). ...

(d). In instances when an offender is placed in administrative segregation for disciplinary purposes, the supervisor will conduct a review of the documentation to ensure it is complete and correct and, as needed, investigate to confirm the reasonableness of the allegation or circumstances prompting the assignment. This shall be done prior to the conclusion of the supervisor's tour of duty.

(e). Time spent in administrative segregation for the offense for which the offender was placed in administrative segregation must be credited against disciplinary detention or extra duty sentences even when these sanctions are suspended. Credit will not be given for

time spent in administrative segregation based upon a request for protection or while an offender is awaiting transfer to another area.

(f). An appropriate review board should review the status of offenders who are in administrative segregation at least every seven days for the first two months and every 30 days thereafter.

ii. - ii.(a). ...

(b). Confirmation that the offender was advised of the charges shall be noted on the original of the disciplinary report by evidence of the offender's signature.

(c). If the offender refuses to sign the disciplinary report, the delivering officer shall note the refusal in the offender signature block and initial the box.

b. - b.ii. ...

iii. Counsel substitutes are only those offenders appointed by the warden or designee to assist other offenders with their legal claims, including but not limited to, assistance with filing of administrative remedy procedure requests, disciplinary board appeals and lost property claims. Counsel substitutes are not required to file disciplinary appeals but should inform the offender who wants to appeal of the proper way to file. They may be removed from their positions if the warden or designee believes it appropriate. Offenders who are not counsel substitutes may not provide services to other offenders without the approval of the warden or designee.

G. - G.3.c. ...

i. Any offender who is placed in administrative segregation for a rule violation must be given a disciplinary hearing within 72 hours of being placed in administrative segregation. Official holidays, weekends, genuine emergencies and good faith efforts by the administration to provide a timely hearing are the only exceptions. The offender must be heard at the next available court date. When it is not possible to provide a full hearing within 72 hours of placement in administrative segregation, the accused must be brought before the disciplinary board, informed of the reasons for the delay and remanded back to administrative segregation or released to his quarters after a date for a full hearing has been set.

G.3.c.ii. - K.2.c. ...

* * *

AUTHORITY NOTE: Promulgated in accordance with R.S. 15:823, *Wolff v. McDonnell*, 94 S.Ct. 2963 (1974), *Ralph v. Dees*, C.A. 71-94, USDC (Md. La.) and *Sandin v. Conner*, 115 S.Ct. 2293 (1995).

HISTORICAL NOTE: Promulgated by the Department of Corrections, Office of Adult Services, LR 27:413 (March 2001), amended by the Department of Public Safety and Corrections, Corrections Services, LR 34:2194 (October 2008), LR 39:3309 (August 2013), LR 40:1010 (May 2014), repromulgated LR 40:1104 (June 2014).

James M. LeBlanc
Secretary

1406#006

RULE

Department of Public Safety and Corrections Gaming Control Board

Application and License and
Enforcement Actions of the Board
(LAC 42:XI.2405 and 2424)

The Louisiana Gaming Control Board, pursuant to R.S. 27:15 and R.S. 27:24, has amended LAC 42:XI.2405.B and LAC 42:XI.2424.B.

Title 42 LOUISIANA GAMING Part XI. Video Poker

Chapter 24. Video Draw Poker

§2405. Application and License

A.1. - B.5. ...

6. Upon discovery, hidden ownership, whether by counter letter or other device or agreement, whether oral or written, shall constitute grounds for immediate suspension, revocation or denial of a license or application.

7. If there is more than one owner of a company, applicants and licensees shall disclose all ownership interests in the company so that the aggregate of percentages of individual ownership totals 100 percent.

8. All licensees shall attend all hearings, meetings, seminars and training sessions required by the division. The division shall not be responsible for any costs incurred by the licensees.

9. All licensees shall maintain compliance with all applicable federal gambling law requirements, including any registration required by the provisions of chapter 24 of title 15 of the *United States Code* (§1171 et seq.), which govern the transportation of gambling devices.

10.a. All licensees shall continue to operate the business described in the application during the term of the license. In the event either the business or the video draw poker devices at the location are not in operation for a period of 30 consecutive calendar days during which the business would normally operate, the licensee and device owner shall immediately notify the division of such fact and the licensee shall immediately surrender its license to the board or division.

b. If surrendered in accordance with §2405.B.10.a, no gaming activities may be conducted at the premises unless and until the license is returned to the licensee.

c. The license may be returned to the licensee when business operations are resumed for the unexpired term of the license provided that the license has not been revoked and is not under suspension and further provided that no more than 180 days has elapsed from the date the license was surrendered.

d. Licenses surrendered in accordance with §2405.B.10.a shall not be subject to renewal unless the license has been returned to the licensee.

e. Failure to surrender the license as provided in §2405.B.10.a shall constitute grounds for revocation or suspension of the license.

11.a. Within 15 days following a force-majeure event which has not affected video poker operation but necessitates closing any part of the licensed entity in order to make repairs, a licensee shall notify the division which may, following an on-site inspection to evaluate damage to the premises, grant the licensee a 60-day waiver from the provisions of LAC 42:XI.2405.B.10.a.

b. The division may grant one 60-day extension if it determines that the licensee has made substantial progress towards completing the necessary repairs within the original 60 day waiver period and the applicant can demonstrate a reasonable likelihood of completing the necessary repairs within the next 60 days.

c. Under no circumstances shall a licensee continue video poker operations without completing the necessary repairs and resuming normal operations for a period longer than 120 days.

C. - D.7. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 27:15 and 24.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of State Police, Gaming Enforcement Section, Video Gaming Division, LR 18:196 (February 1992), amended LR 21:582 (June 1995), amended by the Department of Public Safety and Corrections, Gaming Control Board, LR 23:1322 (October 1997), LR 24:955 (May 1998), LR 26:346 (February 2000), LR 26:2322 (October 2000), LR 27:61 (January 2001), LR 29:362 (March 2003), LR 30:267 (February 2004), repromulgated LR 30:439 (March 2004), amended LR 34:1037 (June 2008), LR 35:82 (January 2009), repromulgated LR 35:490 (March 2009), amended LR 36:2045 (September 2010), LR 38:2935 (November 2012), LR 40:1105 (June 2014).

§2424. Enforcement Actions of the Board

- A. ...
- B. Penalty Schedule

Regulation Number	Violation Description	1st	2nd	3rd
Application and License				
* * *				
2405 B 8	Failure To Attend Required Hearings, Meetings, Etc.	500	1000	Admin Action
Video Gaming Devices				
* * *				
Revenues				
* * *				
Regulatory, Communication, and Reporting Responsibilities				
* * *				
Devices				
* * *				
Gaming Establishments				
* * *				
Code of Conduct of Licensee				
* * *				
Investigations				
* * *				
Miscellaneous				
* * *				

C. - D. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 33:4862.1 et seq.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Gaming Control Board. LR 36:2874 (December 2010), amended LR 38:2936 (November 2012), LR 40:1106 (June 2014).

Ronnie Jones
Chairman

1406#011

RULE

**Department of Public Safety and Corrections
Gaming Control Board**

Distance between Devices
(LAC 42:XI.2415)

The Louisiana Gaming Control Board, pursuant to R.S. 27:15 and R.S. 27:24, has amended LAC 42:XI.2415.C.2.

Title 42

LOUISIANA GAMING

Part XI. Video Poker

Chapter 24. Video Draw Poker

§2415. Gaming Establishments

A. - B.2. ...

C. Placement of Devices in Licensed Establishments

1. ...

2. No device shall be placed closer than 6 inches to any other device, except devices may be placed back to back or in a carousel.

C.3. - E.3. ...

AUTHORITY NOTE: Promulgated in accordance with L.S. 27:15 and 24.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of the State Police, Gaming Enforcement Section, Video Gaming Division, LR 18:197 (February 1992), amended LR 21:582 (June 1995), amended by the Department of Public Safety and Corrections, Gaming Control Board, LR 23:1322 (October 1997), LR 24:1504 (August 1998), LR 26:1321 (June 2000), LR 36:2047 (September 2010), LR 39:329 (February 2013), LR 40:1106 (June 2014).

Ronnie Jones
Chairman

1406#012

RULE

**Department of Public Safety and Corrections
Gaming Control Board**

Operation of Video Draw Poker Devices and
Enforcement Actions of the Board
(LAC 42:XI.2407 and 2424)

The Louisiana Gaming Control Board, pursuant to R.S. 27:15 and R.S. 27:24, has repealed LAC 42:XI.2407.A.13 and has amended LAC 42:XI.2424.B.

Title 42

LOUISIANA GAMING

Part XI. Video Poker

Chapter 24. Video Draw Poker

§2407. Operation of Video Draw Poker Devices

A. - A.12.a. ...

13. Repealed.

A.14. - D.16. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 27:15 and 24.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of State Police, Gaming Enforcement Section, Video Gaming Division, LR 18:196 (February 1992), amended LR 21:582 (June 1995), amended by the Department of Public Safety and Corrections, Gaming Control Board, LR 25:85 (January 1999), LR 27:205 (February 2001), LR 30:267 (February 2004), repromulgated LR 30:441 (March 2004), amended LR 33:857 (May 2007), LR 36:2046 (September 2010), LR 36:2874 (December 2010), LR 38:2936 (November 2012), repromulgated LR 38:3234 (December 2012), amended LR 40:1106 (June 2014).

§2424. Enforcement Actions of the Board

- A. ...
- B. Penalty Schedule

Regulation Number	Violation Description	1st	2nd	3rd
Application and License				
* * *				
Video Gaming Devices				
* * *				
2407 A 13	Repealed.			
* * *				
Revenues				
* * *				
Regulatory, Communication, and Reporting Responsibilities				
* * *				
Devices				
* * *				
Gaming Establishments				
* * *				
Code of Conduct of Licensee				
* * *				
Investigations				
* * *				
Miscellaneous				
* * *				

C. - D. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 33:4862.1 et seq.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Gaming Control Board. LR 36:2874 (December 2010), amended LR 38:2936 (November 2012), LR 40:1107 (June 2014).

Ronnie Jones
Chairman

1406#013

RULE

**Department of Public Safety and Corrections
Gaming Control Board**

Revenues and Enforcement Actions of the Board
(LAC 42:XI.2409 and 2424)

The Louisiana Gaming Control Board, pursuant to R.S. 27:15 and R.S. 27:24, has amended LAC 42:XI.2409.C and LAC 42:XI.2424.B.

**Title 42
LOUISIANA GAMING
Part XI. Video Poker**

Chapter 24. Video Draw Poker

§2409. Revenues

- A. - B.6.d. ...
- C. Franchise Payments

1. All device owners shall remit to the division a franchise payment as provided for by the Act. The franchise payment shall be securely held by the device owner and shall be deemed to be held in trust for the state of Louisiana in accordance with this Subsection until such time as the franchise payment is remitted and received by the division.

2. Franchise payments shall be calculated based upon the net device revenue, as verified by the electronic (soft) meters of the device. Revenues received from franchise payments shall be electronically transferred to the designated bank of the state treasurer.

3. All device owners shall establish and maintain a single bank account exclusively for the electronic funds transfer (sweep) of franchise payments to the designated bank of the state treasurer.

a. The payments shall be transferred electronically into the designated bank of the state treasurer semi-monthly or as otherwise prescribed by the division. Licensees shall authorize the division to initiate these transfers.

b. The funds shall be electronically transferred (swept) no later than the tenth day after the fifteenth and last day of every month. Any account found with insufficient funds shall constitute a violation of this Section.

c. Electronic funds transfers shall be calculated based upon device polling from the first through the fifteenth, and the sixteenth through the last day of every month.

d. Any delinquent monies not forwarded to the bank designated by the state treasurer by electronic funds transfers at the time of the transfer shall be subject to an interest penalty of 0.000575 per day (21 percent per annum). The interest penalty shall be in addition to any other penalties imposed by the division.

4. A device owner who has a nonsufficient fund return within the past three years shall be required to maintain a minimum balance at all times in the video gaming sweep account, or the account shall at all times be secured by a line of credit or bond issued by a bank or security company acceptable to the state treasurer. For purposes of this rule the term "bond" shall include cash, cash equivalent instruments or such other instruments as the division determines provide immediate liquidity.

a. The minimum balance and the security shall be equivalent to at least 15 percent of the previous month's net device revenues of all video gaming devices of the device owner.

b. No withdrawals at any time from the device owner's video gaming account, including electronic funds transfers, shall cause the account balance to be less than the minimum balance requirement prescribed above.

5. All licensed device owners shall be liable for that portion of net device revenues from such times as the funds

are received into the device until said funds are deposited into the designated bank of the state treasurer.

6. Upon failure of a device owner to remit the state's franchise payment in accordance with this Subsection, the device owner and its shareholders, officers and directors, if a corporation; its partners, if a partnership; and its managers and managing member if a limited liability company, shall be jointly and severally liable to the state of Louisiana for the franchise payment until such time as the payment is remitted and received by the division. The board may initiate collection proceedings against any party liable for the payment of the franchise fee pursuant to R.S. 27:435(D)(5) and (6).

D. - E.2.h. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 33:4862.1 et seq.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of State Police, Gaming Enforcement Section, Video Gaming Division, LR 18:196 (February 1992), amended LR 21:582 (June 1995), amended by the Department of Public Safety and Corrections, Gaming Control Board, LR 30:268 (February 2004), repromulgated LR 30:442 (March 2004), amended LR 38:2936 (November 2012), LR 40:1107 (June 2014).

§2424. Enforcement Actions of the Board

- A. ...
- B. Penalty Schedule

Regulation Number	Violation Description	1st	2nd	3rd
Application and License				

Video Gaming Devices				

Revenues				
2409 C 2d	Repealed.			
2409 C 3	Repealed.			
2409 C3d	Insufficient Funds Available For Electronic Transfer—Fine Plus Interest As Per Rule	500	1000	Admin Action
2409 C4	A Device Owner Who Has A Non-Sufficient Fund Return W/I The Past 3 Years Shall Be Required To Maintain A Minimum Balance In The Sweep Account Or Secure With A Line Of Credit Or Bond	500	1000	Admin Action

Regulatory, Communication, and Reporting Responsibilities				

Devices				

Gaming Establishments				

Code of Conduct of Licensee				

Investigations				

Miscellaneous				

C. - D. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 33:4862.1 et seq.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Gaming Control Board. LR 36:2874 (December 2010), amended LR 38:2936 (November 2012), LR 40:1108 (June 2014).

Ronnie Jones
Chairman

1406#014

RULE

**Department of Public Safety and Corrections
Gaming Control Board**

Video Draw Poker (LAC 42:XI.Chapter 24)

The Louisiana Gaming Control Board, pursuant to R.S. 27:15 and R.S. 27:24, has amended LAC 42:XI.2401, 2403, 2405, 2407, 2409, 2413, 2415, 2417 and 2424.

**Title 42
LOUISIANA GAMING
Part XI. Video Poker**

Chapter 24. Video Draw Poker

§2401. Statement of Department Policy

A. The rules contained herein are promulgated by the Video Gaming Division of the Office of State Police in order to facilitate implementation of the video draw poker devices control law, R.S 27:401 et seq., to achieve the effective regulation of the video gaming industry, and to maintain the health, welfare, and safety of the public. These considerations shall control the application and interpretation of the rules. Any subsequent restatement, repeal, or amendment of these rules shall be in accordance with the aforementioned considerations.

B. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 33:4862.1 et seq., the Act.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of State Police, Gaming Enforcement Section, Video Gaming Division, LR 18:196 (February 1992), amended LR 21:582 (June 1995), amended by the Department of Public Safety and Corrections, Gaming Control Board, LR 40:1108 (June 2014).

§2403. Definitions

A. The provisions of the Louisiana video draw poker devices control law relating to the definitions of words, terms, and phrases are hereby incorporated by reference and made a part hereof, and shall apply and govern the interpretation of these regulations, except as otherwise specifically declared or as is clearly apparent from the context of the regulations herein. The following words, terms, and phrases shall have the ascribed meaning indicated below.

Act—the provisions of Chapter 8 of Title 27, R.S. 27:401-457 and its amendments hereafter.

Permittee—for purposes of these rules, shall have the same meaning as "video draw poker employee" as provided in R.S. 27:402.

AUTHORITY NOTE: Promulgated in accordance with R.S. 33:4862.1 et seq.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of State Police, Gaming Enforcement Section, Video Gaming Division, LR 18:196 (February 1992), amended LR 21:582 (June 1995), amended by the Department of Public Safety and Corrections, Gaming Control Board, LR 30:266 (February 2004), repromulgated LR 30:439 (March 2004), amended LR 32:108 (January 2006), LR 36:2045 (September 2010), LR 38:2935 (November 2012), LR 40:1108 (June 2014).

§2405. Application and License

A.1. - A.3. ...

4. All applicants shall be required to disclose any violation of an administrative regulation from any jurisdiction.

5. - 5.a.i. ...

(a). provides proof of application to the local governing authority of the parish where the truck stop is to be located for a certificate of compliance with applicable zoning ordinances and building codes, a statement of approval for the operation of video draw poker devices at a truck stop facility as required by R.S. 27:452(C), and has published the public notices required by R.S. 27:419; or

(b). has applied with the appropriate authority for a building permit, and has published the public notices required by R.S. 27:419.

ii. - ii.(a). ...

(b). proof of publication of the notice of intent to build a qualified truck stop facility as required by R.S. 27:419(A);

(c). proof of issuance of the press release required by R.S. 27:419(D); and

a.ii.(d). - c.iii. ...

d. For purposes of determining compliance with the distance requirements provided in R.S. 27:422, the date of application shall be the date the certificate of compliance was received from the applicable local governing authority or the date the application for a building permit was filed, whichever last occurred.

A.6. - D.7. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 27:15 and 24.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of State Police, Gaming Enforcement Section, Video Gaming Division, LR 18:196 (February 1992), amended LR 21:582 (June 1995), amended by the Department of Public Safety and Corrections, Gaming Control Board, LR 23:1322 (October 1997), LR 24:955 (May 1998), LR 26:346 (February 2000), LR 26:2322 (October 2000), LR 27:61 (January 2001), LR 29:362 (March 2003), LR 30:267 (February 2004), repromulgated LR 30:439 (March 2004), amended LR 34:1037 (June 2008), LR 35:82 (January 2009), repromulgated LR 35:490 (March 2009), amended LR 36:2045 (September 2010), LR 38:2935 (November 2012), LR 40:1109 (June 2014).

§2407. Operation of Video Draw Poker Devices

A. Responsibilities of Licensees

1. - 8. ...

a. All promotions shall comply with the Act and these regulations as well as all federal and state laws and regulations and municipal ordinances including, but not limited to, R.S. 27:502 and the Louisiana charitable raffles, bingo and keno licensing law, R.S. 4:701 et seq. The establishment licensee, and/or the device owner conducting the promotion is/are responsible for ensuring that all promotions are in compliance with this Paragraph.

A.8.b. - D.16. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 27:15 and 24.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of State Police, Gaming Enforcement Section, Video Gaming Division, LR 18:196 (February 1992), amended LR 21:582 (June 1995), amended by the Department of Public Safety and Corrections, Gaming Control Board, LR 25:85 (January 1999), LR 27:205 (February 2001), LR 30:267 (February 2004), repromulgated LR 30:441 (March 2004), amended LR 33:857 (May 2007), LR 36:2046 (September 2010), LR 36:2874 (December 2010), LR 38:2936 (November 2012), repromulgated LR 38:3234 (December 2012), amended LR 40:1109 (June 2014).

§2409. Revenues

A. License Fees

A.1. - B.5. ...

6. The annual device operation fees are as follows:

a. a restaurant, bar, tavern, cocktail lounge, club, motel, or hotel, as provided in R.S. 27:435(A)(5)(a);

b. a Louisiana State Racing Commission licensed pari-mutuel wagering facility, as provided in R.S. 27:435(A)(5)(b)(i);

c. a Louisiana State Racing Commission licensed off-track wagering facility, as provided in R.S. 27:435(A)(5)(b)(ii);

d. a qualified truck stop facility, as provided in R.S. 27:435(A)(5)(c).

C. - E.2.h. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 33:4862.1 et seq.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of State Police, Gaming Enforcement Section, Video Gaming Division, LR 18:196 (February 1992), amended LR 21:582 (June 1995), amended by the Department of Public Safety and Corrections, Gaming Control Board, LR 30:268 (February 2004), repromulgated LR 30:442 (March 2004), amended LR 38:2936 (November 2012), LR 40:1109 (June 2014).

§2413. Devices

A. Device Specifications

1. All devices shall include all of the specifications and features as provided in R.S. 27:405. In addition, all devices shall include the following specifications and features:

1.a. - 3....

4. A valid ticket voucher shall contain all information required by R.S. 27:406. In addition, a valid ticket voucher shall contain the program name and/or software number.

A.5. - L.1.c.ii. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 33:4862.1 et seq. and R.S. 27:1 et seq.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of State Police, Gaming Enforcement Section, Video Gaming Division, LR 18:197 (February 1992), amended LR 21:582 (June 1995), amended by the Department of Public Safety and Corrections, Gaming Control Board, LR 23:1322 (October 1997), amended LR 25:85 (January 1999), LR 30:269 (February 2004), repromulgated LR 30:446 (March 2004), amended LR 32:109 (January 2006), LR 32:1613 (September 2006), LR 40:1109 (June 2014).

§2415. Gaming Establishments

A. Establishment Licenses

1. The division may issue a license to qualified applicants based on the type of business being conducted. The types of licenses and the requirements for these licenses are as follows:

a. *Type "I" License*—any bar, tavern, cocktail lounge, or club only, as defined in R.S. 27:402(14) shall be designated as a type "I" establishment;

b. *Type "II" License*—any restaurant, as defined in R.S. 27:402(14) shall be designated as a type "II" establishment;

c. *Type "III" License*—a hotel or motel as defined in R.S. 27:402(8) and R.S. 27:414 shall be designated as a type "III" establishment;

d. *Type "IV" License*—a Louisiana State Racing Commission licensed race track, pari-mutuel wagering facility, or off-track wagering facility as defined in R.S. 27:402(10) (licensed establishment) shall be designated a type "IV" establishment;

e. *Type "V" License*—a qualified truck stop facility as defined in R.S. 27:417 shall be designated a type "V" establishment.

B. - C.2. ...

3. No video draw poker devices which a qualified truck stop facility is licensed to operate on the premises shall be located or operated in the convenience store, trucker lounges, laundry rooms, shower rooms, and/or hallway areas of the truck stop facility. Video draw poker devices shall be located and operated in areas designated primarily for gaming, as defined in R.S. 27:401 et seq., and/or in lounges/bars and restaurants that meet the criteria of R.S. 27:401 et seq., and part II of chapter 1 or part II of chapter 2 of title 26 of the *Louisiana Revised Statutes* of 1950. In areas legally accessible to minors the device areas shall comply with the provisions of R.S. 27:430(F)(2) and LAC 42:XI.2415.D.2.

D. Structural Requirements for Licensed Establishments

1. ...

2. Any licensed establishments that allow mixed patronage shall have devices for play and operation only in designated areas. These gaming areas shall be physically separated by a partition as provided in R.S. 27:430(F). The partition shall be permanently affixed and solid except for an opening to allow for player access into the gaming area.

D.3. - E.1. ...

2. All applicants for a truck stop license shall comply with the distance requirements as provided in R.S. 27:422.

3. ...

AUTHORITY NOTE: Promulgated in accordance with L.S. 27:15 and 24.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of the State Police, Gaming Enforcement Section, Video Gaming Division, LR 18:197 (February 1992), amended LR 21:582 (June 1995), amended by the Department of Public Safety and Corrections, Gaming Control Board, LR 23:1322 (October 1997), LR 24:1504 (August 1998), LR 26:1321 (June 2000), LR 36:2047 (September 2010), LR 39:329 (February 2013), LR 40:1110 (June 2014).

§2417. Code of Conduct of Licensees and Permittees

A. - B.3. ...

4. any person required to be found suitable or approved in connection with the granting of any license or permit shall have a continuing duty to notify the division of his/her/its arrest, summons, citation or charge for any criminal offense or violation including DWI; however, minor traffic violations need not be included. All licensees

and permittees shall have a continuing duty to notify the division of any fact, event, occurrence, matter or action that may affect the conduct of gaming or the business and financial arrangements incidental thereto or the ability to conduct the activities for which the licensee or permittee is licensed or permitted. Such notification shall be made within ten calendar days of the arrest, summons, citation, charge, fact, event, occurrence, matter or action;

B.5. - C.1.j. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 33:4862.1 et seq., and R.S. 27:15 and 24.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of State Police, Gaming Enforcement Section, Video Gaming Division, LR 18:197 (February 1992), amended LR 21:582 (June 1995), amended by the Department of Public Safety and Corrections, Gaming Control Board, LR 27:59 (January 2001), LR 30:270 (February 2004), repromulgated LR 30:447 (March 2004), amended LR 38:2936 (November 2012), LR 40:1110 (June 2014).

§2424. Enforcement Actions of the Board

A. Pursuant to R.S. 27:432 et seq., in lieu of other administrative action, the division may impose a civil penalty as provided for in the penalty schedule contained in Subsection B.

B. Penalty Schedule

Regulation Number	Violation Description	1st	2nd	3rd
Application and License				

Video Gaming Devices				

Revenues				

Regulatory, Communication, and Reporting Responsibilities				

Devices				

Gaming Establishments				

Code of Conduct of Licensee				

Investigations				

Miscellaneous				
27:402(14)	Expired ATC Permits Renewed during Investigation or Adjudication Establishments Primarily Engaged in the Retail Sale of Prepared Foods and Alcoholic Beverages Must Possess a Valid Class A-General Retail Permit or a Class A-Restaurant Permit			1000 Plus 500 For Each 30-Day (or Portion of A 30-Day) Period
27:435(F)(2)	A Non-Sufficient Fund Return	250	500	1000 or Admin Action
27:435(K)(4)(b)	Required Annual Fees Submitted after July First, but on or before July Thirty-First	Type 1 Or 2 License 250		Type 3-8 License 500
27:435(K)(4)(c)	Required Annual Fees Submitted after July Thirty-First, but on or before August Thirty-First	Type 1 Or 2 License 500		Type 3-8 License 1000

Regulation Number	Violation Description	1st	2nd	3rd
27:435(L)	A Complete Renewal Application Filed within 30 Calendar Days after the Expiration of the License	500		
27:443	Allowing Underage Patron to Play Video Gaming Device	1000	1000	Revocation

C. A violation shall be considered a second or subsequent violation in accordance with the provisions of R.S. 27:432.1(D)(1)(b).

D. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 33:4862.1 et seq.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Gaming Control Board. LR 36:2874 (December 2010), amended LR 38:2936 (November 2012), LR 40:1110 (June 2014).

Ronnie Jones
Chairman

1406#015

RULE

Department of Public Safety and Corrections Office of State Police

Underground Utilities (LAC 55:I.Chapter 21)

The Department of Public Safety and Corrections, Office of State Police, in accordance with R.S. 49:950 et seq., and R.S. 40:1749.11 et seq., hereby amends its rules pertaining to underground utilities and facilities damage prevention by providing for procedures for investigating complaints as authorized in R.S. 40:1749.23(D).

Title 55

PUBLIC SAFETY

Part I. State Police

Chapter 21. Underground Utilities

§2103. Definitions

A. For the purposes of these rules, the following terms shall have the meanings ascribed to them in this Section.

* * *

Locator—any person employed to determine the specific location of the operator's underground facility or utility within the area specified through a notice served by a regional notification center.

* * *

AUTHORITY NOTE: Promulgated in accordance with R. S. 40:1749.11 et seq.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of State Police, LR 26:92 (January 2000), amended LR 40:1111 (June 2014).

§2106. Investigation Procedure

A. In accordance with R.S. 40:1749.23(D)(5), established investigative procedures shall adhere to the minimal standards established by the Police Officer Standards and Training (POST) and be demonstrated by an

officer's completion of a certified law enforcement training course. The procedures may include, but are not limited to; observation, interrogation, documentation, collection, intervention, interdiction, mitigation, remediation, litigation, analyzation and recommendation.

B. Investigative procedures permit department investigators to collect and record information, as outlined in LAC 55:I.2106.C, on a standard investigation form; empowering the department to investigate a complaint, issue a citation and adjudicate the complaint.

C. The department's standard investigation form, titled hazardous materials incident report, may include, but is not limited to, the following:

1. excavator:
 - a. name;
 - b. address;
 - c. representative and title;
 - d. primary and secondary contact phone numbers;
 - e. regional notification center dig ticket number;
 - f. status of dig ticket;
 - g. status of markings;
2. operator:
 - a. name;
 - b. address;
 - c. representative and title;
 - d. primary and secondary contact phone numbers;
 - e. regional notification center dig ticket number;
 - f. status of dig ticket;
 - g. status of markings;
3. effects on general public:
 - a. chemical name;
 - b. hazard class;
 - c. amount released—potential;
 - d. injuries;
 - e. fatalities;
 - f. fire;
 - g. road closures;
 - h. evacuations;
 - i. shelter in place;
 - j. remediation, mutual aid, and additional agencies on-scene;
4. details:
 - a. the department's investigator may provide additional information and data relevant to the investigation.

AUTHORITY NOTE: Promulgated in accordance with R. S. 40:1749.11 et seq.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of State Police, LR 40:1111 (June 2014).

§2107. Citation

A. The citation issued to a party alleged to be in violation of R.S. 40:1479 et seq., or these rules shall be uniform as developed by the department and may include the following:

1. the violation number;
2. the date of the incident;
3. the location of the incident;
4. the specific statute or regulation which is alleged to have been violated;
5. the penalty assessed to the responsible party based on the results of the department's investigation;
6. a brief description of the violation; and
7. an explanation of the responsible party's right to an administrative hearing.

AUTHORITY NOTE: Promulgated in accordance with R. S. 40:1749.11 et seq.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of State Police, LR 26:93 (January 2000), amended LR 40:1111 (June 2014).

§2109. Collection of Data by the Department

A. The department may collect such data that will allow law enforcement agencies to determine the number of existing violations and the results of the adjudication process.

AUTHORITY NOTE: Promulgated in accordance with R. S. 40:1749.11 et seq.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of State Police, LR 26:93 (January 2000), amended LR 40:1112 (June 2014).

§2117. Collection and Distribution of Fees, Fines, or Civil Penalties: Underground Damages Prevention Fund

A. All civil penalties shall be paid to the state treasury for credit to the underground damage prevention fund, and shall be disbursed as follows:

1. 34 percent shall be retained by the underground damages prevention fund;

2. upon request for disbursement by the agency, within one year of the civil penalty being deposited into the underground damages prevention fund, funds shall be disbursed as follows:

a. 50 percent shall be disbursed to the local law enforcement agency that issued the citation if the citation was adjudicated by the local governmental subdivision; or

b. 50 percent shall be disbursed to the state law enforcement agency that issued the citation if the citation was adjudicated by the state; or

c. 25 percent shall be disbursed to the local law enforcement agency that issued the citation and 25 percent retained in the fund if such citation was adjudicated by the state;

3. if the local governing authority:

a. is a member of or participates in a regional notification center; upon request for disbursement by the local governing authority within one year of the civil penalty deposited into the underground damages prevention fund, 16 percent shall be disbursed to the local governing authority of the area in which the violation occurred to be used solely for purposes of compliance with Louisiana Underground Utilities/Facilities Damage Prevention Law;

b. is not a member of nor participates in a regional notification center, but establishes and operates a violations bureau pursuant to R.S. 1749.23(D), then upon request for disbursement by the local governing authority within one year of the civil penalty deposited into the underground damage prevention fund, 16 percent shall be disbursed to the local governing authority for each violation adjudicated by the violations bureau of that local governing authority;

c. otherwise, the amount shall be retained in the underground damages prevention fund and distributed per §2117.A.1 and 2 of this Part.

B. - D. ...

AUTHORITY NOTE: Promulgated in accordance with R. S. 40:1749.11 et seq.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of State Police, LR 26:94 (January 2000), amended LR 40:1112 (June 2014).

Jill Boudreaux
Undersecretary

1406#002

RULE

**Department of Revenue
Office of Alcohol and Tobacco Control**

**Regulation XI—Fairs, Festivals and Special Events
(LAC 55:VII.323)**

In accordance with the provisions of the Administrative Procedures Act, R.S. 49:950 et seq., notice is hereby given that the Department of Revenue, Office of Alcohol and Tobacco Control, has amended LAC 55:VII.323, Regulation Number XI—Fairs, Festivals and Special Events.

This amendment to the above-referenced Rule is offered under authority delegated by R.S. 26:793 relative to the issuance of three-day permits to serve alcoholic beverages at fairs, festivals, civic and fraternal and religious events, Mardi Gras events, and nonprofit functions.

Title 55

PUBLIC SAFETY

Part VII. Alcohol and Tobacco Control

Subpart 1. Beer and Liquor

Chapter 3. Liquor Credit Regulations

§323. Regulation XI—Fairs, Festivals and Special Events

A. ...

B. For such events, this office will issue a special temporary retail alcoholic beverage permit. These permits authorize alcoholic beverages to be sold, served and/or supplied at the special event for a maximum duration of three consecutive days only, but wholesalers may deliver alcoholic beverages to the event location up to 2 days prior to the effective date of the permit. No more than 12 such permits shall be issued to any one person, organization or entity within a single calendar year.

B.1. - E. ...

1. Type A special events held on the premises of a class A, B or C retail alcoholic beverage permit holder shall comply with all of the following conditions:

a. the special event permit is applied for and obtained in the name of the non-profit organization;

b. the non-profit organization is not affiliated, either directly or indirectly, with an alcoholic beverage manufacturer or wholesale dealer;

c. the non-profit organization holding the type A special event permit must return or remove all unused alcoholic beverage products at the conclusion of the event. No alcoholic beverage product purchased or otherwise obtained in the name of the non-profit organization or for the purpose of servicing the special event shall be left on the licensed premises at the conclusion of the event;

d. subject to inspection by the commissioner or his agents, the non-profit organization shall document and maintain record of:

i. the total amount of alcoholic beverages purchased for the event;

ii. the total amount of alcoholic beverages sold or served during the event; and

iii. the total amount of alcoholic beverages removed or returned at the conclusion of the event;

e. any and all signage, equipment or other items provided by an alcoholic beverage manufacturer or wholesale dealer in relation to the non-profit special event shall be removed from the premises of the retail dealer immediately upon conclusion of the special event;

f. the premise's class A, B, or C alcoholic beverage permit was not issued pursuant to R.S. 26:85.1 and R.S. 26:273C;

g. all proceeds generated by or in connection with the event shall be paid to the holder of the type A special event permit;

h. the holder of the class A, B or C retail alcoholic beverage permit shall receive no proceeds, alcoholic beverage products, sponsorship dollars, promotional items or other items of value other than a reasonable rental fee at fair market value; and

i. The provisions of R.S. 26:287(9) and Regulation IX dealing with unfair business practices shall apply with respect to the holder of the class A, B or C retail alcoholic beverage permit holder.

F.1. - F.2. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 26:793.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of Alcoholic Beverage Control, LR 17:606 (June 1991), amended by the Department of Revenue, Office of Alcohol and Tobacco Control, LR 34:1634 (August 2008), LR 40:1112 (June 2014).

Troy Hebert
Commissioner

1406#051

RULE

Department of Revenue Office of Alcohol and Tobacco Control

Regulation XIII—Posting of the National Human Trafficking Resource Center Hotline (LAC 55:VII.331)

Under the authority of R.S. 15:541.1 and in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., the Department of Revenue, Office of Alcohol and Tobacco Control, has enacted LAC 55:VII.331 relative to the posting of certain information regarding the National Human Trafficking Resource Center hotline.

The regulation is enacted to comply with the mandates of Act 430 of the 2013 Regular Session of the Louisiana Legislature.

Title 55

PUBLIC SAFETY

Part VII. Alcohol and Tobacco Control

Subpart 1. Beer and Liquor

Chapter 3. Liquor Credit Regulations

§331. Regulation XIII—Posting of the National

Human Trafficking Resource Center Hotline

A. All establishments listed in R.S. 15:541.1(A) shall prominently display a poster furnished by the Office of Alcohol and Tobacco Control containing information regarding the National Human Trafficking Resource Center hotline in all male and female public restrooms located within the premises.

AUTHORITY NOTE: Promulgated in accordance with R.S. 15:541.1.

HISTORICAL NOTE: Promulgated by the Department of Revenue, Office of Alcohol and Tobacco Control, LR 40:1113 (June 2014).

Troy Hebert
Commissioner

1406#052

RULE

Department of Revenue Office of Alcohol and Tobacco Control

Responsible Vendor Program (LAC 55:VII.505 and 509)

Under the authority of R.S. 26:931 et seq., and in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., the Department of Revenue, Office of Alcohol and Tobacco Control, has amended LAC 55:VII.505 and 509 relative to the forms of personal identification required to be submitted and/or maintained by servers, trainers, providers and vendors of the Responsible Vendor Program.

The amendments are adopted to require that only the last four digits of the Social Security number of servers, security personnel and trainers shall be provided to and maintained by providers, vendors, the program administrator and the Office of Alcohol and Tobacco Control.

Title 55

PUBLIC SAFETY

Part VII. Alcohol and Tobacco Control

Subpart 1. Beer and Liquor

Chapter 5. Responsible Vendor Program

§505. Vendors

A. - B.2. ...

3. The vendor shall maintain server and security personnel training records, which include the name, date of birth, last four digits of Social Security number, and date of hire for all servers and security personnel. The records shall be kept on the licensed premises at all times for inspection by agents of the Office of Alcohol and Tobacco Control or other peace officers.

4. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 26:931 et seq.

HISTORICAL NOTE: Promulgated by the Department of Revenue, Office of Alcohol and Tobacco Control, LR 24:1949 (October 1998), amended LR 25:879 (May 1999), LR 31:939 (April 2005), LR 39:1827 (July 2013), LR 40:1113 (June 2014).

§509. Training: Provider and Trainers

A. - B.1.c. ...

d. the names, date of birth, last four digits of Social Security numbers, addresses and phone numbers, and educational and employment backgrounds of all trainers to be used in teaching the course; and

1.e - 2.a. ...

b. the names, dates of birth, last four digits of Social Security numbers, addresses and phone numbers, and educational and employment backgrounds of all persons engaged in the development/creation of the online (computer-based) training course;

B.2.c. - E.1. ...

a. the name, last four digits of Social Security number, permit number, address, telephone number, and date of birth of each student that completed the training course and passed the required examination;

1.b. - 2. ...

3. The approved provider shall maintain for four years from the date the class was conducted, the course information, which includes the class location, date, and time; trainer's name; and the student's names, last four digits of Social Security number and permit number. These records shall be maintained at the approved provider's place of business available for inspection and copying by agents or employees of the Office of Alcohol and Tobacco Control.

F. - K.4. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 26:931 et seq.

HISTORICAL NOTE: Promulgated by the Department of Revenue, Office of Alcohol and Tobacco Control, LR 24:1950 (October 1998), amended LR 31:939 (April 2005), LR 39:1828 (July 2013), LR 40:1114 (June 2014).

Troy Hebert
Commissioner

1406#053

RULE

**Department of Revenue
Office of Alcohol and Tobacco Control**

Staggering of Expiration Dates (LAC 55:VII.321)

Under the authority of R.S. 26:794 and in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., the Department of Revenue, Office of Alcohol and Tobacco Control, has amended LAC 55:VII.321 relative to the timely filing of renewal applications for alcoholic beverage permits.

The regulation amends the date that applications for the renewal of alcoholic beverage permits shall be due in the Office of Alcohol and Tobacco Control to require that applications are due on or before the expiration date on the current permit. The amendment mirrors the existing regulation for the timely submission of tobacco permit renewal applications to provide for consistency in requirements relative to the submission of applications with the Office of Alcohol and Tobacco Control.

Title 55

PUBLIC SAFETY

Part VII. Alcohol and Tobacco Control

Subpart 1. Beer and Liquor

Chapter 3. Liquor Credit Regulations

§321. Staggering of Expiration Dates

A. - D.2. ...

E. Renewal Deadline: Penalties

1. Applications for the renewal of permits issued pursuant to this regulation shall be due in the Office of Alcohol and Tobacco Control on or before the date of expiration on current permit.

E.2. - G. ...

* * *

AUTHORITY NOTE: Promulgated in accordance with R.S. 26:794.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of Alcoholic Beverage Control, LR 12:247 (April 1986), amended by the Department of Revenue, Office of Alcohol and Tobacco Control, LR 24:1318 (July 1998), LR 40:1114 (June 2014).

Troy Hebert
Commissioner

1406#049

RULE

**Department of Revenue
Office of Alcohol and Tobacco Control**

**Stamping Agent and Exporter Regulations
(LAC 55:VII.Chapter 31)**

Under the authority of R.S. 26:901 et seq., and in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., the Department of Revenue, Office of Alcohol and Tobacco Control, has amended LAC 55:VII.3101, 3103, and 3117 relative to the licensing of wholesale tobacco dealers as stamping agents and exporters of tobacco products.

The amendments to the above-referenced rules are adopted to comply and correlate with the provisions of R.S. 901 et seq., as amended and re-enacted through Act 221 of the 2013 Regular Legislative Session which creates the stamping agent designation and exporter license as additions to the credentials a wholesale tobacco dealer shall obtain when receiving and conducting interstate business with unstamped tobacco products.

Title 55

PUBLIC SAFETY

Part VII. Alcohol and Tobacco Control

Subpart 2. Tobacco

Chapter 31. Tobacco Permits

§3101. Definitions

A. For purposes of this Chapter, the following terms are defined.

Brand Family—all styles of cigarettes sold under the same trade mark and differentiated from one another by means of additional modifiers or descriptors, including but not limited to “menthol,” “lights,” kings,” and “100s,” and includes any brand name (alone or in conjunction with any other word), trademark, logo, symbol, motto, selling message, recognizable pattern of colors, or any other indicia

of product identification identical or similar to, or identifiable with, a previously known brand of cigarettes.

Exporter License—permits wholesale dealers with a valid stamping agent designation to engage in interstate business or to affix the tax stamps of another state.

Knowing Violation—the knowing or intentional act of engaging in conduct without a good faith belief that the conduct was consistent with the title 26 of the *Louisiana Revised Statutes*.

Person—any natural person, trustee, company, partnership, corporation, or other legal entity.

Purchase—acquisition in any manner, for any consideration. Includes the transport or receipt of product in connection with a purchase.

Sale; Sell—any transfer, exchange, or barter in any manner or by any means for any consideration. Includes the distribution or shipment of product in connection with a sale. References to a sale “in” or “into” a state refer to the state of the destination point of the product in the sale, without regard to where title was transferred. References to sale “from” a state refer to the sale of cigarettes that are located in that state to the destination in question without regard to where title was transferred.

Sales Entity Affiliate—an entity that (1) sells cigarettes that it acquires directly from a manufacturer or importer and (2) is affiliated with that manufacturer or importer as established by documentation received directly from that manufacturer or importer to the satisfaction of the attorney general. Entities are affiliated with each other if one, directly or indirectly through one or more intermediaries, controls or is controlled by or is under common control with the other.

Stamping Agent—a dealer that is authorized to affix tax stamps to packages or other containers of cigarettes pursuant to R.S. 47:843 et seq., or any dealer that is required to pay the excise tax or tobacco tax imposed pursuant to R.S. 47:841 et seq., on cigarettes.

State Directory; Directory—the directory compiled by the attorney general pursuant to R.S. 13:5073, or, when referencing another state’s directory, the directory compiled pursuant to the similar law in that other state.

AUTHORITY NOTE: Promulgated in accordance with R.S. 26:901.

HISTORICAL NOTE: Promulgated by the Department of Revenue, Office of Alcohol and Tobacco Control, LR 24:1320 (July 1998), amended LR 38:145 (January 2012), LR 40:1114 (June 2014).

§3103. Identifying Information for Permits

A. Permits

1. An exporter license shall be issued to a wholesale dealer with a valid stamping agent designation if that dealer engages in interstate business or affixes the tax stamps of another state. Such wholesale dealer/stamping agent shall first apply for the license prior to the purchase or possession of unstamped or non-tax paid cigarettes of another state.

2. A retail dealer permit shall be issued to a dealer other than a wholesale dealer, tobacconist, or vending machine operator for each retail outlet where cigars, cigarettes, or other tobacco products are offered for sale either over the counter or by vending machine.

3. A stamping agent designation shall be issued to a dealer that engages in the business of purchasing unstamped or non-tax paid cigarettes and that meets all the requirements of a wholesale dealer as defined in accordance with the provisions of R.S. 26:906(H) and the provisions of this Chapter.

4. A tobacconist permit shall be issued to a dealer engaged in receiving bulk smoking tobacco for the purpose of blending such tobacco for retail sale at a particular outlet where 50 percent or more of the total purchases for the preceding 12 months were purchases of tobacco products, excluding cigarettes, for each retail outlet where cigars, cigarettes, or other tobacco products are offered for sale either over the counter or by vending machine.

5. A vending machine operator permit shall be issued to a vending machine operator operating one or more vending machines. Licensed wholesale dealers who operate vending machines shall not be required to obtain a vending machine operator permit.

6. A vending machine permit shall be issued to the vending machine operator or wholesale dealer for each vending machine he operates and such permit shall be affixed to the upper front surface of the vending machine.

7. A wholesale dealer permit shall be issued to a wholesale dealer for each wholesale place of business operated by the wholesale dealer.

B. - C.5. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 26:902.

HISTORICAL NOTE: Promulgated by the Department of Revenue, Office of Alcohol and Tobacco Control, LR 24:1320 (July 1998), amended LR 38:145 (January 2012), LR 38:2939 (November 2012), LR 40:1115 (June 2014).

§3117. Importation of Cigarettes by Wholesaler Only

A. Cigarettes, as defined in R.S. 26:901, produced or manufactured outside of this state cannot be sold or offered for sale in Louisiana, or shipped or transported into the state except to the holder of a wholesaler’s permit. Delivery of cigarettes produced or manufactured outside of this state must be made at the place of business of the wholesaler shown on the wholesaler’s permit, and must be received and warehoused by the wholesaler at that place of business, where such cigarettes must come to rest before delivery is made to any retailer.

B. Pursuant to the provisions of R.S. 26:902 et seq., a wholesale dealer shall not accept delivery of any unstamped cigarettes produced or manufactured outside the state unless such wholesale dealer is also the holder of a valid stamping agent designation and exporter license. Acting within his duties as stamping agent, a wholesale dealer who comes into receipt of such and unstamped package of cigarettes, shall immediately cause the proper affixation of the required stamps to each package of cigarettes.

C. In accordance with R.S. 47:871, no person who is engaged in the business of selling or distributing cigarettes may ship or transport, or cause to be shipped or transported, cigarettes to any consumer in the state. The provisions of this Section shall apply regardless of whether the person engaged in the business of selling or distributing cigarettes is located within or without the state.

D. Any retailer of cigarettes who violates any provision of this Section will be subject to a civil penalty in the amount of \$25,000. Any retailer that sells and ships directly

to consumers in Louisiana pursuant to Subsection B of this Section must, on the application for authority to make such shipments filed with the secretary of the Department of Revenue in accordance with Subsection C of this Section, acknowledge in writing the civil penalty established in this Subsection and must consent to the imposition thereof upon violation of this Section. The secretary may initiate and maintain a civil action in a court of competent jurisdiction to enjoin any violation of this Section and to recover the civil penalty established in this Subsection, together with all costs and attorney fees incurred by the secretary incidental to any such action.

AUTHORITY NOTE: Promulgated in accordance with R.S. 26:922.

HISTORICAL NOTE: Promulgated by the Department of Revenue, Office of Alcohol and Tobacco Control, LR 31:2036 (August 2005), amended LR 40:1115 (June 2014).

Troy Hebert
Commissioner

1406#050

RULE

**Department of Transportation and Development
Office of Operations**

Noncritical Off-Road Equipment (LAC 73:I.1703)

In accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., and through the authority granted in R.S. 32:385.12(A), the Department of Transportation and Development, Office of Operations has amended Chapter 17, §1703 to add “single-triple” and “triple axles” to the definition of *noncritical off-road equipment*.

Title 73

WEIGHTS, MEASURES AND STANDARDS

Part I. Weights and Standards

Chapter 17 Requirements for Permitting Off-Road Equipment

§1703. Noncritical Off-Road Equipment

A. *Noncritical off-road equipment* is defined as:

1. vehicles or combinations of vehicles without booster units;
2. vehicles with a single-single, single-tandem, single-triple, or tandem-tandem axle configuration in which no single axle is in excess of 30,000 pounds nor tandem or triple axles in excess of 54,000 pounds;
3. vehicles or combinations of vehicles without booster units which are determined to be acceptable in this classification by the department's evaluation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 32:2 et seq.

HISTORICAL NOTE: Promulgated by the Department of Transportation and Development, Office of Highways, LR 5:26 (February 1979), amended by the Office of Weights, Measures and Standards, LR 22:120 (February 1996), amended by the Office of Operations, LR 40:1116 (June 2014).

Sherri H. LeBas
Secretary

1406#032

RULE

**Department of Wildlife and Fisheries
Wildlife and Fisheries Commission**

Reef Fish—Harvest Regulations (LAC 76:VII.335)

Editor's Note: The following Rule is being repromulgated to correct a printing error. The original Rule can be viewed in the January 20, 2014 edition of the *Louisiana Register* on pages 95-96.

The Wildlife and Fisheries Commission does hereby amend a Rule, LAC 76:VII.335, modifying existing reef fish harvest regulations. Authority for adoption of this Rule is included in R.S. 56:6(25)(a), 56:320.2, 56:326.1 and 56:326.3.

The secretary of the Department of Wildlife and Fisheries is authorized to take any and all necessary steps on behalf of the commission to promulgate and effectuate this final Rule.

Title 76

WILDLIFE AND FISHERIES

Part VII. Fish and Other Aquatic Life

Chapter 3. Saltwater Sport and Commercial Fishery §335. Reef Fish—Harvest Regulations

A. Recreational Bag Limits Regarding the Harvest of Reef Fish—triggerfishes, amberjacks, grunts, wrasses, snappers, groupers, sea basses, tilefishes, and porgies, within and without Louisiana's territorial waters.

Species	Recreational Bag Limits
[See Prior Text in 1-2]	
3. Vermilion snapper, lane snapper, gray triggerfish, almaco jack, goldface tilefish, tilefish, blackline tilefish, anchor tilefish, blueline tilefish	20 per person per day (in aggregate) with not more than 2 gray triggerfish and not more than 10 vermilion snapper per person included in the bag limit
[See Prior Text in 4-8]	

B. Reef Fish Permits

1. All persons who do not possess a permit issued by the National Marine Fisheries Service under the federal fishery management plan for the harvest of Gulf of Mexico reef fish resources are limited to the recreational bag limit. To commercially harvest, sell, barter, trade or exchange or possess for commercial purposes all species of reef fish including dwarf sand perch and sand perch, but (excluding queen triggerfish, black seabass, porgies, and grunts) requires a valid federal reef fish vessel permit be on board the vessel and in the immediate possession.

2. For a person aboard a vessel operating as a charter vessel or headboat to fish for, or harvest, or possess, in or from the EEZ, any species of reef fish including dwarf sand perch and sand perch (but excluding queen triggerfish, black seabass, porgies, and grunts) a valid federal charter vessel/headboat reef fish permit must have been issued to the vessel and must be on board the vessel and in immediate possession.

B.3. - D.7. ...

8. Commercial trip limits shall include those limits listed below. For the purposes of this Rule:

Trip—a fishing *trip*, regardless of the number of days duration, that begins with departure from a dock, berth, beach, seawall or ramp and that terminates with return to a dock, berth, beach, seawall or ramp.

Species or Group	Trip Limit
a. Gray Triggerfish	12 fish
b. Greater Amberjack	2,000 pounds

E. - F. ...

* * *

G. Seasons

1. Seasons for the commercial harvest of reef fish species or groups shall be closed during the periods listed below. Possession of reef fish in excess of the daily bag limit while on the water is prohibited during the specified closed season. Any reef fish harvested during the closed season shall not be purchased, sold, traded, bartered or exchanged or attempted to be purchased, sold, traded, bartered or exchanged. This prohibition on sale/purchase does not apply to reef fish that were harvested, landed ashore, sold and purchased prior to the closed season. Nothing shall prohibit the possession or sale of fish legally taken prior to the closure providing that all commercial dealers possessing reef fish taken legally prior to the closure shall maintain appropriate records in accordance with R.S. 56:306.5 and R.S. 56:306.6.

Species or Group	Closed Season
a. Greater Amberjack	March 1-May 31
b. Gray Triggerfish	June 1-July 31 of each year

2. Seasons for the recreational harvest of reef fish species or groups listed below shall be closed during the periods listed below.

Species or Group	Closed Season
a. Gag	January 1-June 30 of each year
b. Black, red, yellowfin, and yellowmouth groupers, rock hind, red hind, and scamp	February 1-March 31 of each year in waters seaward of the 20 fathom boundary
[See Prior Text in c.-d.]	
e. Gray Triggerfish	June 1-July 31 of each year

G.3. - H. ...

I.1. Devices

Circle Hook—a fishing hook designed and manufactured so that the point is turned perpendicularly back to the shank to form a generally circular or oval shape.

Dehooking Device—a device intended to remove a hook embedded in a fish to release the fish with minimum damage.

2. For a person on board a vessel to fish for or possess gulf reef fish in the gulf EEZ, the vessel must possess on board and such person must use the gear as specified below.

a. Non-stainless Steel Circle Hooks. Non-stainless steel circle hooks are required when fishing with natural baits for reef fish.

b. Dehooking Device. At least one dehooking device is required and must be used to remove hooks embedded in gulf reef fish with minimum damage. The hook removal device must be constructed to allow the hook to be secured and the barb shielded without re-engaging during

the removal process. The dehooking end must be blunt, and all edges rounded. The device must be of a size appropriate to secure the range of hook sizes and styles used in the gulf reef fish fishery.

J. ...

AUTHORITY NOTE: Promulgated in accordance with R.S.56:6(25)(a), R.S. 56:320.2(C), R.S. 56:326.1, and R.S. 56:326.3.

HISTORICAL NOTE: Promulgated by the Department of Wildlife and Fisheries, Wildlife and Fisheries Commission, LR 16:539 (June 1990), amended LR 19:1442 (November 1993), LR 20:797 (July 1994), LR 21:1267 (November 1995), LR 22:860 (September 1996), LR 24:1138 (June 1998), LR 24:1139 (June 1998), LR 24:1972 (October 1998), LR 26:793 (April 2000), LR 26:1505 (July 2000), LR 26:2833 (December 2000), LR 31:3166 (December 2005), LR 33:1156 (June 2007), repromulgated LR 33:1397 (July 2007), amended LR 34:2209 (October 2008), LR 34:2682 (December 2008), LR 36:1791 (August 2010), LR 38:1454 (June 2012), LR 40:95 (January 2014), repromulgated LR 40:1116 (June 2014).

The secretary of the Department of Wildlife and Fisheries is authorized to take any and all necessary steps on behalf of the commission to promulgate and effectuate this final Rule.

Billy Broussard
Vice Chairman

1406#041

RULE

**Department of Wildlife and Fisheries
Wildlife and Fisheries Commission**

Spanish Lake State Game and Fishing Preserve
(LAC 76:III.329)

The Wildlife and Fisheries Commission has amended netting restrictions on Spanish Lake (St. Martin and Iberia Parishes).

Title 76

WILDLIFE AND FISHERIES

Part III. Game and Fish Preserves and Sanctuaries

**Chapter 3. Particular Game and Fish Preserves,
Wildlife Management Areas, Refuges and
Conservation Areas**

§329. Spanish Lake State Game and Fishing Preserve

A. General

1. Parking is restricted to designated parking areas.
2. ATVs (three wheelers and four wheelers) and motorbikes are prohibited on the levee.
3. Discharge of any firearms on the levees is prohibited.
4. Overnight camping is prohibited, except by special permit issued by Spanish Lake Game and Fishing Preserve Commission for supervised groups only.
5. No trapping of furbearing animals, except by special permit issued by the Louisiana Department of Wildlife and Fisheries.

AUTHORITY NOTE: Promulgated in accordance with R.S. 56:6, R.S. 56:721 et seq., R.S. 56:801 and R.S. 36:610.

HISTORICAL NOTE: Promulgated by the Department of Wildlife and Fisheries, Wildlife and Fisheries Commission, LR 23:872 (July 1997), amended LR 30:1734 (August 2004), LR 35:968 (May 2009), LR 40:1117 (June 2014).

The secretary of the Department of Wildlife and Fisheries is authorized to take any and all necessary steps on behalf of the commission to promulgate and effectuate this Notice of Intent and the final Rule, including but not limited to, the filing of the Fiscal and Economic Impact Statements, the filing of the Notice of Intent and final Rule and the preparation of reports and correspondence to other agencies of government.

Billy Broussard
Chairman

1406#039

RULE

**Workforce Commission
Office of Unemployment Insurance Administration**

Employment Security Law (LAC 40:IV.365)

Pursuant to the authority granted in R.S. 23:1653 and R.S. 23:1654, and in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., the Louisiana Workforce Commission has repealed §365. The purpose of repealing §365 is to limit appeal rights on tax determinations regarding employer status only to those deadlines set forth by statute.

**Title 40
LABOR AND EMPLOYMENT
Part IV. Employment Security
Subpart 1. Board of Review
Chapter 3. Employment Security Law
§365. Liability Determination Appeal Rights**

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1471-1713.

HISTORICAL NOTE: Promulgated by the Department of Labor, Office of Employment Security, LR 15:495 (June 1989), amended by the Department of Employment and Training, Office of Employment Security, LR 17:47 (January 1991), repealed by the Workforce Commission, Office of Unemployment Insurance Administration, LR 40:1118 (June 2014).

Curt Eysink
Executive Director

1406#007

RULE

**Workforce Commission
Office of Unemployment Insurance Administration**

Overpayment Recovery; Civil Penalties (LAC 40:IV.371)

Pursuant to the authority granted in R.S. 23:1653, R.S. 23:1654, and in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., the Louisiana Workforce Commission has amended §371. The purpose of the amendment is to reincorporate inadvertent omissions in prior amendments, to correct a typographical error in the repayment schedule, and to provide for uniformity in the timeframes for repayment. The heading of

this Section has also been amended to more accurately reflect the contents of the Rule.

Title 40

**LABOR AND EMPLOYMENT
Part IV. Employment Security
Subpart 1. Board of Review**

Chapter 3. Employment and Security Law

§371. Overpayment Recovery

A. This Rule prescribes an acceptable repayment schedule for the purpose of collecting overpaid benefits pursuant to R.S. 23:1713.

1. The amount of overpayment is immediately due and payable on demand upon exhaustion of the right to appeal:

- a. a determination of overpayment; and/or
- b. a denial of waiver of overpayment.

2. If an individual is unable to immediately repay the overpayment in full upon demand, a repayment agreement in writing will be negotiated in compliance with the repayment table for overpayments listed below.

Repayment Tables Total for Overpayments			
Total Overpayment Amount is: At Least	But Less Than:	Number of Months to Repay	Minimum Monthly Payment
\$1	\$500	12	\$42
\$501	\$1,000	12	\$84
\$1,001	\$1,500	18	\$84
\$1,501	\$2,000	18	\$112
\$2,001	\$2,500	24	\$105
\$2,501	\$3,000	24	\$125
\$3,001	\$3,500	30	\$117
\$3,501	\$4,000	30	\$134
\$4,001	\$4,500	36	\$125
\$4,501	\$5,000	36	\$139
\$5,001	\$5,500	42	\$131
\$5,501	\$6,000	42	\$143
\$6,001	\$6,500	48	\$136
\$6,501	\$7,000	48	\$146
\$7,001	\$7,500	54	\$139
\$7,501	\$8,000	54	\$149
\$8,001	\$8,500	60	\$142
\$8,501	\$9,000 or greater	60	\$150

B. The initial payment and signed repayment agreement must be received within 30 days from the day that the repayment agreement is mailed to the individual's last known address. Subsequent payments are to be paid in monthly installments which commence no later than 30 days after the initial payment is received, and are due thereafter each month until paid in full.

C. An adjustment of the repayment schedule may be granted at the written request of the claimant only if there has been material change in his or her financial condition.

D. Requests to adjust the repayment schedule will only be granted if warranted by the criteria set forth in §369.C, waiver of overpayment recovery, equity and good conscience determination.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1471-1713.

HISTORICAL NOTE: Promulgated by the Department of Labor, Office of Employment Security, LR 15:1085 (December 1989), repromulgated LR 17:48 (January 1991), amended by the

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Executive Director

1406#008

RULE

Workforce Commission Office of Workers' Compensation

Medical Guidelines
(LAC 40:I:2001-2011, 2015-2023, 2103,
2119, 2203, 2217, 2303, and 2317)

In accordance with R.S. 49:950, et seq., the Louisiana Workforce Commission, Office of Workers' Compensation, pursuant to the authority vested in the Director of the Office of Workers' Compensation by R.S. 23:1310.1 and in accordance with applicable provisions of the Administrative Provisions Act, has amended LAC 40:I:Chapters 20-23.

Title 40

LABOR AND EMPLOYMENT

Part I. Workers' Compensation Administration

Subpart 2. Medical Guidelines

Chapter 20. Spine Medical Treatment Guidelines

Subchapter A. Cervical Spine Injury

§2001. Introduction

A. This document has been prepared by the Louisiana Workforce Commission, Office of Workers' Compensation (OWCA) and should be interpreted within the context of guidelines for physicians/providers treating individuals qualifying under Louisiana's Workers' Compensation Act as injured workers with cervical spine injuries. These guidelines are enforceable under the Louisiana Workers' Compensation Act. All medical care, services, and treatment owed by the employer to the employee in accordance with the Louisiana Workers' Compensation Act shall mean care, services, and treatment in accordance with these guidelines. Medical care, services and treatment that varies from these guidelines shall also be due by the employer when it is demonstrated to the medical director of the office by a preponderance of the scientific medical evidence, that a variance from these guidelines is reasonably required to cure or relieve the injured worker from the effects of the injury or occupational disease given the circumstances. Therefore, these guidelines are not relevant as evidence of a provider's legal standard of professional care. To properly utilize this document, the reader should not skip nor overlook any sections.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1203.1.

HISTORICAL NOTE: Promulgated by the Louisiana Workforce Commission, Office of Workers' Compensation Administration, LR 37:1631 (June 2011), amended by the Louisiana Workforce Commission, Office of Workers' Compensation, LR 40:1119 (June 2014).

§2003. General Guideline Principles

A. - A.1.

2. Education. Education of the patient and family, as well as the employer, insurer, policy makers and the community should be the primary emphasis in the treatment of workers' compensation injuries. Currently, practitioners often think of education last, after medications, manual therapy, and surgery. Practitioners must develop and implement an effective strategy and skills to educate patients, employers, insurance systems, policy makers, and the community as a whole. An education-based paradigm should always start with inexpensive communication providing reassuring information to the patient. More in-depth education currently exists within a treatment regime employing functional restorative and innovative programs of prevention and rehabilitation. No treatment plan is complete without addressing issues of individual and/or group patient education as a means of facilitating self-management of symptoms and prevention.

3. - 5.

6. Positive Patient Response. Positive results are defined primarily as functional gains that can be objectively measured. Standard measurement tools, including outcome measures, should be used.

a. Objective functional gains include, but are not limited to, positional tolerances, range-of-motion (ROM), strength, and endurance, activities of daily living, cognition, psychological behavior, and efficiency/velocity measures that can be quantified. Subjective reports of pain and function should be considered and given relative weight when the pain has anatomic and physiologic correlation. Anatomic correlation must be based on objective findings.

7. Re-Evaluation of Treatment Every Three to Four Weeks. If a given treatment or modality is not producing positive results within three to four weeks, the treatment should be either modified or discontinued. Reconsideration of diagnosis should also occur in the event of poor response to a seemingly rational intervention.

8. Surgical Interventions. Surgery should be contemplated within the context of expected improvement of functional outcome and not purely for the purpose of pain relief. The concept of "cure" with respect to surgical treatment by itself is generally a misnomer. All operative interventions must be based upon positive correlation of clinical findings, clinical course, and diagnostic tests. A comprehensive assimilation of these factors must lead to a specific diagnosis with positive identification of pathologic conditions. The decision and recommendation for operative treatment, and the appropriate informed consent should be made by the operating surgeon. Prior to surgical intervention, the patient and treating physician should identify functional operative goals and the likelihood of achieving improved ability to perform activities of daily living or work activities and the patient should agree to comply with the pre- and post-operative treatment plan and home exercise requirements. The patient should understand the length of partial and full disability expected post-operatively.

9. Pharmacy-Louisiana Law and Regulation. All prescribing will be done in accordance with the laws of the state of Louisiana as they pertain respectively to each individual licensee, including, but not limited to: Louisiana State Board of Medical Examiners regulations governing medications used in the treatment of non-cancer-related chronic or intractable pain; Louisiana Board of Pharmacy Prescription Monitoring Program; Louisiana Department of Health and Hospitals licensing and certification standards for pain management clinics; other laws and regulations affecting the prescribing and dispensing of medications in the state of Louisiana.

10. Six Month Time Frame. The prognosis drops precipitously for returning an injured worker to work once he/she has been temporarily totally disabled for more than six months. The emphasis within these guidelines is to move patients along a continuum of care and return-to-work within a six-month time frame, whenever possible. It is important to note that time frames may not be pertinent to injuries that do not involve work-time loss or are not occupationally related.

11. Return to Work. Return to work is therapeutic, assuming the work is not likely to aggravate the basic problem or increase long-term pain. The practitioner must provide specific written physical limitations. If a practitioner releases a patient at a level of function lower than their previous job position, the practitioner must provide physical limitations and abilities and job modifications. A patient should never be released to simply “sedentary” or “light duty.” The following physical limitations should be considered and modified as recommended: lifting, pushing, pulling, crouching, walking, using stairs, climbing ladders, bending at the waist, awkward and/or sustained postures, tolerance for sitting or standing, hot and cold environments, data entry and other repetitive motion tasks, sustained grip, tool usage and vibration factors. Even if there is residual chronic pain, return-to-work is not necessarily contraindicated. The practitioner should understand all of the physical demands of the patient’s job position before returning the patient to full duty and should request clarification of the patient’s job duties. Clarification should be obtained from the employer or, if necessary, including, but not limited to, an occupational medicine physician, occupational health nurse, physical therapist, occupational therapist, vocational rehabilitation specialist, or an industrial hygienist.

12. Delayed Recovery. Strongly consider a psychological evaluation, if not previously provided, as well as initiating interdisciplinary rehabilitation treatment and vocational goal setting, for those patients who are failing to make expected progress 6 to 12 weeks after an injury. The OWCA recognizes that 3 to 10 percent of all industrially injured patients will not recover within the timelines outlined in this document despite optimal care. Such individuals may require treatments beyond the limits discussed within this document, but such treatment will require clear documentation by the authorized treating practitioner focusing on objective functional gains afforded by further treatment and impact upon prognosis.

13. Guideline Recommendations and Inclusion of Medical Evidence. Guidelines are recommendations based on available evidence and/or consensus recommendations. When possible, guideline recommendations will note the

level of evidence supporting the treatment recommendation. When interpreting medical evidence statements in the guideline, the following apply to the strength of recommendation.

Strong	Level 1 Evidence	We Recommend
Moderate	Level 2 and Level 3 Evidence	We Suggest
Weak	Level 4 Evidence	Treatment is an Option
Inconclusive	Evidence is Either Insufficient or Conflicting	

a. Consensus guidelines are generated by a professional organization that the guidelines are intended to serve. A committee of specialists and experts are selected by the organization to create an unbiased, vetted recommendation for the treatment of specific issues within the realm of their expertise. All recommendations in the guideline are considered to represent reasonable care in appropriately selected cases, regardless of the level of evidence or consensus statement attached to it. Those procedures considered inappropriate, unreasonable, or unnecessary are designated in the guideline as “not recommended.”

14. Repealed.

B. The remainder of this document should be interpreted within the parameters of these guideline principles that may lead to more optimal medical and functional outcomes for injured workers.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1203.1.

HISTORICAL NOTE: Promulgated by the Louisiana Workforce Commission, Office of Workers Compensation Administration, LR 37:1631 (June 2011), amended by the Louisiana Workforce Commission, Office of Workers Compensation, LR 40:1119 (June 2014).

§2005. Initial Diagnostic Procedures

A. - A.1. ...

a. History of Present Injury. A detailed history, taken in temporal proximity to the time of injury, should primarily guide evaluation and treatment. The history should include pertinent, positive and negative information regarding the following:

i. - iii. ...

iv. alteration of bowel, bladder, or sexual function; and for female patients, alteration in their menstrual cycle;

v. any treatment for current injury and result; and

vi. ability to perform job duties and activities of daily living.

b. Past history:

i. past medical history includes neoplasm, arthritis, and diabetes;

ii. review of systems includes symptoms of rheumatologic, neurologic, endocrine, neoplastic, infectious, and other systemic diseases;

iii. - v. ...

vi. The examiner will screen for concurrent emotional disorders/conditions and, when possible, other known psychosocial predictors of poor outcome;

vii. prior occupational and non-occupational injuries to the same area including specific prior treatment, chronic or recurrent symptoms, and any functional limitations; specific history regarding prior motor vehicle accidents may be helpful.

- c. ...
 - i. general and visual inspection, including posture, stance and gait;
 - ii. palpation of spinous processes, facets, and muscles noting myofascial tightness, tenderness, and trigger points;
 - iii. cervical range-of-motion, quality of motion, and presence of muscle spasm. Motion evaluation of specific joints may be indicated. Range-of-motion should not be checked in acute trauma cases until fracture and instability have been ruled out on clinical examination, with or without radiographic evaluation;
 - iv. examination of thoracic spine;

2. Radiographic imaging of the cervical spine is a generally accepted, well-established and widely used diagnostic procedure. Basic views are the anteroposterior (AP), lateral, right, and left obliques, swimmer's, and odontoid. CT scans may be necessary to visualize C7 and odontoid in some patients. Lateral flexion and extension views are done to evaluate instability but may have a limited role in the acute setting. MRI or CT is indicated when spinal cord injury is suspected. The mechanism of injury and specific indications for the imaging should be listed on the request form to aid the radiologist and x-ray technician. Alert, non-intoxicated patients, who have isolated cervical complaints without palpable midline cervical tenderness, neurologic findings, or other acute or distracting injuries elsewhere in the body, may not require imaging. The following suggested indications are:

- a. - e. ...
 - f. suspected lesion in the cervical spine due to systemic illness such as a rheumatic/rheumatoid disorder or endocrinopathy. Suspected lesions may require special views.
3. - 3.a. ...
- b. erythrocyte sedimentation rate (ESR), rheumatoid factor (RF), antinuclear antigen (ANA), human leukocyte antigen (HLA), and C-reactive protein (CRP), can be used to detect evidence of a rheumatologic, infectious, or connective tissue disorder;
 - c. - d. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1203.1.

HISTORICAL NOTE: Promulgated by the Louisiana Workforce Commission, Office of Workers Compensation Administration, LR 37:1632 (June 2011), amended by the Louisiana Workforce Commission, Office of Workers Compensation, LR 40:1120 (June 2014).

§2007. Follow-Up Diagnostic Imaging and Testing Procedures

A. One diagnostic imaging or testing procedure may provide the same or distinctive information as does another procedure. Therefore, prudent choice of a single diagnostic procedure, a complement of procedures, or a sequence of procedures will optimize diagnostic accuracy, and maximize cost effectiveness (by avoiding redundancy), and minimize potential adverse effects to patients. All imaging and testing procedures have a degree of specificity and sensitivity for various diagnoses. No isolated imaging test can assure a correct diagnosis.

B. Clinical information obtained by history taking and physical examination should form the basis for selecting an

imaging procedure and interpreting its results. Clinical updates must demonstrate the patient's current status to document the need for diagnostic testing or additional treatment. A brief history, changes in clinical findings such as orthopedic and neurological tests, and measurements of function with emphasis on the current, specific physical limitations will be important when seeking approval of future care. The emphasis of the medical treatment schedule are that the determination of the need to continue treatment is based on functional improvement, and that the patient's ability (current capacity) to return to work is needed to assist in disability management.

C. Magnetic resonance imaging (MRI), myelography, or computed axial tomography (CT) scanning following myelography, and other imaging and testing procedures may provide useful information for many spinal disorders. When a diagnostic procedure, in conjunction with clinical information, provides sufficient information to establish an accurate diagnosis, the second diagnostic procedure will become a redundant procedure. At the same time, a subsequent diagnostic procedure can be a complementary diagnostic procedure if the first or preceding procedures, in conjunction with clinical information, cannot provide an accurate diagnosis. Usually, preference of a procedure over others depends upon availability, a patient's tolerance, and/or the treating practitioner's familiarity with the procedure.

1. - 1.a. ...

i. In general, the high field, conventional, MRI provides better resolution. A lower field scan may be indicated when a patient cannot fit into a high field scanner or is too claustrophobic despite sedation. Inadequate resolution on the first scan may require a second MRI using a different technique. All questions in this regard should be discussed with the MRI center and/or radiologist.

ii. Specialized MRI Scans

(a). MRI with Three-Dimensional Reconstruction. On rare occasions, MRI with three-dimensional reconstruction views may be used as a pre-surgical diagnostic procedure to obtain accurate information of characteristics, location, and spatial relationships among soft tissue and bony structures;

(b). Dynamic-Kinetic MRI of the Spine. Dynamic-kinetic MRI of the spine uses an MRI unit configured with a top-front open design which enables upright, weight-bearing patient positioning in a variety of postures not obtainable with the recumbent images derived from conventional, closed unit MRI systems. Imaging can be obtained in flexion, extension, and rotation of the spine, as well as in erect positioning. There is a theoretical advantage to imaging sequences obtained under more physiologic conditions than in the supine position. There is currently ongoing research to establish whether the theoretical advantages of positional and kinetic MRI result in improved sensitivity and specificity in detecting spine pathology. Currently it remains investigational, and is not recommended until the correlation with clinical syndromes is firmly established.

b. Computed axial tomography (CT) provides excellent visualization of bone and is used to further evaluate bony masses and suspected fractures not clearly identified on radiographic evaluation. It may sometimes be done as a complement to MRI scanning to better delineate

bony osteophyte formation in the neural foramen. CT is usually utilized for suspected cervical spine fracture in a patient with negative plain films, or to further delineate a cervical fracture. CT scanning is also quite useful for congenital anomalies at the skull base and at the C1-2 levels. Plain CT scanning is poor for the C6-7 or C7-T1 levels because of shoulder artifact. Instrument-scatter reduction software provides better resolution when metallic artifact is of concern.

c. Myelography is the injection of radiopaque material into the spinal subarachnoid space, with x-rays then taken to define anatomy. It may be used as a diagnostic procedure to obtain accurate information of characteristics, location, and spatial relationships among soft tissue and bony structures. Myelography is an invasive procedure with complications including nausea, vomiting, headache, convulsion, arachnoiditis, CSF leakage, allergic reactions, bleeding, and infection. Therefore, myelography should only be considered when CT and MRI are unavailable, for morbidly obese patients or those who have undergone multiple operations, and when other tests prove non-diagnostic. The use of small needles and a less toxic, water-soluble, nonionic contrast is recommended.

d. CT myelogram provides more detailed information about relationships between neural elements and surrounding anatomy and is appropriate in patients with multiple prior operations or tumorous conditions.

e. Single Photon Emission Computerized Tomography (SPECT). A scanning technique which may be helpful to localize facet joint pathology and is useful in determining which patients are likely to have a response to facet injection. SPECT combines bone scans and CT scans in looking for facet joint pathology.

f. Bone scan (radioisotope bone scanning) is generally accepted, well-established and widely used. Bone scanning is more sensitive but less specific than MRI. ^{99m}Tc diphosphonate uptake reflects osteoblastic activity and may be useful in diagnosing metastatic/primary bone tumors, stress fractures, osteomyelitis, and inflammatory lesions, but cannot distinguish between these entities. In the cervical spine, the usual indication is to evaluate for neoplastic conditions. Other indications include occult fracture or infection.

g. Other radioisotope scanning indium and gallium scans are generally accepted, well-established, and widely used procedures, usually to help diagnose lesions seen on other diagnostic imaging studies. ⁶⁷Ga citrate scans are used to localize tumor, infection, and abscesses. ¹¹¹In leukocyte scanning is utilized for localizing infection or inflammation and is usually not used for the cervical spine.

h. Dynamic [digital] fluoroscopy dynamic [digital] fluoroscopy of the cervical spine measures the motion of intervertebral segments using a videofluoroscopy unit to capture images as the subject performs cervical flexion and extension, storing the anatomic motion of the spine in a computer. Dynamic Fluoroscopy may be used in state-designated trauma centers to evaluate the cervical spine. Its superiority over MRI has not been established. If performed, full visualization of the cervical spine (C1 - T1), in accordance with §2005.A.2. (Initial Diagnostic Procedures-

Imaging), should be accomplished prior to the procedure. In the post-acute setting in some rare cases, Dynamic [Digital] Fluoroscopy may be used but is primarily an investigational tool and therefore, requires prior authorization in the post-acute setting. No studies have yet demonstrated predictive value in terms of standard operative and non-operative therapeutic outcomes.

2. - 2.b.iii. ...

(a). It is obligatory that sufficient data be accumulated by the examiner performing this procedure such that the diagnostic value of the procedure is evident to other reviewers. This entails, at a minimum, documentation of patient response immediately following the procedure with details of any symptoms with a response and the degree of response. Additionally, a log must be recorded as part of the medical records which documents response, if any, on an hourly basis for, at a minimum, the expected duration of local anesthetic phase of the procedure. Responses must be identified as to specific body part (e.g., neck, arm pain). The practitioner must identify the local anesthetic used and the expected duration of response for diagnostic purposes.

(b). Multiple injections provided at the same session without staging may seriously dilute the diagnostic value of these procedures. Practitioners must carefully weigh the diagnostic value of the procedure against the possible therapeutic value.

iv. Special Requirements for Diagnostic Injections. Since multi-planar fluoroscopy during procedures is required to document technique and needle placement, an experienced physician should perform the procedure. Permanent images are required to verify needle placement. The subspecialty disciplines of the physicians performing the injections may be varied, including, but not limited to: anesthesiology, radiology, surgery, or physiatry. The practitioner should have completed fellowship training in pain medicine with interventional training, or its equivalent. They must also be knowledgeable in radiation safety.

v. Complications. General complications of diagnostic injections may include transient neurapraxia, nerve injury, infection, headache, vasovagal effects, as well as epidural hematoma, permanent neurologic damage, dural perforation and CSF leakage, and spinal meningial abscess. Severe complications are remote but can include spinal cord damage, quadriplegia, and/or death. Injections at a C2-C3 level frequently cause temporary neuritis with ataxia. vi.

Contraindications

(a). Absolute contraindications to diagnostic injections include:

- (i). bacterial infection—systemic or localized to region of injection;
- (ii). bleeding diatheses;
- (iii). hematological conditions; and
- (iv). possible pregnancy.

(b). Relative contraindications to diagnostic injections may include: allergy to contrast, poorly controlled diabetes mellitus, and hypertension.

(c). Drugs affecting coagulation may require restriction from use. Anti-platelet therapy and anticoagulations should be addressed individually by a knowledgeable specialist. It is recommended to refer to the American Society of Regional Anesthesia for anticoagulation guidelines.

vii. Specific Diagnostic Injections. In general, relief should last for at least the duration of the local anesthetic used and should significantly relieve pain and result in functional improvement. Refer to “Injections—Therapeutic” for information on specific therapeutic injections.

(a). Medial branch blocks are generally-accepted diagnostic injections, used to determine whether a patient is a candidate for radiofrequency medial branch neurotomy (also known as facet rhizotomy). The International Spine Intervention Society (ISIS) suggests controlled blocks—using either placebo or an anesthetic with a varying length of activity (i.e., bupivacaine longer than lidocaine). To be a positive diagnostic block, the patient should report a reduction of pain of 50 percent or greater from baseline for the length of time appropriate for the local anesthetic used. In almost all cases, this will mean a reduction of pain to 1 or 2 on the Visual Analog Scale (VAS) 10-point scale correlated with functional improvement. The patient should also identify activities of daily living (which may include measurements of range-of-motion) that are impeded by their pain and can be observed to document functional improvement in the clinical setting. Ideally, these activities should be assessed throughout the observation period for function. The observer should not be the physician who performed the procedure. It is suggested that this be recorded on a form similar to ISIS recommendations.

(i). A separate comparative block on a different date may be performed to confirm the level of involvement. A comparative block uses anesthetics with varying lengths of activity. Medial Branch blocks are probably not helpful to determine the likelihood of success for spinal fusion.

(ii). Frequency and maximum duration may be repeated once for comparative blocks. Limited to four levels / five medial branches.

(b). Atlanto-axial and atlanto-occipital injections are generally accepted for diagnosis and treatment but do not lend themselves to denervation techniques owing to variable neuroanatomy. Injection of this articulation is complicated by the proximity of the vertebral artery, which may be tortuous at the level of the C1 joint. Inadvertent injection of the vertebral artery may cause respiratory arrest, seizure, stroke, or permanent neurological sequelae. Only practitioners skilled in these injections should perform them:

(i). frequency and maximum duration: once per side.

(c). Transforaminal injections / Spinal selective nerve root blocks are generally accepted and useful in identifying spinal pathology. When performed for diagnosis, small amounts of local anesthetic should be used to determine the level of nerve root irritation. A positive diagnostic block should result in a positive diagnostic functional benefit and a 50 percent reduction in nerve-root generated pain appropriate for the anesthetic used as measured by accepted pain scales (such as a VAS):

(i). time to produce effect: less than 30 minutes for local anesthesia; corticosteroids up to 72 hours for most patients;

(ii). frequency and maximum duration: once per suspected level. limited to two levels

(d). Zygapophyseal (Facet) Blocks. Facet blocks are generally accepted but should not be considered diagnostic blocks for the purposes of determining the need for a rhizotomy (radiofrequency medial branch neurotomy), nor should they be done with medial branch blocks. These blocks should not be considered a definitive diagnostic tool. They may be used diagnostically to direct functional rehabilitation programs. A positive diagnostic block should result in a positive diagnostic functional benefit and a 50 percent reduction in pain appropriate for the anesthetic used as measured by accepted pain scales (such as a VAS). They then may be repeated per the therapeutic guidelines when they are accompanied by a functional rehabilitation program. (Refer to Therapeutic Spinal Injections):

(i). time to produce effect: less than 30 minutes for local anesthesia; corticosteroids up to 72 hours for most patients;

(ii). frequency and maximum duration: once per suspected level. limited to two levels

c. Personality/ Psychological/ Psychiatric/ Psychosocial Evaluation. These are generally accepted and well-established diagnostic procedures with selective use in the upper extremity population, but have more widespread use in subacute and chronic upper extremity populations. Diagnostic testing procedures may be useful for patients with symptoms of depression, delayed recovery, chronic pain, recurrent painful conditions, disability problems, and for preoperative evaluation. Psychological/psychosocial and measures have been shown to have predictive value for postoperative response, and therefore should be strongly considered for use pre-operatively when the surgeon has concerns about the relationship between symptoms and findings, or when the surgeon is aware of indications of psychological complication or risk factors for psychological complication (e.g. childhood psychological trauma). Psychological testing should provide differentiation between pre-existing conditions versus injury caused psychological conditions, including depression and posttraumatic stress disorder. Psychological testing should incorporate measures that have been shown, empirically, to identify comorbidities or risk factors that are linked to poor outcome or delayed recovery.

i. Formal psychological or psychosocial evaluation should be performed on patients not making expected progress within 6 to 12 weeks following injury and whose subjective symptoms do not correlate with objective signs and test results. In addition to the customary initial exam, the evaluation of the injured worker should specifically address the following areas:

(a). employment history;

(b). interpersonal relationships-both social and work;

(c). patient activities;

(d). current perception of the medical system;

(e). current perception/attitudes toward employer/job

(f). results of current treatment

(g). risk factors and psychological comorbidities that may influence outcome and that may require treatment

(h). childhood history, including history of childhood psychological trauma, abuse and family history of disability.

ii. Personality/ psychological/ psychosocial evaluations consist of two components, clinical interview and psychological testing. Results should help clinicians with a better understanding of the patient in a number of ways. Thus the evaluation result will determine the need for further psychosocial interventions; and in those cases, Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnosis should be determined and documented. The evaluation should also include examination of both psychological comorbidities and psychological risk factors that are empirically associated with poor outcome and/or delayed recovery. An individual with a Ph.D., Psy.D, or psychiatric M.D./D.O. credentials should perform initial evaluations, which are generally completed within one to two hours. A professional fluent in the primary language of the patient is preferred. When such a provider is not available, services of a professional language interpreter should be provided.

iii. Frequency: one-time visit for the clinical interview. If psychometric testing is indicated as a part of the initial evaluation, time for such testing should not exceed an additional two hours of professional time.

d. Provocation Discography

i. Description. Discography is an accepted, but rarely indicated, invasive diagnostic procedure to identify or refute a discogenic source of pain for patients who are surgical candidates. Discography should only be performed by physicians who are experienced and have been proctored in the technique. Discograms have a significant false positive rate. It is essential that all indications, preconditions, special considerations, procedures, reporting requirements, and results, are carefully and specifically followed. Results should be interpreted judiciously. Fewer studies have been published on cervical and thoracic discography than on lumbar discography.

ii. Indications. Discography may be indicated when a patient has a history of functionally limiting, unremitting cervical pain of greater than four months duration, with or without arm pain, which has been unresponsive to all conservative interventions. A patient who does not desire operative therapeutic intervention is not a candidate for an invasive non-therapeutic intervention, such as provocation discography.

iii. Discography may prove useful for the evaluation of the pre-surgical spine, discogenic pain at levels above or below a prior spinal fusion, annular tear, or internal disc disruption.

iv. Discography may show disc degeneration and annular disruption in the absence of cervical pain. Discography may also elicit concordant pain in patients with mild and functionally inconsequential neck pain. Because patients with mild neck pain should not be considered for invasive treatment, discography should not be performed on these patients. The presence of an annular tear does not necessarily identify the tear as a pain generator.

v. Discography is not useful in previously operated discs. Discography may prove useful in evaluating the number of cervical spine levels that might require fusion. CT Discography provides further detailed information about morphological abnormalities of the disc and possible lateral disc herniations.

vi. Preconditions for provocation discography include all of the following:

(a). A patient with functionally limiting, unremitting neck and/or arm pain of greater than four months duration in whom conservative treatment has been unsuccessful and in whom the specific diagnosis of the pain generator has not been made apparent on the basis of other noninvasive imaging studies (e.g., MRI, CT, plain films, etc.). It is recommended that discography be reserved for use in patients with equivocal MRI findings, especially at levels adjacent to clearly pathological levels. Discography may be more sensitive than MRI or CT in detecting radial annular tears. However, radial tears must always be correlated with clinical presentation.

(b). Psychosocial evaluation has been completed. There is some evidence that false positives and complaints of long-term pain arising from the procedure itself occur more frequently in patients with somatoform disorders. Therefore, discograms should not be performed on patients with non-anatomic symptoms consistent with somatoform disorders.

(c). Patients who are considered surgical candidates (e.g., symptoms are of sufficient magnitude and the patient has been informed of the possible surgical options that may be available based upon the results of discography). Discography should never be the sole indication for surgery.

(d). Informed consent regarding the risks and potential diagnostic benefits of discography has been obtained.

vii. Complications include, but are not limited to, discitis, nerve damage, retropharyngeal abscess, chemical meningitis, pain exacerbation, and anaphylaxis. Therefore, prior to consideration of discography, the patient should undergo other diagnostic modalities in an effort to define the etiology of the patient's complaint including psychological evaluation, myelography, CT and MRI.

viii. Contraindications include:

(a). active infection of any type or continuing antibiotic treatment for infection; and/or

(b). bleeding diathesis or pharmaceutical anticoagulation with warfarin, etc.; and/or

(c). significant spinal stenosis at the level being studied as visualized by MRI, myelography or CT scan; and/or

(d). presence of clinical myelopathy; and/or

(e). effacement of the cord, thecal sac or circumferential absence of epidural fat; and

(f). known allergic reactions.

ix. Special Considerations

(a). Discography should not be performed by the physician expected to perform the therapeutic procedure. The procedure should be carried out by an experienced individual who has received specialized training in the technique of provocation discography.

(b). Discography should be performed in a blinded format that avoids leading the patient with anticipated responses. The procedure should always include one or more disc levels thought to be normal or nonpainful in order to serve as an internal control. The patient should not know what level is being injected in order to avoid

spurious results. Adjacent discs may be identified as pain generators in more than half of cases in which discogenic pain is identified at one level. Because surgery is likely to fail in multi-level discogenic pain, injection of as many levels as feasible can prevent many operative failures. Abnormal disc levels may be repeated to confirm concordance.

(c). Sterile technique must be utilized.

(d). Judicious use of light sedation during the procedure is acceptable, represents the most common practice nationally at the current time, and is recommended by most experts in the field. The patient must be awake and able to accurately report pain levels during the provocation portion of the procedure.

(e). CT or MRI should establish cervical spinal dimensions and ruled out spinal stenosis.

(f). Intradiscal injection of local anesthetic may be carried out after the provocation portion of the examination and the patient's response.

(g). It is recommended that a post-discogram CT be considered as it frequently provides additional useful information about disc morphology or other pathology.

x. Reporting of Discography. In addition to a narrative report, the discography report should contain a standardized classification of disc morphology and the pain response. All results should be clearly separated in the report from the narrative portion. Asymptomatic annular tears are common and the concordant pain response is an essential finding for a positive discogram.

xi. When discography is performed to identify the source of a patient's neck pain, both a concordant pain response and morphological abnormalities must be present at the pathological level prior to initiating any treatment directed at that level. The patient must be awake during the provocation phase of the procedure; therefore, sedative medication must be carefully titrated.

xii. Caution should be used when interpreting results from discography. One study using asymptomatic volunteers reported pain in the majority of discs injected, but no subjects reported pain exceeding 6/10 on a pain scale in a normal disc.

xiii. Reporting disc morphology as visualized by the post-injection CT scan (when available) should follow the Modified Dallas Discogram Scale where:

(a). Grade 0 = Normal Nucleus.

(b). Grade 1 = Annular tear confined to inner one-third of annulus fibrosis.

(c). Grade 2 = Annular tear extending to the middle third of the annulus fibrosis.

(d). Grade 3 = Annular tear extending to the outer one-third of the annulus fibrosis.

(e). Grade 4 = A grade 3 tear plus dissection within the outer annulus to involve more than 30 degrees of the disc circumference.

(f). Grade 5 = Full thickness tear with extra-annular leakage of contrast, either focal or diffuse.

xiv. Reporting of pain response should be consistent with the operational criteria of the International Spine Intervention Society Guidelines (ISIS). The report must include the level of concordance for neck and arm pain separately using a 10-point VAS, or similar quantitative assessment. It should be noted that the change in the VAS

score before and after provocation is more important than the number reported.

xv. The diagnosis of discogenic pain is less likely when there are more discs with dissimilar pain and fewer with no pain. At least two discs with no pain on stimulation and one disc with concordant pain registering at least 7 on a 10-point VAS or equivalent should be present to qualify for a diagnosis of discogenic pain. The VAS score prior to the discogram should be taken into account when interpreting the VAS score reported by the patient during the discogram.

(a). Time parameters for provocation discography are as follows:

(i). frequency: one time only;

(ii). maximum: repeat discography is rarely indicated.

xvi. Thermography is an accepted and established procedure, but has no use as a diagnostic test for cervical pain. It may be used to diagnose regional pain disorders and in these cases, refer to the Complex Regional Pain Syndrome/Reflex Sympathetic Dystrophy Medical Treatment Guidelines.

3. - 3.b.ii. ...

iii. Frequency: can be used initially to determine baseline status. Additional evaluations can be performed to monitor and assess progress and aid in determining the endpoint for treatment.

c. Job site evaluation is a comprehensive analysis of the physical, mental and sensory components of a specific job. These components may include, but are not limited to; postural tolerance (static and dynamic); aerobic requirements; range-of-motion; torque/force; lifting/carrying; cognitive demands; social interactions; visual perceptual; sensation; coordination; environmental requirements of a job; repetitiveness; and essential job functions.

i. Job descriptions provided by the employer are helpful but should not be used as a substitute for direct observation. A jobsite evaluation may include observation and instruction of how work is done, what material changes (desk, chair) should be made, and determination of readiness to return-to-work.

ii. Requests for a jobsite evaluation should describe the expected goals for the evaluation. Goals may include, but are not limited to the following.

(a). to determine if there are potential contributing factors to the person's condition and/or for the physician to assess causality;

(b). to make recommendations for, and to assess the potential for ergonomic changes;

(c). to determine the essential demands of the job. To provide a detailed description of the physical and cognitive job requirements;

(d). to assist the patient in their return-to-work by educating them on how they may be able to do their job more safely and in a more bio-mechanically appropriate manner;

(e). to give detailed work/activity restrictions.

iii. Frequency: One time with additional visits as needed for follow-up per jobsite.

d. Vocational Assessment. The vocational assessment should provide valuable guidance in the determination of future rehabilitation program goals. It

should clarify rehabilitation goals, which optimize both patient motivation and utilization of rehabilitation resources. If prognosis for return to former occupation is determined to be poor, except in the most extenuating circumstances, vocational assessment should be implemented within 3 to 12 months post-injury. Declaration of MMI should not be delayed solely due to lack of attainment of a vocational assessment:

i. frequency: one time with additional visits as needed for follow-up.

e. Work tolerance screening is a determination of an individual's tolerance for performing a specific job based on a job activity or task and may be used when a full Functional Capacity Evaluation is not indicated. It may include a test or procedure to specifically identify and quantify work-relevant cardiovascular, physical fitness and postural tolerance. It may also address ergonomic issues affecting the patient's return-to-work potential. Full job description should include a physical assessment of the job requirements:

i. frequency: one time for initial screen. May monitor improvements in strength every 3 to 4 weeks up to a total of six visits.

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§2009. Therapeutic Procedures—Non-Operative

A. - C. ...

1. Reassessment of the patient's status in terms of functional improvement should be documented after each treatment. If patients are not responding within the recommended time periods, alternative treatment interventions, further diagnostic studies or consultations should be pursued. Continued treatment should be monitored using objective measures such as:

a. return-to-work or maintaining work status;

b. fewer restrictions at work or performing activities of daily living;

c. decrease in usage of medications;

d. measurable functional gains, such as increased range of motion or documented increase in strength;

D. - G.1.c.iv. ...

iv. Any of the above acupuncture treatments may extend longer if objective functional gains can be documented or when symptomatic benefits facilitate progression in the patient's treatment program. Treatment beyond 14 treatments must be documented with respect to need and ability to facilitate positive symptomatic or functional gains. Such care should be re-evaluated and documented with each series of treatments.

d. Other Acupuncture Modalities. Acupuncture treatment is based on individual patient needs and therefore treatment may include a combination of procedures to enhance treatment effect. Other procedures may include the use of heat, soft tissue manipulation/massage, and exercise. Refer to active therapy (therapeutic exercise) and passive therapy sections (massage and superficial heat and cold therapy) for a description of these adjunctive acupuncture modalities and time frames.

2. Biofeedback is a form of behavioral medicine that helps patients learn self-awareness and self-regulation skills for the purpose of gaining greater control of their physiology, such as muscle activity, brain waves, and measures of autonomic nervous system activity. Electronic instrumentation is used to monitor the targeted physiology and then displayed or fed back to the patient visually, auditorially, or tactilely, with coaching by a biofeedback specialist. Biofeedback is provided by clinicians certified in biofeedback and/or who have documented specialized education, advanced training, or direct or supervised experience qualifying them to provide the specialized treatment needed (e.g., surface EMG, EEG, or other).

a. Treatment is individualized to the patient's work-related diagnosis and needs. Home practice of skills is required for mastery and may be facilitated by the use of home training tapes. The ultimate goal of biofeedback treatment is to normalize the physiology to the pre-injury status to the extent possible, and involves transfer of learned skills to the workplace and daily life. Candidates for biofeedback therapy or training must be motivated to learn and practice biofeedback and self-regulation techniques.

b. Indications for biofeedback include individuals who are suffering from musculoskeletal injury in which muscle dysfunction or other physiological indicators of excessive or prolonged stress response affects and/or delays recovery. Other applications include training to improve self-management of emotional stress/pain responses such as anxiety, depression, anger, sleep disturbance, and other central and autonomic nervous system imbalances. Biofeedback is often used in conjunction with other treatment modalities:

i. time to produce effect: three to four sessions;

ii. frequency: one to two times per week;

iii. optimum duration: five to six sessions;

iv. maximum duration: 10 to 12 sessions.

Treatment beyond 12 sessions must be documented with respect to need, expectation, and ability to facilitate positive functional gains.

3. Injections—Therapeutic

a. Therapeutic Spinal Injections. Therapeutic spinal injections may be used after initial conservative treatments, such as physical and occupational therapy, medication, manual therapy, exercise, acupuncture, have been undertaken. Therapeutic injections should be used only after imaging studies and diagnostic injections have established pathology. Injections are invasive procedures that can cause catastrophic complications; thus clinical indications and contraindications should be closely adhered to. The purpose of spinal injections is to facilitate active therapy by providing short-term relief through reduction of pain and inflammation. All patients should continue appropriate exercise with functionally directed rehabilitation. Active treatment, which patients should have had prior to injections, will frequently require a repeat of the sessions previously ordered (Refer to Active Therapy). Injections, by themselves, are not likely to provide long-term relief. Rather, active rehabilitation with modified work achieves long-term relief by increasing active ROM, strength, and stability. Subjective reports of pain response (via a recognized pain scale) and function should be considered and given relative

weight when the pain has anatomic and physiologic correlation. Anatomic correlation must be based on objective findings.

i. Special Considerations—for all injections (excluding trigger point and occipital nerve blocks) multi-planar fluoroscopy, during procedures is required to document technique and needle placement, and should be performed by a physician experienced in the procedure. Permanent images are required to verify needle placement. The subspecialty disciplines of the physicians performing injections may be varied, including, but not limited to: anesthesiology, radiology, surgery, neurology or psychiatry. The practitioner should have completed fellowship training in pain medicine with interventional training, or its equivalent. They must also be knowledgeable in radiation safety.

ii. Complications. Appropriate medical disclosures with regard to potential complications should be provided to the patient as deemed appropriate by the treating physician.

iii. Contraindications. Absolute contraindications to therapeutic injections include: bacterial infection – systemic or localized to region of injection, bleeding diatheses, hematological conditions, and possible pregnancy.

(a). Relative contraindications to diagnostic injections may include: allergy to contrast, poorly controlled diabetes mellitus and hypertension. Drugs affecting coagulation may require restriction from use. Anti-platelet therapy and anti-coagulations should be addressed individually by a knowledgeable specialist. It is recommended to refer to American Society of Regional Anesthesia for anticoagulation guidelines.

b. Cervical Epidural Steroid Injection (ESI)

i. Description. Cervical ESIs are injections of corticosteroid into the epidural space. The purpose of ESI is to reduce pain and inflammation in the acute or subacute phases of injury, restoring range-of-motion, and thereby, facilitating progress in more active treatment programs.

ii. Needle Placement. Multi-planar fluoroscopic imaging is required for all epidural steroid injections. Contrast epidurograms allow one to verify the flow of medication into the epidural space. Permanent images are required to verify needle placement.

iii. Indications

(a). Cervical ESIs are useful in patients with symptoms of cervical radicular pain syndromes. They have less defined usefulness in non-radicular pain. There is some evidence that epidural steroid injections are effective for patients with radicular pain or radiculopathy (sensory or motor loss in a specific dermatome or myotome). In one study, 53 percent of patients had 50 percent or greater relief of pain at 6 months with only 20 percent having similar relief at 12 months.

(b). There is some evidence to suggest that epidural injections are not effective for cervical axial pain; however, it is an accepted intervention. Only patients who have pain affected by activity and annular tears verified by appropriate imaging may have injections for axial pain.

(c). There is some evidence in studies of the lumbar spine that patients who smoke or who have pain unaffected by rest or activity are less likely to have a successful

outcome from ESIs. This may also apply to the cervical spine although there are currently no studies to verify this finding. MRI or CT scans are required prior to thoracic and cervical ESIs, to assure that adequate epidural space is present.

iv. Time/Frequency/Duration

(a). Time to Produce Effect. Local anesthetic, less than 30 minutes; corticosteroid, 48 to 72 hours for 80 percent of patients and 72 hours to 2 weeks for 20 percent of patients.

(b). Frequency. One or more divided levels can be injected in one session. Whether injections are repeated depends upon the patient's response to the previous injection. Subsequent injections may occur after one to two weeks if there is a positive patient response. Positive patient response results are defined primarily as functional gains that can be objectively measured. Objective functional gains include, but are not limited to, positional tolerances, range of motion (ROM), strength, endurance, activities of daily living, cognition, psychological behavior, and efficiency/velocity measures that can be quantified. Subjective reports of pain response (via a recognized pain scale) and function should be considered and given relative weight when the pain has anatomic and physiologic correlation. Anatomic correlation must be based on objective findings.

(c). Injections can be repeated after a hiatus of six months if the patient has demonstrated functional gain and pain returns or worsens. If the first injection does not provide a diagnostic response with temporary and sustained pain relief (at least two to six weeks) substantiated by accepted pain scales (i.e., 50 percent pain reduction as measured by tools such as VAS), and improvement in function, similar injections should not be repeated.

(d). Optimal Duration. Usually one to three injection(s), over a period of six months depending upon each patient's response and functional gain.

(e). Maximum Duration: Two sessions consisting of up to three injections each may be done in one year, as per the patient's response to pain and function. Patients should be reassessed after each injection for a 50 percent improvement in pain (as measured by accepted pain scales) and evidence of functional improvement.

c. Zygapophyseal (Facet) Injection

i. Description. A generally accepted intra-articular or pericapsular injection of local anesthetic and corticosteroid. There is conflicting evidence to support long-term therapeutic effect using facet injections. There is no justification for a combined facet and medial branch block.

ii. Indications. Patients with pain suspected to be facet in origin based on exam findings and affecting activity; or patients who have refused a rhizotomy; or patients who have facet findings with a thoracic component. In these patients, facet injections may be occasionally useful in facilitating a functionally-directed rehabilitation program and to aid in identifying pain generators. Patients with recurrent pain should be evaluated with more definitive diagnostic injections, such as medial nerve branch injections, to determine the need for a rhizotomy. Because facet injections are not likely to produce long-term benefit by themselves and are not the most accurate diagnostic tool, they should not be performed at more than two levels.

iii. Timing/Frequency/Duration

(a). Time to Produce Effect: Up to 30 minutes for local anesthetic; corticosteroid up to 72 hours.

(b). Frequency: 1 injection per level with a diagnostic response. If the first injection does not provide a diagnostic response of temporary and sustained pain relief substantiated by accepted pain scales, (i.e., 50 percent pain reduction substantiated by tools such as VAS), and improvement in function, similar injections should not be repeated. At least four to six weeks of functional benefit should be obtained with each therapeutic injection.

(c). Optimum Duration: two to three injections for each applicable joint per year. Not to exceed two joint levels.

(d). Maximum Duration: four per level per year. Prior authorization must be obtained for injections beyond two levels.

(e). Facet injections may be repeated if they result in increased documented functional benefit for at least 4 to 6 weeks and at least a 50 percent initial improvement in pain scales as measured by accepted pain scales (such as VAS).

d. Intradiscal Steroid Therapy. Intradiscal steroid therapy consists of injection of a steroid preparation into the intervertebral disc under fluoroscopic guidance at the time of discography. There is good evidence that it is not effective in the treatment of suspected discogenic low back pain. There is no support for its use in the cervical spine and its use is not recommended.

e. Radio Frequency (RF) Medial Branch Neurotomy/Facet Rhizotomy

i. Description. A procedure designed to denervate the facet joint by ablating the corresponding sensory medial branches. Continuous percutaneous radio-frequency is the method generally used.

ii. There is good evidence to support this procedure in the cervical spine but benefits beyond one year are not yet established. Radio-frequency medial branch neurotomy is the procedure of choice over alcohol, phenol, or cryoablation. Precise positioning of the probe under fluoroscopic guidance is required since the maximum effective diameter of the device is a 5 x 8 millimeter oval. Permanent images should be recorded to verify placement of the device.

iii. Indications. Those patients with proven, significant, facetogenic pain. This procedure is not recommended for patients with multiple pain generators or involvement of more than three medial branch nerves.

iv. Individuals should have met the following indications: pain of well-documented facet origin, unresponsive to active and/or passive therapy, manual therapy, and in which a psychosocial screening has been performed (e.g., pain diagram, thorough psychosocial history, screening questionnaire). It is generally recommended that this procedure not be performed until three months of active therapy and manual therapy have been completed. All patients should continue appropriate exercise with functionally directed rehabilitation. Active treatment, which patients will have had prior to the procedure, will frequently require a repeat of the sessions previously ordered (Refer to Active Therapy).

v. All patients should have a successful response to a diagnostic medial nerve branch block and a separate comparative block. ISIS suggests controlled blocks-using either placebo or anesthetics with varying lengths of activity (i.e., bupivacaine longer than lidocaine). To be a positive diagnostic block the patient should report a reduction of pain of 50 percent or greater from baseline for the length of time appropriate for the local anesthetic used. In almost all cases this will mean a reduction of pain to 1 or 2 on the VAS 10-point scale correlated with functional improvement. The patient should also identify activities of daily living (which may include measurements of range-of-motion) that are impeded by their pain and can be observed to document functional improvement in the clinical setting. Ideally, these activities should be assessed throughout the observation period for function. The observer should not be the physician who performed the procedure. It is suggested that this be recorded on a form similar to ISIS recommendations.

vi. A separate comparative block may be performed on a different date to confirm the level of involvement. A comparative block uses anesthetics with varying lengths of activity.

vii. Complications. Appropriate medical disclosures should be provided to the patient as deemed necessary by the treating physician.

viii. Post-Procedure Therapy. Active therapy. Implementation of a gentle reconditioning program within the first post-procedure week is recommended, barring complications. Instruction and participation in a long-term home-based program of ROM, cervical, scapular, and thoracic strengthening, postural or neuromuscular re-education, endurance, and stability exercises should be accomplished over a period of four to ten visits post-procedure.

ix. Requirements for repeat RF neurotomy (or additional level RF neurotomies). In some cases pain may recur [ISIS]. Successful rhizotomy usually provides from six to eighteen months of relief.

(a). Before a repeat RF neurotomy is done, a confirmatory medial branch injection should be performed if the patient's pain pattern presents differently than in the initial evaluation. In occasional patients, additional levels of RF neurotomy may be necessary. The same indications and limitations apply.

f. Occipital Nerve Block

i. Description. Occipital nerve blocks are generally accepted injections used both diagnostically and therapeutically in the treatment of occipital neuralgia. The greater occipital nerve is the target.

ii. Indications. Diagnosis and treatment of occipital neuralgia/cephalgia. Peripheral block of the greater occipital nerve may be appropriate as initial treatment. It may be indicated in patients unresponsive to peripheral nerve block or those patients in need of additional diagnostic information.

iii. Complications. Bleeding, infection, neural injury. Post procedural ataxia is common and usually lasts 30 minutes post procedure. Because the occipital artery runs with the occipital nerve, inadvertent intravascular injection is a risk of this procedure and may lead to systemic toxicity and/or seizures.

(a). Time to Produce Effect: Approximately 30 minutes for local anesthetic; 48 to 72 hours for corticosteroid.

(b). Optimal Duration: one to three sessions for each nerve

(c). Maximum Duration: Continue up to three injections if progressive symptomatic and functional improvement can be documented.

g. Trigger Point Injections

i. Description. Trigger point injections are a generally accepted treatment. Trigger point treatment can consist of injection of local anesthetic with or without, corticosteroid into highly localized, extremely sensitive bands of skeletal muscle fibers that produce local and referred pain when activated. Medication is injected in a four-quadrant manner in the area of maximum tenderness. Injection efficacy can be enhanced if injections are immediately followed by myofascial therapeutic interventions, such as vapo-coolant spray and stretch, ischemic pressure massage (myotherapy), specific soft tissue mobilization and physical modalities. There is conflicting evidence regarding the benefit of trigger point injections. A truly blinded study comparing dry needle treatment of trigger points is not feasible. There is no evidence that injection of medications improves the results of trigger-point injections. Needling alone may account for some of the therapeutic response.

ii. There is no indication for conscious sedation for patients receiving trigger point injections. The patient must be alert to help identify the site of the injection.

iii. Indications. Trigger point injections may be used to relieve myofascial pain and facilitate active therapy and stretching of the affected areas. They are to be used as an adjunctive treatment in combination with other treatment modalities such as functional restoration programs. Trigger point injections should be utilized primarily for the purpose of facilitating functional progress. Patients should continue in an aggressive aerobic and stretching therapeutic exercise program as tolerated throughout the time period they are undergoing intensive myofascial interventions. Myofascial pain is often associated with other underlying structural problems and any abnormalities need to be ruled out prior to injection.

iv. Trigger point injections are indicated in those patients where well circumscribed trigger points have been consistently observed, demonstrating a local twitch response, characteristic radiation of pain pattern and local autonomic reaction, such as persistent hyperemia following palpation. Generally, these injections are not necessary unless consistently observed trigger points are not responding to specific, noninvasive, myofascial interventions within approximately a six-week time frame.

v. Complications. Potential but rare complications of trigger point injections include infection, pneumothorax, anaphylaxis, neurapraxia, and neuropathy. If corticosteroids are injected in addition to local anesthetic, there is a risk of local myopathy developing. Severe pain on injection suggests the possibility of an intraneural injection, and the needle should be immediately repositioned.

vi. Timing/Frequency/Duration

(a). Time to Produce Effect: Local anesthetic 30 minutes; no anesthesia 24 to 48 hours

(b). Frequency: Weekly, suggest no more than four injection sites per session per week to avoid significant post-injection soreness

(c). Optimal Duration: four Weeks

(d). Maximum Duration: eight weeks.

Occasional patients may require two to four repetitions of trigger point injection series over a one to two year period.

h. Prolotherapy: also known as sclerotherapy consists of a series of injections of hypertonic dextrose, with or without glycerine and phenol, into the ligamentous structures of the neck. There is no evidence that Prolotherapy is effective in cervical pain. The injections are invasive, may be painful to the patient, and are not generally accepted or widely used. Therefore, the use of Prolotherapy for cervical pain is not recommended.

4. Epiduroscopy and Epidural Lysis of Adhesions: is not recommended in the cervical spine secondary to the potential for dural puncture, hematoma, and spinal cord injury.

5. Medications/Pharmacy. Medication used in the treatment of cervical injuries is appropriate for controlling acute and chronic pain and inflammation. Use of medications will vary widely due to the spectrum of injuries from simple strains to post-surgical healing. All drugs should be used according to patient needs. A thorough medication history, including use of alternative and over the counter medications, should be performed at the time of the initial visit and updated periodically. Treatment for pain control is initially accomplished with acetaminophen and/or NSAIDs. The patient should be educated regarding the interaction with prescription and over-the-counter medications as well as the contents of over-the-counter herbal products. The following are listed in alphabetical order:

5.a. - 11.b.ii.(e). ...

(f). The effect of any medications that may pose a safety risk to the patient, co-workers or the general public should be considered with regard to the workplace and home.

11.b.iii. - 12. ...

a. On occasion, specific diagnoses and post-surgical conditions may warrant durations of treatment beyond those listed as "maximum". Factors such as exacerbation of symptoms, re-injury, interrupted continuity of care and comorbidities may also extend durations of care. Specific goals with objectively measured functional improvement during treatment must be cited to justify extended durations of care. It is recommended that, if no functional gain is observed after the number of treatments under "time to produce effect" has been completed alternative treatment interventions, further diagnostic studies or further consultations should be pursued.

b. Patients should be instructed to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Follow-up visits to reinforce and monitor progress and proper technique are recommended. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices.

c. The following active therapies are listed in alphabetical order.

i. Activities of Daily Living (ADL) are well-established interventions which involve instruction, active-

assisted training, and/or adaptation of activities or equipment to improve a person's capacity in normal daily activities such as self-care, work re-integration training, homemaking, and driving.

(a). Time to Produce Effect: four to five treatments.

(b). Frequency: three to five times per week.

(c). Optimum Duration: four to six weeks.

(d). Maximum Duration: six weeks.

ii. Aquatic Therapy is a well-accepted treatment which consists of the therapeutic use of aquatic immersion for therapeutic exercise to promote strengthening, core stabilization, endurance, range-of-motion, flexibility, body mechanics, and pain management. Aquatic therapy includes the implementation of active therapeutic procedures in a swimming or therapeutic pool. The water provides a buoyancy force that lessens the amount of force gravity applies to the body. The decreased gravity effect allows the patient to have a mechanical advantage and more likely have a successful trial of therapeutic exercise. The therapy may be indicated for individuals who:

(a). cannot tolerate active land-based or full-weight bearing therapeutic procedures;

(b). require increased support in the presence of proprioceptive deficit;

(c). are at risk of compression fracture due to decreased bone density;

(d). have symptoms that are exacerbated in a dry environment;

(e). would have a higher probability of meeting active therapeutic goals than in a dry environment;

(f). the pool should be large enough to allow full extremity range-of-motion and fully erect posture. Aquatic vests, belts, and other devices may be used to provide stability, balance, buoyancy, and resistance.

(i). Time to Produce Effect: four to five treatments

(ii). Frequency: three to five times per week.

(iii). Optimum Duration: four to six weeks.

(iv). Maximum Duration: eight weeks.

(v). A self-directed program is recommended after the supervised aquatics program has been established, or, alternatively a transition to a self-directed dry environment exercise program.

iii. Functional activities are well-established interventions which involve the use of therapeutic activities to enhance mobility, body mechanics, employability, coordination, balance, and sensory motor integration.

(a). Time to Produce Effect: four to five treatments

(b). Frequency: three to five times per week

(c). Optimum Duration: four to six weeks

(d). Maximum Duration: six weeks

iv. Functional electrical stimulation is an accepted treatment in which the application of electrical current to elicit involuntary or assisted contractions of atrophied and/or impaired muscles. It may be indicated for muscle atrophy due to radiculopathy.

(a). Time to Produce Effect: two to six treatments.

(b). Frequency: three times per week.

(c). Optimum Duration: eight weeks.

(d). Maximum Duration: eight weeks. If beneficial, provide with home unit.

v. Neuromuscular re-education is a generally accepted treatment. It is the skilled application of exercise with manual, mechanical, or electrical facilitation to enhance strength, movement patterns, neuromuscular response, proprioception, kinesthetic sense, and coordination, education of movement, balance, and posture. Indications include the need to promote neuromuscular responses through carefully timed proprioceptive stimuli, to elicit and improve motor activity in patterns similar to normal neurologically developed sequences, and improve neuromotor response with independent control.

(a). Time to Produce Effect: two to six treatments.

(b). Frequency: three times per week.

(c). Optimum Duration: four to eight weeks.

(d). Maximum Duration: eight weeks.

vi. Spinal stabilization is a generally accepted treatment. The goal of this therapeutic program is to strengthen the spine in its neural and anatomic position. The stabilization is dynamic which allows whole body movements while maintaining a stabilized spine. It is the ability to move and function normally through postures and activities without creating undue vertebral stress.

(a). Time to Produce Effect: four to eight treatments.

(b). Frequency: three to five times per week.

(c). Optimum Duration: four to eight weeks.

(d). Maximum Duration: eight weeks.

vii. Therapeutic exercise is a generally well-accepted treatment. Therapeutic exercise with or without mechanical assistance or resistance, may include isoinertial, isotonic, isometric and isokinetic types of exercises. Indications include the need for cardiovascular fitness, reduced edema, improved muscle strength, improved connective tissue strength and integrity, increased bone density, promotion of circulation to enhance soft tissue healing, improvement of muscle recruitment, improved proprioception and coordination, increased range-of-motion and are used to promote normal movement patterns. Therapeutic exercise can also include complementary/alternative exercise movement therapy (with oversight of a physician or appropriate healthcare professional).

(a). Time to Produce Effect: two to six treatments.

(b). Frequency: three to five times per week.

(c). Optimum Duration: four to eight weeks.

(d). Maximum Duration: eight weeks.

13. - 13.f.iv.

g. Intramuscular Manual Therapy: Trigger Point Dry Needling. IMT involves using filament needles to treat "Trigger Points" within muscle. It may require multiple advances of a filament needle to achieve a local twitch response to release muscle tension and pain. Dry needling is an effective treatment for acute and chronic pain of neuropathic origin with very few side effects. Dry needling is a technique to treat the neuro-musculoskeletal system based on pain patterns, muscular dysfunction and other orthopedic signs and symptoms.

i. Time to produce effect: immediate
ii. Frequency: one to two times a week
iii. Optimum duration: 6 weeks
iv. Maximum duration: 2 months
h. Mobilization (Soft Tissue): is a generally well-accepted treatment. Mobilization of soft tissue is the skilled application of muscle energy, strain/counter strain, myofascial release, manual trigger point release, and other manual therapy techniques designed to improve or normalize movement patterns through the reduction of soft tissue pain and restrictions. These can be interactive with the patient participating or can be with the patient relaxing and letting the practitioner move the body tissues. Indications include muscle spasm around a joint, trigger points, adhesions, and neural compression. Mobilization should be accompanied by active therapy.

i. Time to Produce Effect: four to nine treatments.

ii. Frequency: Up to three times per week.

iii. Optimum Duration: four to six weeks.

iv. Maximum Duration: six weeks

i Short-Wave Diathermy is an accepted treatment which involves the use of equipment that exposes soft tissue to a magnetic or electrical field. Indications include enhanced collagen extensibility before stretching, reduced muscle guarding, reduced inflammatory response, and enhanced reabsorption of hemorrhage/hematoma or edema.

i. Time to Produce Effect: two to four treatments

ii. Frequency: two to three times per week up to three weeks

iii. Optimum Duration: three to five weeks

iv. Maximum Duration: five weeks

j. Superficial Heat and Cold Therapy (Excluding Infrared Therapy is a generally accepted treatment. Superficial heat and cold are thermal agents applied in various manners that lower or raise the body tissue temperature for the reduction of pain, inflammation, and/or effusion resulting from injury or induced by exercise. It includes application of heat just above the surface of the skin at acupuncture points. Indications include acute pain, edema and hemorrhage, need to increase pain threshold, reduce muscle spasm, and promote stretching/flexibility. Cold and heat packs can be used at home as an extension of therapy in the clinic setting.

i. Time to Produce Effect: Immediate

ii. Frequency: two to five times per week

iii. Optimum Duration: three weeks as primary or intermittently as an adjunct to other therapeutic procedures up to two months

iv. Maximum Duration: two months

k. Traction-Manual—is an accepted treatment and an integral part of manual manipulation or joint mobilization. Indications include decreased joint space, muscle spasm around joints, and the need for increased synovial nutrition and response. Manual traction is contraindicated in patients with tumor, infection, fracture, or fracture dislocation.

i. Time to Produce Effect: one to three sessions

ii. Frequency: two to three times per week

iii. Optimum Duration: 30 days

iv. Maximum Duration: one month

l. Traction. Mechanical is a generally accepted treatment and most commonly used for patients with radicular findings. It is sometimes used to treat symptoms from decreased joint space and muscle spasm around the joints. If successful it should be shifted to home traction. Traction modalities are contraindicated in patients with tumor, infections, fracture, or fracture dislocation. Non-oscillating inversion traction methods are contraindicated in patients with glaucoma or hypertension. A home cervical traction unit may be purchased if therapy proves effective.

i. Time to Produce Effect: 1 to 3 sessions up to 30 minutes. If response is negative after 3 treatments, discontinue this modality

ii. Frequency: two to three times per week. A home cervical traction unit may be purchased if therapy proves effective.

iii. Optimum Duration: four weeks.

iv. Maximum Duration: four weeks.

m. Transcutaneous electrical nerve stimulation (TENS) is a generally accepted treatment which should include at least one instructional session for proper application and use. Indications include muscle spasm, atrophy, and decreased circulation and pain control. Minimal TENS unit parameters should include pulse rate, pulse width and amplitude modulation. Consistent, measurable, functional improvement must be documented prior to the purchase of a home unit.

i. Time to Produce Effect: Immediate

ii. Frequency: Variable

iii. Optimum Duration: three sessions

iv. Maximum Duration: three sessions. Purchase or provide with home unit if effective.

n. Ultrasound (including phonophoresis) is an accepted treatment which uses sonic generators to deliver acoustic energy for therapeutic thermal and/or non-thermal soft tissue effects. Indications include scar tissue, adhesions, collagen fiber and muscle spasm, and the need to extend muscle tissue or accelerate the soft tissue healing. Ultrasound with electrical stimulation is concurrent delivery of electrical energy that involves dispersive electrode placement. Indications include muscle spasm, scar tissue, pain modulation, and muscle facilitation.

i. Phonophoresis is the transfer of medication through the use of sonic generators to the target tissue to control inflammation and pain. These topical medications include, but are not limited to, steroidal anti-inflammatory and anesthetics.

(a). Time to Produce Effect: 6 to 15 treatments

(b). Frequency: three times per week

(c). Optimum Duration: four to eight weeks

(d). Maximum Duration: eight weeks

14 - 14.a.

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§2011. Therapeutic Procedures—Operative

A. - B.

1. Referral for surgical evaluation and treatment. Consultation should be made to an appropriate surgical specialist for surgical evaluation and treatment when operative treatment is considered.

a. The decision and recommendation for operative treatment, and the appropriate informed consent should be made by the operating surgeon.

b. Prior to surgical intervention, the patient and treating physician should identify functional operative goals and the likelihood of achieving improved ability to perform activities of daily living or work activities and the patient should agree to comply with the pre- and post-operative treatment plan and home exercise requirements. The patient should understand the length of partial and full disability expected post-operatively

C. - E. ...

F. Cervical Operative Procedures and Conditions

1. Acute fractures and dislocations: Decisions regarding the need for surgery in acute traumatic injury will depend on the specific injury type and possibility of long-term neurologic damage. Acute disc herniations may occur in the presence of traumatic injury.

a. Halo Immobilization

i. Description. Intervention that restricts flexion-extension motion. Halo vest will provide significant but not complete rotational control and is the most effective device for treating unstable injuries to the cervical spine.

ii. Complications. May include pin infection, pin loosening, and palsy of the sixth cranial nerve.

iii. Surgical Indications. Cervical fractures requiring the need for nearly complete restriction of rotational control, and to prevent graft dislodgment, spine mal-alignment, or pseudarthrosis. Decision for use of halo is at the discretion of the surgeon based upon the patients' specific injury. Not indicated for unstable skull fractures or if skin overlying pin sites is traumatized.

iv. Operative Treatment. Placement of the pins and apparatus.

v. Post-Operative Therapy. Traction may be required for re-alignment and or fracture reduction (amount to be determined by surgeon), active and/or passive therapy, pin care.

b. Anterior or Posterior Decompression with Fusion

i. Description—to provide relief of pressure on the cervical spinal cord and nerve roots, and alignment and stabilization of the spine. May involve the use of bone grafts, sometimes combined with metal devices, to produce a rigid connection between two or more adjacent vertebrae.

ii. Complications—appropriate medical disclosures should be provided to the patient as deemed necessary by the treating physician.

iii. Surgical Indications—when a significant or progressive neurological deficit exists in the presence of spinal canal compromise. Whether early decompression and reduction of neural structures enhances neurological recovery continues to be debated. Currently, a reasonable approach would be to treat non-progressive neurological deficits on a semi-urgent basis, when the patient's systemic condition is medically stable.

iv. Operative Treatment—both anterior and posterior surgical decompression of the cervical spine are widely accepted. The approach is guided by location of the compressive pathology as well as the presence of other concomitant injuries. Posterior stabilization and fusion alone may be indicated for patients who have been realigned with traction and do not have significant canal compromise. The anterior approach is acceptable if there is disc and/or vertebral body anteriorly compromising the canal. The posterior approach may be indicated in radiculopathy in the absence of myelopathy and with evidence of pseudarthrosis on radiographs, or if the compression pathology is arising posteriorly.

(a). The number of levels involved in the fracture pattern determines the choice between the use of wire techniques versus spinal plates. In injuries treated with an anterior decompression procedure, anterior bone grafting alone does not provide immediate internal fixation and an anterior cervical plate is significantly beneficial. Patients who undergo surgery for significant fracture dislocations of the spine (three level injury) with canal compromise are best managed with anterior cervical decompression, fusion, and plating but in some cases posterior stabilization and fusion are also considered.

(b). Recombinant human bone morphogenetic protein (rhBMP-2) is a member of a family of cytokines capable of inducing bone formation. It is produced from genetically modified cell lines using molecular cloning techniques. Use of rhBMP-2 in the cervical spine may carry a risk of swelling and ectopic bone formation which can encroach on neurovascular structures and on the esophagus. BMP usage in the anterior cervical spine is generally not indicated.

v. Post-Operative Treatment. Cervical bracing may be appropriate (usually 6-12 weeks with fusion). Home programs with instruction in ADLs, sitting, posture, and a daily walking program should be an early part of the rehabilitation process. Referral to a formal rehabilitation program, with emphasis on cervical, scapular, and thoracic strengthening, and restoration of ROM, is appropriate once the fusion is solid and without complication. Active treatment, which patients should have had prior to surgery, will frequently require a repeat of the sessions previously ordered. The goals of the therapy program should include instruction in a long-term home-based exercise program. (Refer to Active Therapy).

2. Disc herniation and other cervical conditions. Operative treatment is indicated only when the natural history of an operatively treatable problem is better than the natural history of the problem without operative treatment. All patients being considered for surgical intervention should undergo a comprehensive neuromuscular examination to identify pain generators that may respond to nonsurgical techniques or may be refractory to surgical intervention. Timely decision making for operative intervention is critical to avoid deconditioning, and increased disability of the cervical spine.

a. General Recommendations. There is some evidence to suggest that recovery from cervical radiculopathy in patients without clinical signs of spinal cord compression at one year is similar with one-level fusion,

physical therapy, or rigid cervical collar use. For patients with whiplash injury (Quebec Classification Grade Levels I or II), there is no evidence of any beneficial effect of operative treatment. Refer to (Soft Tissue Injury Evaluation), for Discussion on Quebec Classification Levels.

b. If cervical fusion is being considered, it is recommended that the injured worker refrain from smoking for at least six weeks prior to surgery and during the time of healing. Because smokers have a higher risk of non-union and higher post-operative costs, it is recommended that insurers cover a smoking cessation program peri-operatively.

c. General indications for surgery. Operative intervention should be considered and a consultation obtained when improvement of symptoms has plateaued and the residual symptoms of pain and functional disability are unacceptable at the end of six weeks of treatment, or at the end of longer duration of non-operative intervention for debilitated patients with complex problems. Choice of hardware instrumentation is based on anatomy, the patient's pathology, and surgeon's experience and preference.

i. Specific indications include:

(a). for patients with myelopathy immediate surgical evaluation and treatment is indicated;

(b). for patients with cervical radiculopathy:

(i). early intervention may be required for acute incapacitating pain or in the presence of progressive neurological deficits;

(ii). persistent or recurrent arm pain with functional limitations, unresponsive to conservative treatment after six weeks; or

(iii). progressive functional neurological deficit; or

(iv). static neurological deficit associated with significant radicular pain; and

(v). confirmatory imaging studies consistent with clinical findings;

(c). for patients with persistent non-radicular cervical pain: in the absence of a radiculopathy, it is recommended that a decisive commitment to surgical or nonsurgical interventions be made within four to five months following injury. The effectiveness of three-level cervical fusion for non-radicular pain has not been established. In patients with non-radicular cervical pain for whom fusion is being considered, required pre-operative indications include all of the following.

(i). In general, if the program of non-operative treatment fails, operative treatment is indicated when:

[a]. improvement of the symptoms has plateaued, and the residual symptoms of pain and functional disability are unacceptable at the end of 6 to 12 weeks of active treatment, or at the end of longer duration of non-operative programs for debilitated patients with complex problems; and/or

[b]. frequent recurrences of symptoms cause serious functional limitations even if a non-operative active treatment program provides satisfactory relief of symptoms, and restoration of function on each recurrence;

[c]. mere passage of time with poorly guided treatment is not considered an active treatment program;

(ii). all pain generators are adequately defined and treated; and

(iii). all physical medicine and manual therapy interventions are completed; and

(iv). x-ray, MRI, or CT/discography demonstrating disc pathology or spinal instability; and

(v). spine pathology limited to two levels; and

(vi). psychosocial evaluation for confounding issues addressed;

(vii). for any potential surgery, it is recommended that the injured worker refrain from smoking for at least six weeks prior to surgery and during the period of healing. Because smokers have a higher risk of non-union and higher post-operative costs, it is recommended that insurers cover a smoking cessation program peri-operatively.

ii. Surgical procedures include:

(a). Cervical Discectomy with or without Fusion

(i). Description. Procedure to relieve pressure on one or more nerve roots or spinal cord. It may be performed with or without the use of a microscope.

(ii). Complications. Appropriate medical disclosures should be provided to the patient as deemed necessary by the treating physician.

(iii). Surgical Indications. Radiculopathy from ruptured disc or spondylosis, spinal instability, or patients with non-radicular neck pain meeting fusion criteria. There is no evidence that discectomy with fusion versus discectomy without fusion has superior long-term results. Discectomy alone is generally considered in patients with pure radicular symptoms from their herniated disc and who have sufficiently large foramen that disc space collapse is unlikely to further compromise the nerve root. Failure rates increase with disease at more than two levels.

(iv). Operative Treatment. Cervical plating may be used to prevent graft dislodgment especially for multi-level disease.

[a]. Recombinant Human Bone Morphogenetic Protein (rhBMP-2) is a member of a family of cytokines capable of inducing bone formation. It is produced from genetically modified cell lines using molecular cloning techniques. Use of rhBMP-2 in the cervical spine may carry a risk of swelling and ectopic bone formation which can encroach on neurovascular structures and on the esophagus. BMP usage in the anterior cervical spine is generally not indicated.

(v). Post-Operative Therapy. Cervical bracing may be appropriate (usually 6 - 12 weeks with fusion). Home programs with instruction in ADLs, sitting, posture, and a daily walking program should be an early part of the rehabilitation process. Referral to a formal rehabilitation program, with emphasis on cervical, scapular, and thoracic strengthening and restoration of ROM is appropriate, once fusion is solid and without complication. Active treatment, which patients should have had prior to surgery, will frequently require a repeat of the sessions previously ordered. The goals of the therapy program should include instruction in a long-term home-based exercise program. (Refer to Active Therapy).

(b). Cervical Corpectomy

(i). Description. Removal of a portion or the entire vertebral body from the front of the spine. May also include removal of the adjacent discs. Usually involves fusion.

(ii). Complications. Appropriate medical disclosures should be provided to the patient as deemed necessary by the treating physician.

(iii). Surgical Indications. Single or two-level spinal stenosis, spondylolisthesis, or severe kyphosis, with cord compression.

(iv). Operative Treatment. Neural decompression, fusion with instrumentation, or halo vest placement to maintain cervical position. Hemicorpectomy may be done when only a portion of the vertebral body needs to be resected. Allografts may be used for single bone graft fusion; however, autografts are generally preferable for multi-level fusions unless a large strut graft is required.

(v). Post-Operative Therapy—dependent upon number of vertebral bodies involved, healing time may be longer than discectomy. Halo vest care is required. Home programs with instruction in ADLs, sitting, posture, and a daily walking program should be an early part of the rehabilitation process. Referral to a formal rehabilitation program with emphasis on cervical, scapular, and thoracic strengthening is appropriate for most patients once the cervical spine is deemed stable and without complication. The goals of the therapy program should include instruction in a long-term home-based exercise program. (Refer to Active Therapy).

(c). Cervical Laminectomy with or without Foraminotomy or Fusion:

(i). Description. Surgical removal of the posterior portion of a vertebrae in order to gain access to the spinal cord or nerve roots with or without stabilization fusion. /instrumentation.

(ii). Complications. May include perineural fibrosis, kyphosis in fractures without fusion or with failed fusion, nerve injury, post surgical instability (with foraminotomies), CSF leak, infection, in-hospital mortality, non-union of fusion, donor site pain (autograft only).

(iii). Surgical Indications. Neural compression.

(iv). Operative Treatment. Laminotomy, partial discectomy, and nerve root decompression.

(v). Post-Operative Therapy. Cervical bracing may be appropriate (usually 6 to 12 weeks with fusion). Home programs with instruction in ADLs, sitting, posture, and a daily walking program should be an early part of the rehabilitation process. Referral to a formal rehabilitation program with emphasis on cervical, scapular, and thoracic strengthening and restoration of ROM is appropriate for most patients once the cervical spine is deemed stable and without complication. The goals of the therapy program should include instruction in a long-term home-based exercise program. (Refer to Active Therapy).

(d). Cervical Laminoplasty

(i). Description. Technique that increases anterior or posterior dimensions of the spinal canal while leaving posterior elements partially intact. It may be performed with or without the use of a microscope.

(ii). Complications. Loss of cervical motion, especially extension.

(iii). Surgical Indications. Multi-level disease: cervical spinal stenosis or spondylitic myelopathy. Not indicated in cervical kyphosis.

(iv). Operative Treatment. Posterior approach, with or without instrumentation.

(v). Post-Operative Therapy. May include 4 to 12 weeks of cervical bracing. Home programs with instruction in ADLs, sitting, posture, and daily walking program should be an early part of the rehabilitation process. Referral to a formal rehabilitation program with emphasis on cervical, scapular, and thoracic strengthening and restoration of ROM is appropriate once the cervical spine is stable and without complication. Active treatment which patients should have had prior to surgery will frequently require a repeat of the sessions previously ordered. The goals of the therapy program should include instruction in a long-term, home-based exercise program. (Refer to Active Therapy).

(e). Percutaneous Discectomy:

(i). Description. An invasive operative procedure to accomplish partial removal of the disc through a needle which allows aspiration of a portion of the disc trocar under imaging control.

(ii). Complications include, but are not limited to, injuries to the nerve or vessel, infection, and hematoma.

(iii). Surgical Indications. Percutaneous discectomy is indicated only in cases of suspected septic discitis in order to obtain diagnostic tissue. The procedure is not recommended for contained disc herniations or bulges with associated radiculopathy due to lack of evidence to support long-term improvement.

(iv). Operative Treatment: Partial Discectomy

3. Artificial Cervical Disc Replacement. This involves the insertion of an FDA approved prosthetic device into the cervical intervertebral space with the goal of maintaining physiologic motion at the treated cervical segment. The use of artificial discs in motion-preserving technology should be based on the surgeon's skill and training.

4. Percutaneous radiofrequency disc decompression of the cervical spine is an investigational procedure which introduces a 19 gauge cannula under local anesthesia and fluoroscopic guidance into the nucleus pulposus of a contained herniated disc, using radiofrequency energy to dissolve and remove disc material. Pressure inside the disc is lowered as a result. There have been no randomized clinical trials of this procedure at this time. It is not recommended.

5. Epiduroscopy and Epidural Lysis of Adhesions. Refer to Therapeutic Injections.

6. Intraoperative neurophysiologic monitoring (IONM) is a battery of neurophysiologic tests used to assess the functional integrity of the spinal cord, nerve roots, and other peripheral nervous system structures (eg, brachial plexus) during spinal surgery. The underlying principle of IONM is to identify emerging insult to nervous system structures, pathways, and/or related vascular supply and to provide feedback regarding correlative changes in neural function before development of irreversible neural injury. IONM data provide an opportunity for intervention to

prevent or minimize postoperative neurologic deficit. Current multimodality monitoring techniques permit intraoperative assessment of the functional integrity of afferent dorsal sensory spinal cord tracts, efferent ventral spinal cord motor tracts, and nerve roots. Combined use of these techniques is useful during complex spinal surgery because these monitoring modalities provide important complementary information to the surgery team. Intraoperative neurophysiologic monitoring should be used during spinal surgery when information regarding spinal cord and nerve root function is desired. The appropriate diagnostic modality for the proposed surgical intervention should be utilized at the discretion of the surgeon.

7. Non invasive electrical bone growth stimulators may be considered:

a. as an adjunct to becomespinal fusion surgery for those at high risk for pseudoarthrosis, including one or more of the following fusion failure risk factors:

- i. one or more previous failed spinal fusion(s);
- ii. grade ii or worse spondylolisthesis;
- iii. fusion to be performed at more than one level;
- iv. presence of other risk factors that may

contribute to non-healing:

- (a). current smoking;
- (b). diabetes;
- (c). renal disease;
- (d). other metabolic diseases where bone healing is likely to be compromised (e.g.: significant osteoporosis);
- (e). active alcoholism;
- (f). common Morbid obesity BMI >40;

b. as treatment for individuals with failed spinal fusion. Failed spinal fusion is defined as percutaneous spinal procedures gain greater acceptance.a spinal fusion that has not healed at a minimum of 6 months after the original surgery, as evidenced by serial x-rays over a course of 3 months during the latter portion of the 6 month period;

c. no strict criteria for device removal are suggested in the literature. Implanted devices are generally removed only when the patient complains of discomfort, when there is device malfunction, or to allow for future ability to use MRI. Removal of batteries is not recommended unless there is a device malfunction or other complication.

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Subpart 2. Medical Treatment Guidelines

Chapter 20. Spine Medical Treatment Guidelines

Subchapter B. Low Back Pain

§2015. General Guideline Principles

A. - A.1. ...

2. Education. Education of the patient and family, as well as the employer, insurer, policy makers and the community should be the primary emphasis in the treatment of workers' compensation injuries. Currently, practitioners often think of education last, after medications, manual therapy, and surgery. Practitioners must develop and implement an effective strategy and skills to educate patients, employers, insurance systems, policy makers, and the community as a whole. An education-based paradigm

should always start with inexpensive communication providing reassuring information to the patient. More in-depth education currently exists within a treatment regime employing functional restorative and innovative programs of prevention and rehabilitation. No treatment plan is complete without addressing issues of individual and/or group patient education as a means of facilitating self-management of symptoms and prevention.

3. - 5.

6. Positive Patient Response. Positive results are defined primarily as functional gains that can be objectively measured. Standard measurement tools, including outcome measures, should be used.

a. Objective functional gains include, but are not limited to, positional tolerances, range-of-motion (ROM), strength, and endurance, activities of daily living, cognition, psychological behavior, and efficiency/velocity measures that can be quantified. Subjective reports of pain and function should be considered and given relative weight when the pain has anatomic and physiologic correlation. Anatomic correlation must be based on objective findings.

7. Re-Evaluation of Treatment Every Three to Four Weeks. If a given treatment or modality is not producing positive results within three to four weeks, the treatment should be either modified or discontinued. Reconsideration of diagnosis should also occur in the event of poor response to a seemingly rational intervention.

8. Surgical Interventions. Surgery should be contemplated within the context of expected improvement of functional outcome and not purely for the purpose of pain relief. The concept of "cure" with respect to surgical treatment by itself is generally a misnomer. All operative interventions must be based upon positive correlation of clinical findings, clinical course, and diagnostic tests. A comprehensive assimilation of these factors must lead to a specific diagnosis with positive identification of pathologic conditions. The decision and recommendation for operative treatment, and the appropriate informed consent should be made by the operating surgeon. Prior to surgical intervention, the patient and treating physician should identify functional operative goals and the likelihood of achieving improved ability to perform activities of daily living or work activities and the patient should agree to comply with the pre- and post-operative treatment plan and home exercise requirements. The patient should understand the length of partial and full disability expected post-operatively.

9. Pharmacy-Louisiana Law and Regulation. All prescribing will be done in accordance with the laws of the state of Louisiana as they pertain respectively to each individual licensee, including, but not limited to: Louisiana State Board of Medical Examiners regulations governing medications used in the treatment of non-cancer-related chronic or intractable pain; louisiana Board of Pharmacy Prescription Monitoring Program; Louisiana Department of Health and Hospitals licensing and certification standards for pain management clinics; other laws and regulations affecting the prescribing and dispensing of medications in the state of Louisiana.

10. Six Month-Time Frame. The prognosis drops precipitously for returning an injured worker to work once he/she has been temporarily totally disabled for more than

six months. The emphasis within these guidelines is to move patients along a continuum of care and return-to-work within a six-month time frame, whenever possible. It is important to note that time frames may not be pertinent to injuries that do not involve work-time loss or are not occupationally related.

11. Return To Work. Return to work is therapeutic, assuming the work is not likely to aggravate the basic problem or increase long-term pain. The practitioner must provide specific written physical limitations. If a practitioner releases a patient at a level of function lower than their previous job position, the practitioner must provide physical limitations and abilities and job modifications. A patient should never be released to simply “sedentary” or “light duty.” The following physical limitations should be considered and modified as recommended: lifting, pushing, pulling, crouching, walking, using stairs, climbing ladders, bending at the waist, awkward and/or sustained postures, tolerance for sitting or standing, hot and cold environments, data entry and other repetitive motion tasks, sustained grip, tool usage and vibration factors. Even if there is residual chronic pain, return-to-work is not necessarily contraindicated. The practitioner should understand all of the physical demands of the patient’s job position before returning the patient to full duty and should request clarification of the patient’s job duties. Clarification should be obtained from the employer or, if necessary, including, but not limited to, an occupational medicine physician, occupational health nurse, physical therapist, occupational therapist, vocational rehabilitation specialist, or an industrial hygienist.

12. Delayed Recovery. Strongly consider a psychological evaluation, if not previously provided, as well as initiating interdisciplinary rehabilitation treatment and vocational goal setting, for those patients who are failing to make expected progress 6 to 12 weeks after an injury. The OWCA recognizes that 3 to 10 percent of all industrially injured patients will not recover within the timelines outlined in this document despite optimal care. Such individuals may require treatments beyond the limits discussed within this document, but such treatment will require clear documentation by the authorized treating practitioner focusing on objective functional gains afforded by further treatment and impact upon prognosis.

13. Guideline Recommendations and Inclusion of Medical Evidence. Guidelines are recommendations based on available evidence and/or consensus recommendations. When possible, guideline recommendations will note the level of evidence supporting the treatment recommendation. When interpreting medical evidence statements in the guideline, the following apply to the strength of recommendation.

Strong	Level 1 Evidence	We Recommend
Moderate	Level 2 and Level 3 Evidence	We Suggest
Weak	Level 4 Evidence	Treatment is an Option
Inconclusive	Evidence is Either Insufficient or Conflicting	

a. Consensus guidelines are generated by a professional organization that the guidelines are intended to serve. A committee of specialists and experts are selected by the organization to create an unbiased, vetted recommendation for the treatment of specific issues within

the realm of their expertise. All recommendations in the guideline are considered to represent reasonable care in appropriately selected cases, regardless of the level of evidence or consensus statement attached to it. Those procedures considered inappropriate, unreasonable, or unnecessary are designated in the guideline as “not recommended.”

14. Repealed.

B. The remainder of this document should be interpreted within the parameters of these guideline principles that may lead to more optimal medical and functional outcomes for injured workers.

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HISTORICAL NOTE: Promulgated by the Louisiana Workforce Commission, Office of Workers Compensation Administration, LR 37:1631 (June 2011), amended by the Louisiana Workforce Commission, Office of Workers Compensation, LR 40:1135 (June 2014).

§2017. Initial Diagnostic Procedures

- A. - A.1.a.iv. ...
 - v. any treatment for current injuries or results;
 - vi. ability to perform job duties and activities of daily living.
- b. Past History
 - i. past medical history includes neoplasm, gout, arthritis, hypertension, kidney stones, and diabetes;
 - ii. - iii.
 - iv. vocational and recreational pursuits;
 - v. history of depression, anxiety, or other psychiatric illness; and
 - vi. prior occupational and non-occupational injuries to the same area including specific prior treatment, chronic or recurrent symptoms, and any functional limitations; specific history regarding prior motor vehicle accidents may be helpful.
- c. Physical Examination—should include accepted tests and exam techniques applicable to the area being examined, including:
 - i. general and visual inspection, including posture, stance and gait;
 - ii. palpation of spinous processes, facets, and pelvis; and muscles noting myofascial tightness, tenderness and trigger points
 - iii. lumbar range of motion, and quality of motion, and presence of muscle spasm. Motion evaluation of specific joints may be indicated;
 - iv. examination of thoracic spine and pelvis;
 - v. nerve tension testing;
 - vi. sensory and motor examination of the lower extremities with specific nerve root focus;
 - vii. deep tendon reflexes with or without Babinski’s;
 - viii. if applicable to injury, anal sphincter tone and/or perianal sensation; and
 - ix. if applicable, abdominal examination, vascular examination, circumferential lower extremity measurements, or evaluation of hip or other lower extremity abnormalities;
 - x. if applicable, Waddell Signs, which include five categories of clinical signs tenderness; superficial and non-anatomic, pain with simulation: axial loading and rotation; regional findings: sensory and motor, inconsistent

with nerve root patterns; distraction/inconsistency in straight leg raising findings, and over-reaction to physical examination maneuvers. Significance may be attached to positive findings in three out of five of these categories, but not to isolated findings. Waddell advocates considering Waddell's signs prior to recommending a surgical procedure. These signs should be measured routinely to identify patients requiring further assessment (i.e., biopsychosocial) prior to undergoing back surgery.

(a). It is generally agreed that Waddell Signs are associated with decreased functional performance and greater subjective pain levels, though they provide no information on the etiology of pain. Waddell Signs cannot be used to predict or diagnose malingering. Their presence of three out of five signs may most appropriately be viewed as a "yellow flag", or screening test, alerting clinicians to those patients who require a more comprehensive approach to their assessment and care plan. Therefore, if three out of five Waddell Signs are positive in a patient with subacute or chronic back pain, a psychosocial evaluation should be part of the total evaluation of the patient. Refer to Personality/Psychological/Psychosocial Evaluation.

d. Relationship to Work. This includes a statement of the probability that the illness or injury is work-related. If further information is necessary to determine work relatedness, the physician should clearly state what additional diagnostic studies or job information is required.

2.

a. history of significant trauma, especially blunt trauma or fall from a height; greater than one meter; high impact motor vehicle accident, rollover, ejection, bicycle, or recreational vehicle collision; seatbelt use;

2.b. - 3.e. ...

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§2019. Follow-Up Diagnostic Imaging and Testing Procedures

A. One diagnostic imaging or testing procedure may provide the same or distinctive information as does another procedure. Therefore, prudent choice of a single diagnostic procedure, a complement of procedures, or a sequence of procedures will optimize diagnostic accuracy; and maximize cost effectiveness (by avoiding redundancy), and minimize potential adverse effects to patients. All imaging and testing procedures have a degree of specificity and sensitivity for various diagnoses. No isolated imaging test can assure a correct diagnosis.

B. Clinical information obtained by history taking and physical examination should form the basis for selecting an imaging procedure and interpreting its results. Clinical updates must demonstrate the patient's current status to document the need for diagnostic testing or additional treatment. A brief history, changes in clinical findings such as orthopedic and neurological tests, and measurements of function with emphasis on the current, specific physical limitations will be important when seeking approval of future care. The emphasis of the medical treatment schedule are that the determination of the need to continue treatment

is based on functional improvement, and that the patient's ability (current capacity) to return to work is needed to assist in disability management.

C. Magnetic resonance imaging (MRI), myelography, or computed axial tomography (CT) scanning following myelography, and other imaging procedures and testing may provide useful information for many spinal disorders. When a diagnostic procedure, in conjunction with clinical information, can provide sufficient information to establish an accurate diagnosis, the second diagnostic procedure will become a redundant procedure. At the same time, a subsequent diagnostic procedure can be a complementary diagnostic procedure if the first or preceding procedures, in conjunction with clinical information, cannot provide an accurate diagnosis. Usually, preference of a procedure over others depends upon availability, a patient's tolerance, and/or the treating practitioner's familiarity with the procedure.

1. - 2.b.v.

vi. Contraindications

(a). absolute contraindications to diagnostic injections include: bacterial infection-systemic or localized to region of injection; bleeding diatheses; hematological conditions; and possible pregnancy;

(b). relative contraindications to diagnostic injections may include: allergy to contrast, poorly controlled diabetes mellitus and hypertension;

(c). drugs affecting coagulation may require restriction from use. Anti-platelet therapy and anti-coagulations should be addressed individually by a knowledgeable specialist. It is recommended to refer to the American Society of Regional Anesthesia for anticoagulation guidelines.

vii. Specific Diagnostic Injections. In general, relief should last for at least the duration of the local anesthetic used and should significantly relieve pain and result in functional improvement. Refer to "Injections – Therapeutic" for information on specific therapeutic injections.

(a). Medial Branch Blocks are generally accepted diagnostic injections, used to determine whether a patient is a candidate for radiofrequency medial branch neurotomy (also known as facet rhizotomy). ISIS suggests controlled blocks, using either placebo or anesthetics with varying lengths of activity (i.e., bupivacaine longer than lidocaine). To be a positive diagnostic block, the patient should report a reduction of pain of 50 percent or greater relief from baseline for the length of time appropriate for the local anesthetic used. In almost all cases, this will mean a reduction of pain to one or two on the Visual Analog Scale (VAS) 10-point scale correlated with functional improvement. The patient should also identify activities of daily living (which may include measurements of range of motion) that are impeded by their pain and can be observed to document functional improvement in the clinical setting. Ideally, these activities should be assessed throughout the observation period for function. The observer should not be the physician who performed the procedure. It is suggested that this be recorded on a form similar to ISIS recommendations or American Society of Interventional Pain Physicians (ASIPP)

(i). A separate comparative block on a different date may be performed to confirm the level of

involvement. A comparative block uses anesthetics of varying lengths of activity. Medial Branch blocks are probably not helpful to determine the likelihood of success for spinal fusion.

(ii). Frequency and Maximum Duration: May be repeated once for comparative blocks. Limited to four levels

(b). Transforaminal injections/spinal selective nerve block (SSNB) are generally accepted and useful in identifying spinal pathology. When performed for diagnosis, small amounts of local anesthetic up to a total volume of 1.0 cc should be used to determine the level of nerve root irritation. A positive diagnostic block should result in a positive diagnostic functional benefit and a 50 percent reduction in nerve-root generated pain appropriate for the anesthetic used as measured by accepted pain scales (such as a VAS).

(i). Time to Produce Effect: less than 30 minutes for local anesthesia; corticosteroids up to 72 hours for most patients.

(ii). Frequency and Maximum Duration: once per suspected level. Limited to two levels

(c). Zygapophyseal (Facet) Blocks. Facet blocks are generally accepted but should not be considered diagnostic blocks for the purposes of determining the need for a rhizotomy (radiofrequency medial branch neurotomy), nor should they be done with medial branch blocks. These blocks should not be considered a definitive diagnostic tool. They may be used diagnostically to direct functional rehabilitation programs. A positive diagnostic block should result in a positive diagnostic functional benefit and a 50 percent reduction in pain appropriate for the anesthetic used as measured by accepted pain scales (such as a VAS). They then may be repeated per the therapeutic guidelines when they are accompanied by a functional rehabilitation program. (Refer to Therapeutic Spinal Injections).

(i). Time to Produce Effect: Less than 30 minutes for local anesthesia; corticosteroids up to 72 hours for most patients;

(ii). Frequency and Maximum Duration: Once per suspected level, limited to two levels.

(d). Sacroiliac Joint Injection. A generally accepted Injection of local anesthetic in an intra-articular fashion into the sacroiliac joint under fluoroscopic guidance. Long-term therapeutic effect has not yet been established. Indications: Primarily diagnostic to rule out sacroiliac joint dysfunction versus other pain generators. Intra-articular injection can be of value in diagnosing the pain generator. There should be documented relief from previously painful maneuvers (e.g., Patrick's test) and at least 50 percent pain relief on post-injection physical exam (as measured by accepted pain scales such as a VAS) correlated with functional improvement. Sacroiliac joint blocks should facilitate functionally directed rehabilitation programs.

(i). Time to produce effect: Up to 30 minutes for local anesthetic;

(ii). Frequency and Maximum Duration: 1.

c. Personality/ Psychological/ Psychiatric/ Psychosocial Evaluation. These are generally accepted and well-established diagnostic procedures with selective use in the upper extremity population, but have more widespread

use in subacute and chronic upper extremity populations. Diagnostic testing procedures may be useful for patients with symptoms of depression, delayed recovery, chronic pain, recurrent painful conditions, disability problems, and for preoperative evaluation. Psychological/psychosocial and measures have been shown to have predictive value for postoperative response, and therefore should be strongly considered for use pre-operatively when the surgeon has concerns about the relationship between symptoms and findings, or when the surgeon is aware of indications of psychological complication or risk factors for psychological complication (e.g. childhood psychological trauma). Psychological testing should provide differentiation between pre-existing conditions versus injury caused psychological conditions, including depression and posttraumatic stress disorder. Psychological testing should incorporate measures that have been shown, empirically, to identify comorbidities or risk factors that are linked to poor outcome or delayed recovery.

i. Formal psychological or psychosocial evaluation should be performed on patients not making expected progress within 6 to 12 weeks following injury and whose subjective symptoms do not correlate with objective signs and test results. In addition to the customary initial exam, the evaluation of the injured worker should specifically address the following areas:

- (a). employment history;
- (b). interpersonal relationships-both social and work;
- (c). patient activities;
- (d). current perception of the medical system;
- (e). current perception/attitudes toward employer/job;
- (f). results of current treatment;
- (g). risk factors and psychological comorbidities that may influence;

(h). outcome and that may require treatment:
(i). childhood history, including history of childhood psychological trauma, abuse and family history of disability;

ii. personality/ psychological/ psychosocial evaluations consist of two components, clinical interview and psychological testing. Results should help clinicians with a better understanding of the patient in a number of ways. Thus the evaluation result will determine the need for further psychosocial interventions; and in those cases, diagnostic and statistical manual of mental disorders (DSM) diagnosis should be determined and documented. The evaluation should also include examination of both psychological comorbidities and psychological risk factors that are empirically associated with poor outcome and/or delayed recovery. An individual with a Ph.D., Psy.D, or psychiatric M.D./D.O. credentials should perform initial evaluations, which are generally completed within one to two hours. A professional fluent in the primary language of the patient is preferred. When such a provider is not available, services of a professional language interpreter should be provided.

(a). Frequency: one-time visit for the clinical interview. If psychometric testing is indicated as a part of the initial evaluation, time for such testing should not exceed an additional two hours of professional time.

d. Provocation Discography

i. Description. Discography is an accepted, but rarely indicated, invasive diagnostic procedure to identify or refute a discogenic source of pain for patients who are surgical candidates. Discography should only be performed by physicians who are experienced and have been proctored in the technique. Discograms have a significant false positive rate. It is essential that all indications, pre-conditions, special considerations, procedures, reporting requirements, and results are carefully and specifically followed. Results should be interpreted judiciously.

ii. Indications. Discography may be indicated when a patient has a history of functionally limiting, unremitting low back pain of greater than four months duration, with or without leg pain, which has been unresponsive to all conservative interventions. A patient who does not desire operative therapeutic intervention is not a candidate for an invasive non-therapeutic intervention, such as provocation discography.

(a). Discography may prove useful for the evaluation of the pre-surgical spine, such as pseudarthrosis, discogenic pain at levels above or below a prior spinal fusion, annular tear, or internal disc disruption.

(b). Discography may show disc degeneration and annular disruption in the absence of low back pain. Discography may also elicit concordant pain in patients with mild and functionally inconsequential back pain. Because patients with mild back pain should not be considered for invasive treatment, discography should not be performed on these patients. In symptomatic patients with annular tears on discography, the side of the tear does not necessarily correlate with the side on which the symptoms occur. The presence of an annular tear does not necessarily identify the tear as the pain generator.

(c). Discography is not useful in previously operated discs, but may have a limited place in the work-up of pseudarthrosis. Discography may prove useful in evaluating the number of lumbar spine levels that might require fusion. CT-Discography provides further detailed information about morphological abnormalities of the disc and possible lateral disc herniations.

iii. Pre-conditions for provocation discography include all of the following.

(a). A patient with functionally limiting, unremitting back and/or leg pain of greater than four months duration in whom conservative treatment has been unsuccessful and in whom the specific diagnosis of the pain generator has not been made apparent on the basis of other noninvasive imaging studies (e.g., MRI, CT, plain films, etc.). It is recommended that discography be reserved for use in patients with equivocal MRI findings, especially at levels adjacent to clearly pathological levels. Discography may be more sensitive than MRI or CT in detecting radial annular tears. However, radial tears must always be correlated with clinical presentation.

(b). Psychosocial Evaluation has been completed. There is some evidence that false positives and complaints of long-term pain arising from the procedure itself occur more frequently in patients with somatoform disorders. Therefore, discograms should not be performed on patients with somatoform disorders.

(c). Patients who are considered surgical candidates (e.g., symptoms are of sufficient magnitude and the patient has been informed of the possible surgical options that may be available based upon the results of discography). Discography should never be the sole indication for surgery.

(d). Informed consent regarding the risks and potential diagnostic benefits of discography has been obtained.

iv. Complications-include, but are not limited to, discitis, nerve damage, chemical meningitis, pain exacerbation, and anaphylaxis therefore, prior to consideration of discography, the patient should undergo other diagnostic modalities in an effort to define the etiology of the patient's complaint including psychological evaluation, myelography, CT and MRI.

v. Contraindications-include:

(a). active infection of any type or continuing antibiotic treatment for infection; and/or

(b). bleeding diathesis or pharmaceutical anticoagulation with warfarin, etc.; and/or

(c). significant spinal stenosis at the level being studied as visualized by MRI, myelography or CT scan; and/or

(d). presence of clinical myelopathy; and/or

(e). effacement of the cord, thecal sac or circumferential absence of epidural fat; and

(f). known allergic reactions.

vi. Special Considerations

(a). Discography should not be performed by the physician expected to perform the therapeutic procedure. The procedure should be carried out by an experienced individual who has received specialized training in the technique of provocation discography.

(b). Discography should be performed in a blinded format that avoids leading the patient with anticipated responses. The procedure should always include one or more disc levels thought to be normal or non-painful in order to serve as an internal control. The patient should not know what level is being injected in order to avoid spurious results. Abnormal disc levels may be repeated to confirm concordance.

(c). Sterile technique must be utilized.

(d). Judicious use of light sedation during the procedure is acceptable, represents the most common practice nationally at the current time, and is recommended by most experts in the field. The patient must be awake and able to accurately report pain levels during the provocation portion of the procedure.

(e). The discography should be performed using a manometer to record pressure. Pressure should not exceed 50 pounds per square inch (psi) above opening pressure.

(f). Intradiscal injection of local anesthetic may be carried out after the provocation portion of the examination and the patient's response.

(g). It is recommended that a post-discogram CT be considered as it frequently provides additional useful information about disc morphology or other pathology.

vii. Reporting of Discography. In addition to a narrative report, the discography report should contain a standardized classification of disc morphology the pain

response, and the pressure at which pain is produced. All results should be clearly separated in the report from the narrative portion. Asymptomatic annular tears are common and the concordant pain response is an essential finding for a positive discogram.

(a). When discography is performed to identify the source of a patient's low-back pain, both a concordant pain response and morphological abnormalities must be present at the pathological level prior to initiating any treatment directed at that level. The patient must be awake during the provocation phase of the procedure; therefore, sedative medication must be carefully titrated.

(b). Caution should be used when interpreting results from discography. Several studies indicate that a false positive discogram for pain is likely above a pressure reading of 50 psi above opening pressure. The false positive rate appears to drop to approximately 25 percent using a pressure of 20 psi above opening pressure in a population with low back pain.

(i). Reporting disc morphology as visualized by the post-injection CT scan (when available) should follow the Modified Dallas Discogram Scale where:

[a]. Grade 0 = Normal Nucleus

[b]. Grade 1 = Annular tear confined to inner one-third of annulus fibrosis.

[c]. Grade 2 = Annular tear extending to the middle third of the annulus fibrosis.

[d]. Grade 3 = Annular tear extending to the outer one-third of the annulus fibrosis.

[e]. Grade 4 = A grade 3 tear plus dissection within the outer annulus to involve more than 30 degrees of the disc circumference.

[f]. Grade 5 = Full thickness tear with extra-annular leakage of contrast, either focal or diffuse.

(ii). Reporting of pain response should be consistent with the operational criteria of the International Spine Intervention Society (ISIS) Guidelines or American Society of Interventional Pain Physicians (ASIPP) Guidelines. The report must include the level of concordance for back pain and /or leg pain using a 10-point VAS, or similar quantitative assessment. It should be noted that change in the VAS scale before and after provocation is more important than the number reported.

[a]. Unequivocal Discogenic Pain

[i]. stimulation of the target disc reproduces concordant pain

[ii]. the pain should be registered at least 7 on a 10-point VAS.

[iii].the pain is reproduced at a pressure of less than 15 psi above opening pressure; and

[iv].stimulation of two adjacent discs does not produce pain at all

[b]. Definite Discogenic Pain

[i]. stimulation of the target disc reproduces concordant pain

[ii]. the pain should be registered as at least 7 on a 10-point VAS.

[iii].the pain is reproduced at a pressure of less than 15 psi above opening pressure; and

[iv].stimulation of at least one adjacent disc does not produce pain at all

[c]. Highly Probable Discogenic Pain

[i]. stimulation of the target disc reproduces concordant pain

[ii]. that pain should be registered as at least 7 on a 10-point VAS.

[iii].that the pain is reproduced at a pressure of less than 50 psi above opening pressure; and,

[iv].stimulation of two adjacent discs does not produce pain at all

[d]. Probable Discogenic Pain

[i]. stimulation of the target disc reproduces concordant pain;

[ii]. that pain should be registered as at least 7 on a 10-point VAS;

[iii].the pain is reproduced at a pressure of less than 50 psi above opening pressure; and

[iv].stimulation of one adjacent disc does not produce pain at all, and stimulation of another adjacent disc at greater than 50 psi, produces pain, but the pain is not concordant.

[e]. Multiple combinations of factors are possible. However, if the patient does not qualify for at least a 'Probable Discogenic Pain' level, then the discogram should be considered negative. The VAS score prior to the discogram should be taken into account when interpreting the VAS score reported by the patient during the discogram.

[i]. Time Parameters for Provocation Discography are as follows:

aa. Frequency: One time only

bb. Maximum: Repeat

Discography is rarely indicated

e. Thermography is an accepted and established procedure, but has no use as a diagnostic test for low back pain. It may be used to diagnose regional pain disorders and in these cases, refer to the OWCA's Complex Regional Pain Syndrome/Reflex Sympathetic Dystrophy Medical Treatment Guidelines.

3. - 3.e.i. ...

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§2021. Therapeutic Procedures-Non-Operative

A. - C.

1. Reassessment of the patient's status in terms of functional improvement should be documented after each treatment. If patients are not responding within the recommended time periods, alternative treatment interventions, further diagnostic studies or consultations should be pursued. Continued treatment should be monitored using objective measures such as:

a. return-to-work or maintaining work status;

b. fewer restrictions at work or performing activities of daily living;

c. decrease in usage of medications;

d. measurable functional gains, such as increased range of motion or documented increase in strength;

D. - H. ...

1. Acupuncture. Acupuncture is an accepted and widely used procedure for the relief of pain and inflammation, and there is some scientific evidence to support its use. The exact mode of action is only partially understood. Western medicine studies suggest that acupuncture stimulates the nervous system at the level of the brain, promotes deep relaxation, and affects the release of neurotransmitters. Acupuncture is commonly used as an alternative or in addition to traditional Western pharmaceuticals. While it is commonly used when pain medication is reduced or not tolerated, it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten the return of functional activity. Acupuncture should be performed by licensed practitioners.

a. - c.iv.(a).

d. Other Acupuncture Modalities. Acupuncture treatment is based on individual patient needs and therefore treatment may include a combination of procedures to enhance treatment effect. Other procedures may include the use of heat, soft tissue manipulation/massage, and exercise. Refer to Active Therapy (Therapeutic Exercise) and Passive Therapy sections (Massage and Superficial Heat and Cold Therapy) for a description of these adjunctive acupuncture modalities and time frames.

2. Biofeedback. A form of behavioral medicine that helps patients learn self-awareness and self-regulation skills for the purpose of gaining greater control of their physiology, such as muscle activity, brain waves, and measures of autonomic nervous system activity. Electronic instrumentation is used to monitor the targeted physiology and then displayed or fed back to the patient visually, auditorially, or tactilely, with coaching by a biofeedback specialist. Biofeedback is provided by clinicians certified in biofeedback and/or who have documented specialized education, advanced training, or direct or supervised experience qualifying them to provide the specialized treatment needed (e.g., surface EMG, EEG, or other).

2.a. - 3.a.iii.(a).

b. Epidural Steroid Injection (ESI)

i. Description. Epidural steroid injections are injections of corticosteroid into the epidural space. The purpose of ESI is to reduce pain and inflammation in the acute or sub-acute phases of injury, restoring range of motion and, thereby, facilitating progress in more active treatment programs. ESI uses three approaches: transforaminal/Spinal Selective Nerve Block (SNRB), interlaminar (midline), and caudal. The transforaminal/Spinal Selective Nerve Root Block approach is the preferred method for unilateral, single-level pathology and for post-surgical patients. There is good evidence that the transforaminal/ Spinal Selective Nerve Root Block approach can deliver medication to the target tissue with few complications and can be used to identify the specific site of pathology. The interlaminar approach is the preferred approach for multi-level pathology or spinal stenosis. Caudal therapeutic injections may be used, but it is difficult to target the exact treatment area, due to diffuse distribution.

ii. Needle Placement. Multi-planar fluoroscopic imaging is required for all epidural steroid injections. Contrast epidurograms allow one to verify the flow of medication into the epidural space. Permanent images are required to verify needle replacement.

iii. Indications

(a). There is some evidence that epidural steroid injections are effective for patients with radicular pain or radiculopathy (sensory or motor loss in a specific dermatome or myotome). Up to 80 percent of patients with radicular pain may have initial relief. However, only 25-57 percent are likely to have excellent long-term relief.

(b). Although there is no evidence regarding the effectiveness of ESI for non-radicular disc herniation, it is an accepted intervention. Only patients who have pain affected by activity and annular tears verified by appropriate imaging may have injections for axial pain.

(c). There is some evidence that ESI injections are not effective for spinal stenosis without radicular findings. Additionally, there is some evidence that patients who smoke or who have pain unaffected by rest or activity are less likely to have a successful outcome from ESIs.

iv. Timing/Frequency / Duration

(a). Time to produce effect: local anesthetic, less than 30 minutes; corticosteroid, 48 to 72 hours for 80 percent of patients and 72 hours to 2 weeks for 20 percent of patients.

(b). Frequency: interlaminar (midline) or caudal techniques should be limited to one level per session. Transforaminal epidural injections should be limited to two levels per session. Whether injections are repeated depends upon the patient's response to the previous injection. Subsequent injections may occur after one to two weeks if patient response has been favorable. Injections can be repeated after a hiatus of six months if the patient has demonstrated functional gain and pain returns or worsens. . Injections should provide a positive patient response: Positive patient response results are defined primarily as functional gains that can be objectively measured. Objective functional gains include, but are not limited to, positional tolerances, range of motion (ROM), strength, endurance, activities of daily living, cognition, psychological behavior, and efficiency/velocity measures that can be quantified. Subjective reports of pain response (via a recognized pain scale) and function should be considered and given relative weight when the pain has anatomic and physiologic correlation.

(c). Optimum duration: usually one to three injection(s) over a period of six months depending upon each patient's response and functional gain.

(d). Maximum duration: two sessions (consisting of up to three injections each) may be done in one year, as per the patient's response to pain and function. Patients should be reassessed after each injection for an 50 percent improvement in pain (as measured by accepted pain scales) and evidence of functional improvement.

c. Zygapophyseal (Facet) Injection

i. Description-a generally accepted intra-articular or pericapsular injection of local anesthetic and corticosteroid. Medial branch nerve blocks are diagnostic only. There is conflicting evidence to support a long-term therapeutic effect using facet injections. There is no justification for a combined facet and medial branch block.

ii. Indications-patients with pain suspected to be facet in origin based on exam findings and affecting activity; or, patients who have refused a rhizotomy; or, patients who have facet findings with a thoracic component. In these

patients, facet injections may be occasionally useful in facilitating a functionally-directed rehabilitation program and to aid in identifying pain generators. Patients with recurrent pain should be evaluated with more definitive diagnostic injections, such as medial nerve branch injections, to determine the need for a rhizotomy. Because facet injections are not likely to produce long-term benefit by themselves and are not the most accurate diagnostic tool, they should not be performed at more than two levels.

iii. Timing/Frequency/Duration

(a). Time to produce effect: up to 30 minutes for local anesthetic; corticosteroid up to 72 hours.

(b). Frequency: one injection per level with a diagnostic response. If the first injection does not provide a diagnostic response of temporary and sustained pain relief substantiated by accepted pain scales, (i.e., 50 percent pain reduction substantiated by tools such as VAS), and improvement in function, similar injections should not be repeated. At least four to six weeks of functional benefit should be obtained with each therapeutic injection.

(c). Optimum duration: two to three injections for each applicable joint per year. Not to exceed two joint levels.

(d). Maximum Duration: four per level per year. Prior authorization must be obtained for injections beyond two levels.

(e). Facet injections may be repeated if they result in increased documented functional benefit for at least four to six weeks and at least an 50 percent initial improvement in pain scales as measured by accepted pain scales (such as VAS).

d. Sacroiliac Joint Injection

i. Description—a generally accepted injection of local anesthetic in an intra-articular fashion into the sacroiliac joint under radiographic guidance. May include the use of corticosteroids. Long-term therapeutic effect has not yet been established.

ii. Indications—primarily diagnostic to rule out sacroiliac joint dysfunction vs. other pain generators. Intra-articular injection can be of value in diagnosing the pain generator. There should be documented relief from previously painful maneuvers (e.g., Patrick's test) on post-injection physical exam. These injections may be repeated if they result in increased documented functional benefit for at least 6 weeks and at least a 50 percent initial improvement in pain scales as measured by accepted pain scales (such as VAS). Sacroiliac joint blocks should facilitate a functionally directed rehabilitation program.

iii. Timing/Frequency/Duration

(a). Time to produce effect: approximately 30 minutes for local anesthetic; 48 to 72 hours for corticosteroid.

(b). Frequency and optimum duration: two to three injections per year. If the first injection does not provide a diagnostic response of temporary and sustained pain relief substantiated by accepted pain scales, (i.e., 50 percent pain reduction substantiated by tools such as VAS), and improvement in function, similar injections should not be repeated. At least six weeks of functional benefit should be obtained with each therapeutic injection.

(c). Maximum duration: four injections per year.

(d). These injections may be repeated if they result in increased documented functional benefit for at least 6 weeks and at least a 50 percent initial improvement in pain scales as measured by accepted pain scales (such as VAS). Sacroiliac joint blocks should facilitate a functionally directed rehabilitation program.

e. Intradiscal Steroid Therapy

i. Intradiscal Steroid Therapy consists of injection of a steroid preparation into the intervertebral disc under fluoroscopic guidance at the time of discography. There is good evidence that it is not effective in the treatment of suspected discogenic back pain and its use is not recommended.

f. Radio Frequency Medial Branch Neurotomy/Facet Rhizotomy

i. Description—a procedure designed to denervate the facet joint by ablating the corresponding sensory medial branches. Continuous percutaneous radiofrequency is the method generally used. There is good evidence to support Radio Frequency Medial Branch Neurotomy in the cervical spine but benefits beyond one year are not yet established. Evidence in the lumbar spine is conflicting; however, the procedure is generally accepted. In one study, 60 percent of patients maintained at least 90 percent pain relief at 12 months. Radio-frequency Medial Branch Neurotomy is the procedure of choice over alcohol, phenol, or cryoablation. Precise positioning of the probe using fluoroscopic guidance is required since the maximum effective diameter of the device is a 5x8 millimeter oval. Permanent images should be recorded to verify placement of the device.

ii. Indications—those patients with proven, significant, facetogenic pain. A minority of low back patients would be expected to qualify for this procedure. This procedure is not recommended for patients with multiple pain generators or involvement of more than 3 levels of medial branch nerves.

(a). Individuals should have met all of the following indications: Pain of well-documented facet origin, unresponsive to active and/or passive therapy; unresponsive to manual therapy, and in which a psychosocial screening has been performed (e.g., pain diagram, Waddell's signs, thorough psychosocial history, screening questionnaire). It is generally recommended that this procedure not be performed until three months of active therapy and manual therapy have been completed. All patients should continue appropriate exercise with functionally directed rehabilitation. Active treatment, which patients will have had prior to the procedure, will frequently require a repeat of the sessions previously ordered (Refer to Active Therapy.)

(b). All patients should have a successful response to a diagnostic medial nerve branch block and a separate comparative block. ISIS suggests controlled blocks using either placebo or anesthetics with varying lengths of activity (i.e., bupivacaine longer than lidocaine). To be a positive diagnostic block the patient should report a reduction of pain of 50 percent or greater from baseline for the length of time appropriate for the local anesthetic used. In almost all cases this will mean a reduction of pain to one

or two on the VAS 10-point scale correlated with functional improvement. The patient should also identify activities of daily living (which may include measurements of range of motion) that are impeded by their pain and can be observed to document functional improvement in the clinical setting. Ideally, these activities should be assessed throughout the observation period for function. The observer should not be the physician who performed the procedure. It is suggested that this be recorded on a form similar to ISIS recommendations.

(c). A separate comparative block on a different date may be performed to confirm the level of involvement. A comparative block uses anesthetics with varying lengths of activity.

iii. Complications-bleeding, infection, or neural injury. The clinician must be aware of the risk of developing a localized neuritis, or rarely, a deafferentation centralized pain syndrome as a complication of this and other neuroablative procedures.

iv. Post-Procedure Therapy-active therapy. Implementation of a gentle aerobic reconditioning program (e.g., walking) and back education within the first post-procedure week, barring complications. Instruction and participation in a long-term home-based program of ROM, core strengthening, postural or neuromuscular re-education, endurance, and stability exercises should be accomplished over a period of four to ten visits post-procedure.

v. Requirements for Repeat Radiofrequency Medial Branch Neurotomy (or additional-level RF Neurotomies): In some cases pain may recur. Successful RF Neurotomy usually provides from six to eighteen months of relief.

(a). Before a repeat RF Neurotomy is done, a confirmatory medial branch injection should be performed if the patient's pain pattern presents differently than the initial evaluation. In occasional patients, additional levels of RF neurotomy may be necessary. The same indications and limitations apply.

g. Sacro-iliac (SI) joint radiofrequency denervation is a denervation of the SI joint. This procedure has limited evidence to support efficacy for its use and may be considered for therapeutic purposes.

h. Trigger Point Injections

i. Description. Trigger point injections are a generally accepted treatment. Trigger point treatment can consist of injection of local anesthetic, with or without corticosteroid, into highly localized, extremely sensitive bands of skeletal muscle fibers that produce local and referred pain when activated. Medication is injected in a four-quadrant manner in the area of maximum tenderness. Injection efficacy can be enhanced if injections are immediately followed by myofascial therapeutic interventions, such as vapo-coolant spray and stretch, ischemic pressure massage (myotherapy), specific soft tissue mobilization and physical modalities. There is conflicting evidence regarding the benefit of trigger point injections. A truly blinded study comparing dry needle treatment of trigger points is not feasible. There is no evidence that injection of medications improves the results of trigger-point injections. Needling alone may account for some of the therapeutic response.

(a). There is no indication for conscious sedation for patients receiving trigger point injections. The patient must be alert to help identify the site of the injection.

ii. Indications. Trigger point injections may be used to relieve myofascial pain and facilitate active therapy and stretching of the affected areas. They are to be used as an adjunctive treatment in combination with other treatment modalities such as functional restoration programs. Trigger point injections should be utilized primarily for the purpose of facilitating functional progress. Patients should continue in an aggressive aerobic and stretching therapeutic exercise program as tolerated throughout the time period they are undergoing intensive myofascial interventions. Myofascial pain is often associated with other underlying structural problems and any abnormalities need to be ruled out prior to injection.

(a). Trigger point injections are indicated in those patients where well circumscribed trigger points have been consistently observed, demonstrating a local twitch response, characteristic radiation of pain pattern and local autonomic reaction, such as persistent hyperemia following palpation. Generally, these injections are not necessary unless consistently observed trigger points are not responding to specific, noninvasive, myofascial interventions within approximately a six-week time frame. However, trigger point injections may be occasionally effective when utilized in the patient with immediate, acute onset of low back pain.

iii. Complications. Potential but rare complications of trigger point injections include infection, pneumothorax, anaphylaxis, penetration of viscera, neurapraxia, and neuropathy. If corticosteroids are injected in addition to local anesthetic, there is a risk of local myopathy developing. Severe pain on injection suggests the possibility of an intraneural injection, and the needle should be immediately repositioned.

iv. Timing/Frequency/Duration

(a). Time to produce effect: Local anesthetic 30 minutes; 24 to 48 hours for no anesthesia;

(b). Frequency: weekly. Suggest no more than 4 injection sites per session per week to avoid significant post-injection soreness;

(c). Optimum duration: four weeks;

(d). Maximum duration: eight weeks. Occasional patients may require two to four repetitions of trigger point injection series over a one to two year period.

i. Prolotherapy. Also known as sclerotherapy consists of a series of injections of hypertonic dextrose, with or without glycerine and phenol, into the ligamentous structures of the low back. Its proponents claim that the inflammatory response to the injections will recruit cytokine growth factors involved in the proliferation of connective tissue, stabilizing the ligaments of the low back when these structures have been damaged by mechanical insults.

i. There are conflicting studies concerning the effectiveness of Prolotherapy in the low back. Lasting functional improvement has not been shown. The injections are invasive, may be painful to the patient, and are not generally accepted or widely used. Therefore, the use of Prolotherapy for low back pain is not recommended.

4. Epiduroscopy and Epidural Lysis of Adhesions: An investigational treatment of low back pain. It involves the introduction of a fiberoptic endoscope into the epidural space via the sacral hiatus. With cephalad advancement of the endoscope under direct visualization, the epidural space is irrigated with saline. Adhesiolysis may be done mechanically with a fiberoptic endoscope. The saline irrigation is performed with or without epiduroscopy and is intended to distend the epidural space in order to obtain an adequate visual field. It is designed to produce lysis of adhesions, which are conjectured to produce symptoms due to traction on painful nerve roots. Saline irrigation is associated with risks of elevated pressures which may impede blood flow and venous return, possibly causing ischemia of the cauda equina and retinal hemorrhage.

a. Other complications associated with instrumented lysis include catheter shearing, need for catheter surgical removal, infection (including meningitis), hematoma, and possible severe hemodynamic instability during application. Although epidural adhesions have been postulated to cause chronic low back pain, studies have failed to find a significant correlation between the level of fibrosis and pain or difficulty functioning. Studies of epidural lysis demonstrate no transient pain relief from the procedure. Given the low likelihood of a positive response, the additional costs and time requirement, and the possible complications from the procedure, epidural injection, or mechanical lysis, is not recommended.

b. Epiduroscopy—directed steroid injections are also not recommended as there is no evidence to support an advantage for using an epiduroscope with steroid injections.

5. Medications/Pharmacy. Medication use in the treatment of low back injuries is appropriate for controlling acute and chronic pain and inflammation. Use of medications will vary widely due to the spectrum of injuries from simple strains to post-surgical healing. All drugs should be used according to patient needs. A thorough medication history, including use of alternative and over the counter medications, should be performed at the time of the initial visit and updated periodically. Treatment for pain control is initially accomplished with acetaminophen and/or NSAIDs. The patient should be educated regarding the interaction with prescription and over-the-counter medications as well as the contents of over-the-counter herbal products. The following are listed in alphabetical order:

a. Acetaminophen: is an effective analgesic with antipyretic but not anti-inflammatory activity. Acetaminophen is generally well tolerated, causes little or no gastrointestinal irritation, and is not associated with ulcer formation. Acetaminophen has been associated with liver toxicity in overdose situations or in chronic alcohol use. Patients may not realize that many over-the-counter preparations may contain acetaminophen. The total daily dose of acetaminophen is recommended not to exceed 2250 mg per 24-hour period, from all sources, including narcotic-acetaminophen combination preparations:

i. optimum duration: 7 to 10 days;
ii. maximum duration: chronic use as indicated on a case-by-case basis. Use of this substance long-term for 3 days per week or greater may be associated with rebound pain upon cessation.

b. Muscle Relaxants: are appropriate for muscle spasm with pain. There is strong evidence that muscle relaxants are more effective than placebo for providing short-term pain relief in acute low back pain. When prescribing these agents, physicians must seriously consider side effects of drowsiness or dizziness and the fact that benzodiazepines may be habit-forming.

i. optimum duration: one week;
ii. maximum duration: two weeks (or longer if used only at night).

c. Narcotics: should be primarily reserved for the treatment of severe low back pain. In mild to moderate cases of low back pain, narcotic medication should be used cautiously on a case-by-case basis. Adverse effects include respiratory depression, the development of physical and psychological dependence, and impaired alertness.

i. Narcotic medications should be prescribed with strict time, quantity, and duration guidelines, and with definitive cessation parameters. Pain is subjective in nature and should be evaluated using a scale to rate effectiveness of the narcotic prescribed. Any use beyond the maximum should be documented and justified based on the diagnosis and/or invasive procedures:

(a). optimum duration: three to seven days;
(b). maximum duration: two weeks. Use beyond two weeks is acceptable in appropriate cases. Refer to Chronic Pain Guidelines which gives a detailed discussion regarding medication use in chronic pain management.

(c). Nonsteroidal Anti-Inflammatory Drugs (NSAIDs) are useful for pain and inflammation. In mild cases, they may be the only drugs required for analgesia. There are several classes of NSAIDs, and the response of the individual injured worker to a specific medication is unpredictable. For this reason, a range of NSAIDs may be tried in each case with the most effective preparation being continued. Patients should be closely monitored for adverse reactions. The US Food and Drug Administration advise that many NSAIDs may cause an increased risk of serious cardiovascular thrombotic events, myocardial infarction, and stroke, which can be fatal. Naproxen sodium does not appear to be associated with increased risk of vascular events. Administration of proton pump inhibitors, Histamine 2 Blockers or prostaglandin analog misoprostol along with these NSAIDs may reduce the risk of duodenal and gastric ulceration but do not impact possible cardiovascular complications. Due to the cross-reactivity between aspirin and NSAIDs, NSAIDs should not be used in aspirin-sensitive patients, and should be used with caution in all asthma patients. NSAIDs are associated with abnormal renal function, including renal failure, as well as, abnormal liver function. Certain NSAIDs may have interactions with various other medications. Individuals may have adverse events not listed above. Intervals for metabolic screening are dependent upon the patient's age, general health status and should be within parameters listed for each specific medication. Complete Blood Count (CBC), and liver and renal function should be monitored at least every six months in patients on chronic NSAIDs and initially when indicated.

(i). Non-Selective Nonsteroidal Anti-Inflammatory Drugs

[a]. Includes NSAIDs and acetylsalicylic acid (aspirin). Serious GI toxicity, such as bleeding, perforation, and ulceration can occur at any time, with or without warning symptoms in patients treated with traditional NSAIDs. Physicians should inform patients about the signs and/or symptoms of serious gastrointestinal toxicity and what steps to take if they occur. Anaphylactoid reactions may occur in patients taking NSAIDs. NSAIDs may interfere with platelet function. Fluid retention and edema have been observed in some patients taking NSAIDs.

[i]. optimal duration: one week;

[ii]. maximum duration: one year. Use of these substances long-term (three days per week or greater) is associated with rebound pain upon cessation.

[ii]. Selective Cyclo-oxygenase-2 (COX-2) Inhibitors

[b]. COX-2 inhibitors are more recent NSAIDs and differ in adverse side effect profiles from the traditional NSAIDs. The major advantages of selective COX-2 inhibitors over traditional NSAIDs are that they have less gastrointestinal toxicity and no platelet effects. COX-2 inhibitors can worsen renal function in patients with renal insufficiency, thus renal function may need monitoring.

[c]. COX-2 inhibitors should not be first-line for low risk patients who will be using an NSAID short term but are indicated in select patients for whom traditional NSAIDs are not tolerated. Serious upper GI adverse events can occur even in asymptomatic patients. Patients at high risk for GI bleed include those who use alcohol, smoke, are older than 65, take corticosteroids or anti-coagulants, or have a longer duration of therapy. Celecoxib is contraindicated in sulfonamide allergic patients.

[i]. Optimal Duration: 7 to 10 days.

[ii]. Maximum Duration: Chronic use is appropriate in individual cases. Use of these substances long-term (three days per week or greater) is associated with rebound pain upon cessation.

d. Oral Steroids: have limited use but are accepted in cases requiring potent anti-inflammatory drug effect. There is no evidence supporting oral steroids for patients with low back pain with or without radiculopathy and are not recommended.

e. Intravenous Steroids: the risks of permanent neurological damage from acute spinal cord compression generally outweigh the risks of pharmacologic side effects of steroids in an emergent situation.

f. Psychotropic/anti-anxiety/hypnotic agents may be useful for treatment of mild and chronic pain, dysesthesias, sleep disorders, and depression. Antidepressant medications, such as tricyclics and, Selective Serotonin reuptake inhibitors (SSRIs) and norepinephrine reuptake inhibitors (SSNRIs) are useful for affective disorder and chronic pain management. Tricyclic antidepressant agents, in low dose, are useful for chronic pain but have more frequent side effects. Anti-anxiety medications should generally be limited to short-term use. Combinations of the above agents may be useful. As a general rule, providers (i.e., physician or medical psychologist) should access the patient's prior history of substance abuse or depression prior to prescribing any of these agents. Due to the habit-forming potential of the benzodiazepines and other drugs found in this class, they are

not routinely recommended. Refer to the Chronic Pain Guidelines which give a detailed discussion regarding medication use in chronic pain management:

i. optimum duration: one to six months;

ii. maximum duration: 6 to 12 months, with monitoring.

g. Tramadol is useful in relief of low back pain and has been shown to provide pain relief equivalent to that of commonly prescribed NSAIDs. Although Tramadol may cause impaired alertness, it is generally well tolerated, does not cause gastrointestinal ulceration, or exacerbate hypertension or congestive heart failure. Tramadol should be used cautiously in patients who have a history of seizures or who are taking medication that may lower the seizure threshold, such as monoamine oxidase (MAO) inhibitors, SSRIs, and tricyclic antidepressants. This medication has physically addictive properties and withdrawal may follow abrupt discontinuation and is not recommended for those with prior opioid addiction.

i. optimum duration: three to seven days;

ii. maximum duration: two weeks. Use beyond two weeks is acceptable in appropriate cases.

6. Occupational Rehabilitation Programs

a. Non-Interdisciplinary. These generally accepted programs are work-related, outcome-focused, individualized treatment programs. Objectives of the program include, but are not limited to, improvement of cardiopulmonary and neuromusculoskeletal functions (strength, endurance, movement, flexibility, stability, and motor control functions), patient education, and symptom relief. The goal is for patients to gain full or optimal function and return to work. The service may include the time-limited use of passive modalities with progression to active treatment and/or simulated/real work.

i. Work Conditioning

(a). These programs are usually initiated once reconditioning has been completed but may be offered at any time throughout the recovery phase. Work conditioning should be initiated when imminent return of a patient to modified or full duty is not an option, but the prognosis for returning the patient to work at completion of the program is at least fair to good:

(i). length of visit: one to two hours per day;

(ii). frequency: two to five visits per week;

(iii). optimum duration: two to four weeks

(iv). maximum duration: six weeks.

Participation in a program beyond six weeks must be documented with respect to need and the ability to facilitate positive symptomatic or functional gains.

ii. Work Simulation

(a). Work simulation is a program where an individual completes specific work-related tasks for a particular job and return to work. Use of this program is appropriate when modified duty can only be partially accommodated in the work place, when modified duty in the work place is unavailable, or when the patient requires more structured supervision. The need for work place simulation should be based upon the results of a Functional Capacity Evaluation and/or Jobsite Analysis.

(i). length of visit: two to six hours per day;

- (ii). frequency: two to five visits per week;
- (iii). optimum duration: two to four weeks;
- (iv). maximum duration: six weeks.

Participation in a program beyond six weeks must be documented with respect to need and the ability to facilitate positive symptomatic or functional gains.

(b). Interdisciplinary: programs are well-established treatment for patients with sub-acute and functionally impairing low back pain. They are characterized by a variety of disciplines that participate in the assessment, planning, and/or implementation of an injured worker's program with the goal for patients to gain full or optimal function and return to work. There should be close interaction and integration among the disciplines to ensure that all members of the team interact to achieve team goals. Programs should include cognitive-behavioral therapy as there is good evidence for its effectiveness in patients with chronic low back pain. These programs are for patients with greater levels of disability, dysfunction, de-conditioning and psychological involvement. For patients with chronic pain, refer to the OWCA's Chronic Pain Disorder Medical Treatment Guidelines.

(i). Work Hardening

[a]. Work Hardening is an interdisciplinary program addressing a patient's employability and return to work. It includes a progressive increase in the number of hours per day that a patient completes work simulation tasks until the patient can tolerate a full workday. This is accomplished by addressing the medical, psychological, behavioral, physical, functional, and vocational components of employability and return-to-work.

[b]. This can include a highly structured program involving a team approach or can involve any of the components thereof. The interdisciplinary team should, at a minimum, be comprised of a qualified medical director who is board certified with documented training in occupational rehabilitation; team physicians having experience in occupational rehabilitation; occupational therapist; physical therapist; case manager; and psychologist. As appropriate, the team may also include: chiropractor, RN, vocational specialist or Certified Biofeedback Therapist:

- [i]. length of visit: Up to 8 hours/day;
- [ii]. frequency: two to five visits per week;
- [iii]. optimum duration: two to four weeks;
- [iv]. maximum duration: six weeks.

Participation in a program beyond six weeks must be documented with respect to need and the ability to facilitate positive symptomatic or functional gains.

(ii). Spinal Cord Programs

[a]. Spinal Cord Systems of Care provide coordinated, case-managed, and integrated service for people with spinal cord dysfunction, whether due to trauma or disease. The system includes an inpatient component in an organization licensed as a hospital and an outpatient component. Each component endorses the active participation and choice of the persons served throughout the entire program. The Spinal Cord System of Care also

provides or formally links with key components of care that address the lifelong needs of the persons served.

[b]. This can include a highly structured program involving a team approach or can involve any of the components thereof. The interdisciplinary team should, at a minimum, be comprised of a qualified medical director who is board certified and trained in rehabilitation, a case manager, occupational therapy, physical therapy, psychologist, rehabilitation RN and MD, and therapeutic recreation specialist. As appropriate, the team may also include: rehabilitation counselor, respiratory therapist, social worker, or speech-language pathologist.

[c]. Timeframe durations for any spinal cord program should be determined based upon the extent of the patient's injury and at the discretion of the rehabilitation physician in charge.

7. Orthotics

a. Foot Orthoses and Inserts are accepted interventions for spinal disorders that are due to aggravated mechanical abnormalities, such as leg length discrepancy, scoliosis, or lower extremity misalignment. Shoe insoles or inserts may be effective for patients with acute low back problems who stand for prolonged periods of time.

b. Lumbar support devices include backrests for chairs and car seats. Lumbar supports may provide symptomatic relief of pain and movement reduction in cases of chronic low back problems.

c. Lumbar Corsets and Back Belts. There is insufficient evidence to support their use. They are an accepted treatment with limited application. The injured worker should be advised of the potential harm from using a lumbar support for a period of time greater than that which is prescribed. Harmful effects include de-conditioning of the trunk musculature, skin irritation, and general discomfort.

d. Lumbosacral Bracing. Rigid bracing devices are well accepted and commonly used for post-fusion, scoliosis, and vertebral fractures.

8. Patient Education. No treatment plan is complete without addressing issues of individual and/or group patient education as a means of prolonging the beneficial effects of treatment, as well as facilitating self-management of symptoms and injury prevention. The patient should be encouraged to take an active role in the establishment of functional outcome goals. They should be educated on their specific injury, assessment findings, and plan of treatment. Instruction on proper body mechanics and posture, positions to avoid, self-care for exacerbation of symptoms, and home exercise should also be addressed:

- a. time to produce effect: varies with individual patient;
- b. frequency: should occur at every visit.

9. Personality/Psychological/Psychiatric/ Psychosocial Intervention. Psychosocial treatment is generally accepted, widely used, and well-established Intervention. This group of therapeutic and diagnostic modalities includes, but is not limited to, individual counseling, group therapy, stress management, psychosocial crises intervention, hypnosis, and meditation. Any evaluation or diagnostic workup should clarify and distinguish between pre-existing versus aggravated versus purely causative psychological conditions. Psychosocial intervention is recommended as an important

component in the total management program that should be implemented as soon as the problem is identified. There is some evidence that early cognitive-behavioral treatment reduces health care use in comparison to written information alone. This can be used alone, or in conjunction with other treatment modalities. Providers treating patients with chronic pain should refer to the OWCA's Chronic Pain Disorder Medical Treatment Guidelines:

- a. time to produce effect: two to four weeks;
- b. frequency: one to three times weekly for the first four weeks (excluding hospitalization, if required), decreasing to one to two times per week for the second month. Thereafter, two to four times monthly;
- c. optimum duration: six weeks to three months;
- d. maximum duration: 3 to 12 months. Counseling is not intended to delay but to enhance functional recovery. For select patients, longer supervised treatment may be required and if further counseling beyond three months is indicated, extensive documentation addressing which pertinent issues are pre-existing versus aggravated versus causative, as well as projecting a realistic functional prognosis, should be provided by the authorized treating provider every four to six weeks during treatment.

10. Restriction of Activities. Continuation of normal daily activities is the recommendation for acute and chronic low back pain without neurologic symptoms. There is good evidence against the use of bed rest in cases without neurologic symptoms. Bed rest may lead to de-conditioning and impair rehabilitation. Complete work cessation should be avoided, if possible, since it often further aggravates the pain presentation. Modified return-to-work is almost always more efficacious and rarely contraindicated in the vast majority of injured workers with low back pain.

11. Return-to-Work. Early return-to-work should be a prime goal in treating occupational injuries given the poor return-to-work prognosis for an injured worker who has been out of work for more than six months. It is imperative that the patient be educated regarding the benefits of return-to-work, work restrictions, and follow-up if problems arise. When attempting to return a patient to work after a specific injury, clear objective restrictions of activity level should be made. An accurate job description with detailed physical duty restrictions is often necessary to assist the physician in making return-to-work recommendations. This may require a jobsite evaluation.

a. Employers should be prepared to offer transitional work. This may consist of temporary work in a less demanding position, return to the regular job with restrictions, or gradual return to the regular job. Company policies which encourage return-to-work with positive communication are most likely to have decreased worker disability.

b. Return-to-work is defined as any work or duty that the patient is able to perform safely. It may not be the patient's regular work. Due to the large spectrum of injuries of varying severity and varying physical demands in the work place, it is not possible to make specific return-to-work guidelines for each injury. Therefore, the OWCA recommends the following.

c. Establishment of a Return-To-Work Status: Ascertaining a return-to-work status is part of medical care, should be included in the treatment and rehabilitation plan,

and addressed at every visit. A description of daily activity limitations is part of any treatment plan and should be the basis for restriction of work activities. In most non-surgical cases, the patient should be able to return-to-work in some capacity or in an alternate position consistent with medical treatment within several days unless there are extenuating circumstances. Injuries requiring more than two weeks off work should be thoroughly documented.

d. Establishment of Activity Level Restrictions. Communication is essential between the patient, employer, and provider to determine appropriate restrictions and return-to-work dates. It is the responsibility of the physician to provide clear concise restrictions, and it is the employer's responsibility to determine if temporary duties can be provided within the restrictions. For low back pain injuries, the following should be addressed when describing the patient's activity level:

i. lifting limits with the maximum amount of weight to be lifted. This may vary depending on the frequency of the lifting and/or the object height level. Pushing, pulling, as well as bending and twisting at the waist should be considered as well;

ii. lower body postures such as squatting, kneeling, crawling, stooping, awkward or static positions, and climbing ladders or stairs should include duration and frequency;

iii. ambulatory level for distance, frequency, and terrain should be specified;

iv. duration and frequency of sitting, standing, and walking should be delineated. Balance issues should also be considered in these determinations;

v. use of adaptive devices or equipment for proper office ergonomics to enhance capacities can be included;

vi. the effect of any medications that may pose a safety risk to the patient, co-workers or the general public should be considered with regard to the workplace and home.

e. Compliance with Activity Restrictions: In some cases, compliance with restriction of activity levels may require a complete jobsite evaluation, a functional capacity evaluation (FCE) or other special testing. Refer to the "Special Tests" section of this guideline.

12. Therapy—Active. The following active therapies are widely used and accepted methods of care for a variety of work-related injuries. They are based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy requires supervision from a therapist or medical provider such as verbal, visual, and/or tactile instruction(s). At times, the provider may help stabilize the patient or guide the movement pattern but the energy required to complete the task is predominately executed by the patient.

a. On occasion, specific diagnoses and post-surgical conditions may warrant durations of treatment beyond those listed as "maximum". Factors such as exacerbation of symptoms, re-injury, interrupted continuity of care and comorbidities may also extend durations of care. Specific goals with objectively measured functional improvement during

treatment must be cited to justify extended durations of care. It is recommended that, if no functional gain is observed after the number of treatments under “time to produce effect” has been completed alternative treatment interventions, further diagnostic studies or further consultations should be pursued.

b. Patients should be instructed to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Follow-up visits to reinforce and monitor progress and proper technique are recommended. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. The following active therapies are listed in alphabetical order:

c. Activities of daily living (ADL) are well-established interventions which involve instruction, active-assisted training, and/or adaptation of activities or equipment to improve a person's capacity in normal daily activities such as self-care, work re-integration training, homemaking, and driving.

- i. time to produce effect: four to five treatments;
- ii. frequency: three to five times per week;
- iii. optimum duration: four to six weeks;
- iv. maximum duration: six weeks.

d. Aquatic Therapy is a well-accepted treatment which consists of the therapeutic use of aquatic immersion for therapeutic exercise to promote strengthening, core stabilization, endurance, range of motion, flexibility, body mechanics, and pain management. Aquatic therapy includes the implementation of active therapeutic procedures in a swimming or therapeutic pool. The water provides a buoyancy force that lessens the amount of force gravity applies to the body. The decreased gravity effect allows the patient to have a mechanical advantage and more likely have a successful trial of therapeutic exercise. The therapy may be indicated for individuals who:

- i. cannot tolerate active land-based or full-weight bearing therapeutic procedures;
- ii. require increased support in the presence of proprioceptive deficit;
- iii. are at risk of compression fracture due to decreased bone density;
- iv. have symptoms that are exacerbated in a dry environment;
- v. would have a higher probability of meeting active therapeutic goals than in a dry environment.

(a). The pool should be large enough to allow full extremity range of motion and fully erect posture. Aquatic vests, belts and other devices can be used to provide stability, balance, buoyancy, and resistance:

- (i). time to produce effect: four to five treatments;
- (ii). frequency: three to five times per week;
- (iii). optimum duration: four to six weeks;
- (iv). maximum duration: eight weeks;

(b). A self-directed program is recommended after the supervised aquatics program has been established, or, alternatively a transition to a self-directed dry environment exercise program.

e. Functional activities are well-established interventions which involve the use of therapeutic activity to

enhance mobility, body mechanics, employability, coordination, balance, and sensory motor integration.

- i. time to produce effect: four to five treatments;
- ii. frequency: three to five times per week;
- iii. optimum duration: four to six weeks;
- iv. maximum duration: six weeks.

f. Functional electrical stimulation is an accepted treatment in which the application of electrical current to elicit involuntary or assisted contractions of atrophied and/or impaired muscles. It may be indicated for muscle atrophy due to radiculopathy:

- i. time to produce effect: two to six treatments;
- ii. frequency: three times per week;
- iii. optimum duration: eight weeks;
- iv. maximum duration: eight weeks. If beneficial, provide with home unit.

g. Neuromuscular re-education is a generally accepted treatment. It is the skilled application of exercise with manual, mechanical, or electrical facilitation to enhance strength; movement patterns; neuromuscular response; proprioception, kinesthetic sense, coordination; education of movement, balance, and posture. Indications include the need to promote neuromuscular responses through carefully timed proprioceptive stimuli, to elicit and improve motor activity in patterns similar to normal neurologically developed sequences, and improve neuromotor response with independent control:

- i. time to produce effect: two to six treatments;
- ii. frequency: three times per week;
- iii. optimum duration: four to eight weeks;
- iv. maximum duration: eight weeks.

h. Spinal stabilization is a generally well-accepted treatment. The goal of this therapeutic program is to strengthen the spine in its neural and anatomic position. The stabilization is dynamic which allows whole body movements while maintaining a stabilized spine. It is the ability to move and function normally through postures and activities without creating undue vertebral stress:

- i. time to produce effect: four to eight treatments;
- ii. frequency: three to five times per week;
- iii. optimum duration: four to eight weeks;
- iv. maximum duration: eight weeks.

i. Therapeutic exercise is a generally well-accepted treatment. There is some evidence to support the effectiveness of yoga therapy in alleviating symptoms and decreasing medication use in uncomplicated low back pain. Therapeutic exercise, with or without mechanical assistance or resistance, may include isoinertial, isotonic, isometric and isokinetic types of exercises. Indications include the need for cardiovascular fitness, reduced edema, improved muscle strength, improved connective tissue strength and integrity, increased bone density, promotion of circulation to enhance soft tissue healing, improvement of muscle recruitment, improved proprioception, and coordination, increased range of motion. Therapeutic exercises are used to promote normal movement patterns, and can also include complementary/alternative exercise movement therapy (with oversight of a physician or appropriate healthcare professional):

- i. time to produce effect: two to six treatments;
- ii. frequency: three to five times per week;
- iii. optimum duration: four to eight weeks;

iv. maximum duration: eight weeks.

13. - 13.a.

b. The following passive therapies are listed in alphabetical order.

i. Electrical stimulation (unattended) is an accepted treatment. Once applied, unattended electrical stimulation requires minimal on-site supervision by the physical therapist, occupational therapist, or other provider. Indications include pain, inflammation, muscle spasm, atrophy, decreased circulation, and the need for osteogenic stimulation. A home unit should be purchased if treatment is effective and frequent use is recommended:

(a). time to produce effect: two to four treatments;

(b). frequency: Varies, depending upon indication, between two to three times/day to one time/week. Home unit should be purchased if treatment is effective and frequent use is recommended;

(c). optimum duration: four treatments for clinic use;

(d). maximum duration: eight treatments for clinic use.

ii. Iontophoresis is an accepted treatment which consists of the transfer of medication, including, but not limited to, steroidal anti-inflammatories and anesthetics, through the use of electrical stimulation. Indications include pain (Lidocaine), inflammation (hydrocortisone, salicylate), edema (mecholy, hyaluronidase, salicylate), ischemia (magnesium, mecholy, iodine), muscle spasm (magnesium, calcium), calcific deposits (acetate), scars, and keloids (sodium chloride, iodine, acetate). There is no proven benefit for this therapy in the low back:

(a). time to produce effect: one to four treatments;

(b). frequency: three times per week with at least 48 hours between treatments;

(c). optimum duration: four to six weeks;

(d). maximum duration: six weeks.

iii. Manipulation is generally accepted, well-established and widely used therapeutic intervention for low back pain. Manipulative Treatment (not therapy) is defined as the therapeutic application of manually guided forces by an operator to improve physiologic function and/or support homeostasis that has been altered by the injury or occupational disease, and has associated clinical significance.

(a). High velocity, low amplitude (HVLA) technique, chiropractic manipulation, osteopathic manipulation, muscle energy techniques, counter strain, and non-force techniques are all types of manipulative treatment. This may be applied by osteopathic physicians (D.O.), chiropractors (D.C.), properly trained physical therapists (P.T.), properly trained occupational therapists (O.T.), or properly trained medical physicians. Under these different types of manipulation exist many subsets of different techniques that can be described as direct- a forceful engagement of a restrictive/pathologic barrier; indirect- a gentle/non-forceful disengagement of a restrictive/pathologic barrier; the patient actively assists in the treatment; and the patient relaxing, allowing the practitioner to move the body tissues. When the proper diagnosis is made and coupled with the appropriate

technique, manipulation has no contraindications and can be applied to all tissues of the body. Pre-treatment assessment should be performed as part of each manipulative treatment visit to ensure that the correct diagnosis and correct treatment is employed.

(b). High velocity, low amplitude (HVLA) manipulation is performed by taking a joint to its end range of motion and moving the articulation into the zone of accessory joint movement, well within the limits of anatomical integrity. There is good scientific evidence to suggest that HVLA manipulation can be helpful for patients with acute low back pain problems without radiculopathy when used within the first four to six weeks of symptoms. Although the evidence for sub-acute and chronic low back pain and low back pain with radiculopathy is less convincing, it is a generally accepted and well-established intervention for these conditions. Indications for manipulation include joint pain, decreased joint motion, and joint adhesions. Contraindications to HVLA manipulation include joint instability, fractures, severe osteoporosis, infection, metastatic cancer, active inflammatory arthritides, aortic aneurysm, and signs of progressive neurologic deficits.

(c.). Manipulation/Grade I - V:

(i). time to produce effect for all types of manipulative treatment: one to six treatments;

(ii). frequency: Up to three times per week for the first four weeks as indicated by the severity of involvement and the desired effect, then up to two treatments per week for the next four weeks. For further treatments, twice per week or less to maintain function;

(iii). optimum duration: 8 to 12 weeks;

(iv). maximum duration: three months.

Extended durations of care beyond what is considered "maximum" may be necessary in cases of re-injury, interrupted continuity of care, exacerbation of symptoms, and in those patients with comorbidities. Refer to the Chronic Pain Guidelines for care beyond three months.

(d). Manipulation under general anesthesia (MUA) refers to manual manipulation of the lumbar spine in combination with the use of a general anesthetic or conscious sedation. It is intended to improve the success of manipulation when pain, muscle spasm, guarding, and fibrosis appear to be limiting its application in patients otherwise suitable for their use. There have been no high quality studies to justify its benefits given the risks of general anesthetic and conscious sedation. It is not recommended.

(e). Manipulation under joint anesthesia (MUJA) refers to manipulation of the lumbar spine in combination with a fluoroscopically guided injection of anesthetic with or without corticosteroid agents into the facet joint at the level being manipulated. There are no controlled clinical trials to support its use. It is not recommended.

iv. Massage—Manual or Mechanical. Massage is manipulation of soft tissue with broad ranging relaxation and circulatory benefits. This may include stimulation of acupuncture points and acupuncture channels (acupressure), application of suction cups and techniques that include pressing, lifting, rubbing, pinching of soft tissues by, or with, the practitioner's hands. Indications include edema (peripheral or hard and non-pliable edema), muscle spasm,

adhesions, the need to improve peripheral circulation and range of motion, or to increase muscle relaxation and flexibility prior to exercise.

(a). In sub-acute low back pain populations there is good evidence that massage can increase function when combined with exercise and patient education. Some studies have demonstrated a decrease in provider visits and pain medication use with combined therapy. One study indicated improved results with acupressure massage. It is recommended that all massage be performed by trained, experienced therapists and be accompanied by an active exercise program and patient education. In contrast to the sub-acute population, massage is a generally accepted treatment for the acute low back pain population, although no studies have demonstrated its efficacy for this set of patients:

- (i). time to produce effect: immediate;
- (ii). frequency: one to two times per week;
- (iii). optimum duration: six weeks;
- (iv). maximum duration: two months.

v. Mobilization (joint) is a generally well-accepted treatment. Mobilization is passive movement involving oscillatory motions to the vertebral segment(s). The passive mobility is performed in a graded manner (I, II, III, IV, or V), which depicts the speed and depth of joint motion during the maneuver. For further discussion on Level V joint mobilization please see section on HVLA manipulation [Refer to Clause 12.c.ii.]. It may include skilled manual joint tissue stretching. Indications include the need to improve joint play, segmental alignment, improve intracapsular arthrokinematics, or reduce pain associated with tissue impingement. Mobilization should be accompanied by active therapy. For Level V mobilization contraindications include joint instability, fractures, severe osteoporosis, infection, metastatic cancer, active inflammatory arthritides, aortic aneurysm, and signs of progressive neurologic deficits:

- (a). time to produce effect: six to nine treatments;
- (b). frequency: up to three times per week;
- (c). optimum duration: four to six weeks;
- (d). maximum duration: six weeks.

vi. Mobilization (soft tissue): is a generally well-accepted treatment. Mobilization of soft tissue is the skilled application of muscle energy, strain/counter strain, myofascial release, manual trigger point release, and manual therapy techniques designed to improve or normalize movement patterns through the reduction of soft tissue pain and restrictions. These can be interactive with the patient participating or can be with the patient relaxing and letting the practitioner move the body tissues. Indications include muscle spasm around a joint, trigger points, adhesions, and neural compression. Mobilization should be accompanied by active therapy:

- (a). time to produce effect: four to nine treatments;
- (b). frequency: up to three times per week;
- (c). optimum duration: four to six weeks;
- (d). maximum duration: six weeks.

vii. Intramuscular Manual Therapy: Trigger Point Dry Needling. IMT involves using filament needles to treat "Trigger Points" within muscle. It may require multiple advances of a filament needle to achieve a local twitch

response to release muscle tension and pain. Dry needling is an effective treatment for acute and chronic pain of neuropathic origin with very few side effects. Dry needling is a technique to treat the neuro-musculoskeletal system based on pain patterns, muscular dysfunction and other orthopedic signs and symptoms:

- (a). time to produce effect: immediate
- (b). frequency: one to two times a week
- (c). optimum duration: six weeks
- (d). maximum duration: two months

viii. Short-wave diathermy is an accepted treatment which involves the use of equipment that exposes soft tissue to a magnetic or electrical field. Indications include enhanced collagen extensibility before stretching, reduced muscle guarding, reduced inflammatory response, and enhanced re-absorption of hemorrhage/hematoma or edema.

- (a). time to produce effect: two to four treatments;
- (b). frequency: two to three times per week up to three weeks;
- (c). optimum duration: three to five weeks;
- (d). maximum duration: five weeks.

ix. Superficial heat and cold therapy (excluding Infrared Therapy) is a generally accepted treatment. Superficial heat and cold are thermal agents applied in various manners that lower or raise the body tissue temperature for the reduction of pain, inflammation, and/or effusion resulting from injury or induced by exercise. Includes application of heat just above the surface of the skin at acupuncture points. Indications include acute pain, edema and hemorrhage, need to increase pain threshold, reduce muscle spasm, and promote stretching/flexibility. Cold and heat packs can be used at home as an extension of therapy in the clinic setting:

- (a). time to produce effect: Immediate;
- (b). frequency: two to five times per week;
- (c). optimum duration: three weeks as primary or intermittently as an adjunct to other therapeutic procedures up to two months;
- (d). maximum duration: two months.

x. Traction—manual is an accepted treatment and an integral part of manual manipulation or joint mobilization. Indications include decreased joint space, muscle spasm around joints, and the need for increased synovial nutrition and response. Manual traction is contraindicated in patients with tumor, infection, fracture, or fracture dislocation:

- (a). time to produce effect: one to three sessions;
- (b). frequency: two to three times per week;
- (c). optimum duration: 30 days;
- (d). maximum duration: one month.

xi. Traction—Mechanical. There is no evidence that mechanical traction is useful for low back pain patients without radicular symptoms. Therefore, it is not recommended in this population. It may be trialed in patients with radicular findings, and if successful, should be shifted to home traction. Traction modalities are contraindicated in patients with tumor, infections, fracture, or fracture dislocation. Non-oscillating inversion traction methods are contraindicated in patients with glaucoma or hypertension. A home lumbar traction unit can be purchased if therapy proves effective:

(a). time to produce effect: one to three sessions up to 30 minutes. If response is negative after three treatments, discontinue this modality;

(b). frequency: two to three times per week. A home lumbar traction unit can be purchased if therapy proves effective;

(c). optimum duration: four weeks;

(d). maximum duration: four weeks.

xii. Transcutaneous electrical nerve stimulation (TENS) is a generally accepted treatment. TENS should include at least one instructional session for proper application and use. Indications include muscle spasm, atrophy, and decreased circulation and pain control. Minimal TENS unit parameters should include pulse rate, pulse width and amplitude modulation. Consistent, measurable functional improvement must be documented prior to the purchase of a home unit:

(a). time to produce effect: immediate;

(b). frequency: variable;

(c). optimum duration: three sessions;

(d). maximum duration: three sessions. If beneficial, provide with home unit or purchase if effective.

xiii. Ultrasound (including phonophoresis) is an accepted treatment. Ultrasound uses sonic generators to deliver acoustic energy for therapeutic thermal and/or non-thermal soft tissue effects. Indications include scar tissue, adhesions, collagen fiber and muscle spasm, and the need to extend muscle tissue or accelerate the soft tissue healing. Ultrasound with electrical stimulation is concurrent delivery of electrical energy that involves dispersive electrode placement. Indications include muscle spasm, scar tissue, pain modulation, and muscle facilitation.

(a). Phonophoresis is the transfer of medication to the target tissue to control inflammation and pain through the use of sonic generators. These topical medications include, but are not limited to, steroidal anti-inflammatory and anesthetics:

(i). time to produce effect: 6 to 15 treatments;

(ii). frequency: three times per week;

(iii). optimum duration: four to eight weeks;

(iv). maximum duration: eight weeks.

xiv. Vertebral axial decompression (VAX-D)/DRX, 9000 Motorized traction devices which purport to produce non-surgical disc decompression by creating negative intradiscal pressure in the disc space include devices with the trade names of VAX-D and DRX 9000. There are no good studies to support their use. They are not recommended.

xv. Whirlpool/hubbard tank is a generally accepted treatment in which conductive exposure to water at varied temperatures that best elicits the desired effect. It generally includes massage by water propelled by a turbine or Jacuzzi jet system and has the same thermal effects as hot packs, if water temperature exceeds tissue temperature. It has the same thermal effects as cold application, if comparable temperature water is used. Indications include the need for analgesia, relaxing muscle spasm, reducing joint stiffness, and facilitating and preparing for exercise:

(a). time to produce effect: two to four treatments

(b). frequency: three to five times per week

(c). optimum duration: three weeks as primary, or intermittently as an adjunct to other therapeutic procedures up to two months;

(d). maximum duration: two months.

14. - 14.a.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1203.1.

HISTORICAL NOTE: Promulgated by the Louisiana Workforce Commission, Office of Workers Compensation Administration, LR 37:1664 (June 2011), amended by the Louisiana Workforce Commission, Office of Workers Compensation, LR 40:1140 (June 2014).

§2023. Therapeutic Procedures—Operative

A. - C.I.c.

2. Referral for surgical evaluation and treatment. Consultation should be made to an appropriate surgical specialist for surgical evaluation and treatment when operative treatment is considered.

a. The decision and recommendation for operative treatment, and the appropriate informed consent should be made by the operating surgeon.

b. Prior to surgical intervention, the patient and treating physician should identify functional operative goals and the likelihood of achieving improved ability to perform activities of daily living or work activities and the patient should agree to comply with the pre- and post-operative treatment plan and home exercise requirements. The patient should understand the length of partial and full disability expected post-operatively.

D. - F. ...

G. Lumbar Operative Procedures and Conditions:

1. Discectomy

a. Description: To enter into and partially remove the disc.

b. Complications. Appropriate medical disclosures should be provided to the patient as deemed necessary by the physician.

c. Surgical Indications. To include all of the following: Primary radicular symptoms, radiculopathy on exam, correlating imaging study, and failure of non-surgical care. There is good evidence that surgery provides initial improvement of radicular symptoms with respect to chronic low back pain. There is conflicting evidence that the long-term outcome differs from that of the natural history of healing.

d. Operative Treatment: Partial Discectomy and Root Decompression

e. Post-Operative Therapy. A formal physical therapy program should be implemented post-operatively. Active treatment, which patients should have had prior to surgery, will frequently require a repeat of the sessions previously ordered.

2. Percutaneous Discectomy

a. Description. Percutaneous discectomy is an invasive operative procedure to accomplish partial removal of the disc through a needle which allows aspiration of a portion of the disc trocar under imaging control.

b. Complications. Appropriate medical disclosures should be provided to the patient as deemed necessary by the treating physician.

c. Surgical Indications. Percutaneous discectomy is indicated only in cases of suspected septic discitis in order to obtain diagnostic tissue. The procedure is not recommended

for contained disc herniations or bulges with associated radiculopathy due to lack of evidence to support long-term improvement.

d. Operative Treatment: Partial Discectomy

3. Laminotomy/Laminectomy/Foramenotomy/Facetectomy

a. Description. These procedures provide access to produce neural decompression by partial or total removal of various parts of vertebral bone.

b. Complications. Appropriate medical disclosures should be provided to the patient as deemed necessary by the treating physician.

c. Surgical Indications include all of the following: Primary radicular symptoms, radiculopathy and radiculitis on exam, correlating imaging study, and failure of non-surgical care.

d. Operative Treatment. Laminotomy, and/or partial discectomy and root decompression.

e. Post-Operative Therapy. A formal physical therapy program should be implemented post-operatively. Active treatment, which patients should have had prior to surgery, will frequently require a repeat of the sessions previously ordered. The implementation of a gentle aerobic reconditioning program (e.g., walking) and back education within the first post-operative week is appropriate in uncomplicated post-surgical cases. Some patients may benefit from several occupational therapy visits to improve performance of ADLs. Participation in an active therapy program which includes restoration of ROM, core stabilization, strengthening, and endurance is recommended to be initiated 3-6 weeks post-operatively. The goals of the therapy program should include instruction in a long-term home based exercise program. (Refer to Active Therapy.)

4. Spinal Fusion

a. Description. Use of bone grafts, sometimes combined with metal devices, to produce a rigid connection between two or more adjacent vertebrae.

b. Complications. Appropriate medical disclosures should be provided to the patient as deemed necessary by the treating physician.

c. Surgical Indications. A timely decision-making process is recommended when considering patients for possible fusion. For chronic low back problems, fusion should not be considered within the first five months of symptoms, except for fracture or dislocation.

i. Although there is a statistical correlation between successful radiographic fusion and a good functional outcome, the relationship is not strong in the first two years. However, a recent observational study appears to indicate clinical deterioration in patients with unsuccessful radiographic fusion at an average of seven years post-operatively. There is good evidence that instrumented fusion, compared to non-instrumented fusion, produces a slightly better radiographically-confirmed bony union, with small to moderate functional advantages. Studies of surgical procedures report higher rates of complications with instrumented fusion.

ii. There is good evidence that intensive exercise for approximately 25 hours per week for four weeks combined with cognitive interventions emphasizing the benefits of maintaining usual activity, produces functional results similar to those of posterolateral fusion after one

year. There is some evidence that lumbar fusion produces better symptomatic and functional results in patients with chronic non-radicular pain when several months of conservative treatment have not produced a satisfactory outcome. Fusions associated with decompression are more likely to reduce leg pain.

iii. Recombinant human bone morphogenetic protein (rhBMP-2) is a member of a family of cytokines capable of inducing bone formation. It is produced from genetically modified cell lines using molecular cloning techniques. At the time of this guideline writing, rhBMP-2 is FDA approved for use in anterior lumbar interbody fusion (ALIF) and is used with a carrier such as a collagen sponge or other matrix, and a cage. There is some evidence that anterior interbody cage fusion using rhBMP-2 results in shorter operative time compared with the use of iliac crest bone autograft. Minor pain at the iliac crest donor site may persist for 24 months or longer in approximately 30 percent of patients who undergo an autograft procedure. RhBMP-2 avoids the need for harvesting iliac crest donor bone and can therefore, avoid this complication of persistent pain. There is a potential for patients to develop sensitizing or blocking antibodies to rhBMP-2 or to the absorbable collagen sponge. The long-term effects are unknown. The rhBMP-2 used with the interbody fusion device is contraindicated for patients with a known hypersensitivity to Recombinant Human Bone Morphogenetic Protein -2, bovine type 1 collagen, or to other components of the formulation. Use of rhBMP-2 outside the anterior cage may carry a risk of swelling and ectopic bone formation which can encroach on neurovascular structures. At the time of this guideline writing, it is still investigational. Information concerning safe and effective dosing and application are being submitted to the FDA. All other applications are considered off-label and not FDA approved. There is insufficient information to form a recommendation with instrumentation other than the cage specifically designed for anterior procedures. If the FDA approves its use for other operative approaches, prior authorization is required. The patient must meet all indications on the device manufacturer's list and have no contraindications. The formation of exuberant or ectopic bone growth at the upper levels (L2-L4) may have a deleterious impact on certain neurovascular structures, such as the aorta and sympathetic nerve chain. There are also reports of osteoclastic activity with the use of rhBMP-2.

d. Indications for spinal fusion may include:

i. neural arch defect—spondylolytic spondylolisthesis, congenital unilateral neural arch hypoplasia;

ii. segmental instability—excessive motion, as in degenerative spondylolisthesis, surgically induced segmental instability;

iii. primary mechanical back pain/functional spinal unit failure—multiple pain generators objectively involving two or more of the following:

(a). internal disc disruption (poor success rate if more than one disc involved);

(b). painful motion segment, as in annular tears;

(c). disc resorption;

(d). facet syndrome; and/or

(e). ligamentous tear;

iv. revision surgery for failed previous operation(s) if significant functional gains are anticipated;

v. infection, tumor, or deformity of the lumbosacral spine that cause intractable pain, neurological deficit, and/or functional disability.

e. Pre-operative Surgical Indications: Required pre-operative clinical surgical indications for spinal fusion include all of the following:

i. all pain generators are adequately defined and treated; and

ii. all physical medicine and manual therapy interventions are completed; and

iii. x-ray, MRI, or CT/Discography demonstrate disc pathology or spinal instability; and

iv. spine pathology is limited to two levels; and

v. psychosocial evaluation with confounding issues addressed;

vi. for any potential fusion surgery, it is recommended that the injured worker refrain from smoking for at least six weeks prior to surgery and during the period of fusion healing. Because smokers have a higher risk of non-union and higher post-operative costs, it is recommended that insurers cover a smoking cessation program peri-operatively.

f. Operative Therapy. Operative procedures may include:

(a). intertransverse fusion;

(b). anterior fusion (with or without rhBMP-2)—generally used for component of discogenic pain where there is no significant radicular component requiring decompression;

(c). posterior interbody fusion—generally used for component of discogenic pain where posterior decompression for radicular symptoms also performed; or

(d). anterior/posterior (360°) Fusion—most commonly seen in unstable or potentially unstable situations or non-union of a previous fusion.

g. Post-Operative Therapy. A formal physical therapy program should be implemented post-operatively. Active treatment, which patients should have had prior to surgery, will frequently require a repeat of the sessions previously ordered. The implementation of a gentle aerobic reconditioning program (e.g., walking), and back education within the first post-operative week is appropriate in uncomplicated post-surgical cases. Some patients may benefit from several occupational therapy visits to improve performance of ADLs. Participation in an active therapy program which includes core stabilization, strengthening, and endurance is recommended to be initiated once the fusion is solid and without complication. The goals of the therapy program should include instruction in a long-term home based exercise program. (Refer to Active Therapy).

h. Return-to-Work. Barring complications, patients responding favorably to spinal fusion may be able to return to sedentary-to-light work within 6 to 12 weeks post-operatively, light-to-medium work within six to nine months post-operatively and medium-to-medium/heavy work within 6 to 12 months post-operatively. Patients requiring fusion whose previous occupation involved heavy-to-very-heavy labor should be considered for vocational assessment as soon as reasonable restrictions can be predicted. The practitioner should release the patient with specific physical

restrictions and should obtain a clear job description from the employer, if necessary. Once an injured worker is off work greater than six months, the functional prognosis with or without fusion becomes guarded for that individual.

5. Sacroiliac Joint Fusion

a. Description. Use of bone grafts, sometimes combined with metal devices, to produce a rigid connection between two or more adjacent vertebrae providing symptomatic instability as a part of major pelvic ring disruption.

b. Complications. Instrumentation failure, bone graft donor site pain, in-hospital mortality, deep infection, superficial infection, and graft extrusion.

c. Surgical Indications. Sacroiliac (SI) joint fusion may be indicated for stabilization of a traumatic severe disruption of the pelvic ring. This procedure has limited use in minor trauma and would be considered only on an individual case-by-case basis. In patients with typical mechanical low back pain, this procedure is considered to be investigational. Until the efficacy of this procedure for mechanical low back pain is determined by an independent valid prospective outcome study, this procedure is not recommended for mechanical low back pain.

6. Implantable spinal cord stimulators are reserved for those low back pain patients with pain of greater than six months duration who have not responded to the standard non-operative or operative interventions previously discussed within this document. Refer to OWCA's Chronic Pain Disorder Medical Treatment Guidelines.

7. Laser discectomy involves the delivery of laser energy into the center of the nucleus pulposus using a fluoroscopically guided laser fiber under local anesthesia. The energy denatures protein in the nucleus, causing a structural change which is intended to reduce intradiscal pressure. Its effectiveness has not been shown. Laser discectomy is not recommended.

8. Artificial Lumbar Disc Replacement

a. Description. This involves the insertion of a prosthetic device into an intervertebral space from which a degenerated disc has been removed, sparing only the peripheral annulus. The endplates are positioned under intraoperative fluoroscopic guidance for optimal placement in the sagittal and frontal planes. The prosthetic device is designed to distribute the mechanical load of the vertebrae in a physiologic manner and maintain range of motion.

i. General selection criteria for lumbar disc replacement includes symptomatic one-level degenerative disc disease. The patient must also meet fusion surgery criteria, and if the patient is not a candidate for fusion, a disc replacement procedure should not be considered. Additionally, the patient should be able to comply with pre- and post-surgery protocol.

ii. The theoretical advantage of total disc arthroplasty is that it preserves range of motion and physiologic loading of the disc. This could be an advantage for adults who are physically active. Studies do not demonstrate a long-term advantage of measured function or pain over comparison groups undergoing fusion. The longevity of this prosthetic device has not yet been determined. Significant technical training and experience is required to perform this procedure successfully. Surgeons must be well-versed in anterior spinal techniques and should

have attended appropriate training courses, or have undergone training during a fellowship. Mentoring and proctoring of procedures is highly recommended. Reasonable pre-operative evaluation may include an angiogram to identify great vessel location. The angiogram may be either with contrast or with magnetic resonance imaging. An assistant surgeon with anterior access experience is required.

b. Complications:

- i. nerve and vascular injury;
- ii. dural tears;
- iii. sexual dysfunction (retrograde ejaculation);
- iv. mal-positioning of the prosthesis;
- v. suboptimal positioning of the prosthetic may compromise the long-term clinical result;
- vi. Complex Regional Pain Syndrome (CRPS);
- vii. complications from Abdominal Surgery, (e.g., hernia or adhesions);
- viii. re-operation due to complications;
- ix. appropriate medical disclosures should be provided to the patient as deemed necessary by the treating physician.

c. Surgical Indications:

- i. symptomatic one-level degenerative disc disease established by objective testing (CT or MRI scan followed by positive provocation discogram);
- ii. symptoms unrelieved after six months of active non-surgical treatment;
- iii. all pain generators are adequately defined and treated;
- iv. all physical medicine and manual therapy interventions are completed;
- v. spine pathology limited to one level;
- vi. psychosocial evaluation with confounding issues addressed.

d. Contraindications:

- i. significant spinal deformity/scoliosis;
- ii. facet joint arthrosis;
- iii. spinal instability;
- iv. deficient posterior elements;
- v. infection;
- vi. any contraindications to an anterior abdominal approach (including multiple prior abdominal procedures);
- vii. evidence of nerve root compression, depending on the device used;
- viii. previous compression or burst fracture ;
- ix. multiple-level degenerative disc disease (DDD);
- x. spondylolysis;
- xi. spondylolisthesis greater than 3 mm;
- xii. osteoporosis or any metabolic bone disease;
- xiii. chronic steroid use or use of other medication known to interfere with bone or soft tissue healing;
- xiv. autoimmune disorder;
- xv. allergy to device components/materials;
- xvi. depending on the device selected, pregnancy or desire to become pregnant;
- xvii. morbid obesity (e.g., body/mass index [BMI] of greater than 40, over 100 pounds overweight);
- xviii. active malignancy.

e. Post-Operative Therapy. Bracing may be appropriate. A formal physical therapy program should be

implemented post-operatively. Active treatment, which patients should have had prior to surgery, will frequently require a repeat of the sessions previously ordered. The implementation of a gentle aerobic reconditioning program (e.g., walking) and back education within the first post-operative week is appropriate in uncomplicated post-surgical cases. Some patients may benefit from several occupational therapy visits to improve performance of ADLs. Participation in an active therapy program which includes restoration of ROM, core stabilization, strengthening, and endurance is recommended to be initiated at the discretion of the surgeon. Lifting and bending are usually limited for several months at least. Sedentary duty may be able to begin within six weeks in uncomplicated cases. The goals of the therapy program should include instruction in a long-term home based exercise program. (Refer to Active Therapy.)

9. Kyphoplasty

a. Description. A surgical procedure for the treatment of symptomatic thoracic or lumbar vertebral compression fractures, most commonly due to osteoporosis or other metabolic bone disease, and occasionally with post-traumatic compression fractures and minor burst fractures that do not significantly compromise the posterior cortex of the vertebral body. Pain relief can be expected in approximately 90 percent of patients. Vertebral height correction is inconsistent, with approximately 35 percent to 40 percent of procedures failing to restore height or kyphotic angle.

b. Complications. Cement leakage occurs in approximately nine percent of kyphoplasties and may cause complications. New vertebral compression fracture may occur following kyphoplasty, but their occurrence does not appear to exceed that of osteoporotic patients who did not receive treatment.

c. Operative Treatment. Kyphoplasty involves the percutaneous insertion of a trocar and inflatable balloon or expanding polymer into the vertebral body, which re-expands the body, elevating the endplates and reducing the compression deformity. Polymethylmethacrylate (PMMA) bone cement is injected under low pressure into the cavity created by the balloon inflation. In contrast to vertebroplasty, which introduces PMMA cement under high pressure, the space created by balloon inflation allows a higher viscosity PMMA to be injected under lower pressure, which may reduce the risks associated with extravertebral extravasation of the material. There may be an advantage to performing the procedure within one month of the fracture, since the elevation of the endplates may be more readily achieved than when the procedure is delayed.

d. Surgical Indications. Kyphoplasty is an accepted treatment for the following indications:

- i. compression fracture;
- ii. vertebral height loss between 20 percent and 85 percent;
- iii. vertebral height restoration. Kyphoplasty is more likely to increase vertebral height if performed within 30 days of fracture occurrence.

e. Contraindications:

- i. the presence of neurologic compromise related to fracture;
- ii. high-velocity fractures with a significant burst component;

- iii. significant posterior vertebral body wall fracture;
- iv. severe vertebral collapse (vertebra plana);
- v. infection, and
- vi. coagulopathy.

10. Vertebroplasty

a. Description vertebroplasty is a procedure for the treatment of painful thoracic and lumbar vertebral compression fractures caused by osteoporosis or other metabolic bone disease. Polymethylmethacrylate (PMMA) bone cement is injected with high pressure into the vertebral body via an 11- to 13-gauge needle, with the goal of stabilizing the spine and relieving pain. The procedure does not correct spinal deformity. Pain relief can be expected in approximately 90 percent of patients. Vertebral height correction is inconsistent, with approximately 35 percent to 40 percent of procedures failing to restore height or kyphotic angle.

b. Complications

i. Because the bone cement is of low viscosity, its injection under pressure frequently results in extravertebral extravasation of the material, with rare serious complications such as pulmonary embolism. Cement leakage alone occurs in approximately 40 percent of vertebroplasties.

ii. New vertebral compression fractures may occur following vertebroplasty, but their occurrence does not appear to exceed that of osteoporotic patients who did not receive treatment.

c. Indications:

- i. compression fracture of preferably less than 30 days;
- ii. vertebral height loss between 20 percent and 85 percent;
- iii. intact posterior wall.

d. Contraindications:

- i. the presence of neurologic compromise related to the fracture;
- ii. high velocity fractures with a significant burst component;
- iii. posterior vertebral body wall fracture;
- iv. severe vertebral collapse (vertebra plana); and
- v. infection; and
- vi. coagulopathy.

11. Percutaneous radiofrequency disc decompression is an investigational procedure which introduces a 17 gauge cannula under local anesthesia and fluoroscopic guidance into the nucleus pulposus of the contained herniated disc, using radiofrequency energy to dissolve and remove disc material. Pressure inside the disc is lowered as a result. There have been no randomized clinical trials of this procedure at this time. Percutaneous radiofrequency disc decompression is not recommended.

12. Nucleus pulposus replacement involves the introduction of a prosthetic implant into the intervertebral disc, replacing the nucleus while preserving the annulus fibrosus. It is limited to investigational use in the United States at this time. It is not recommended.

13. Epiduroscopy and Epidural Lysis of Adhesions (Refer to Injections-Therapeutic).

14. Intraoperative neurophysiologic monitoring (IONM) is a battery of neurophysiologic tests used to assess the functional integrity of the spinal cord, nerve roots, and

other peripheral nervous system structures (eg, brachial plexus) during spinal surgery. The underlying principle of IONM is to identify emerging insult to nervous system structures, pathways, and/or related vascular supply and to provide feedback regarding correlative changes in neural function before development of irreversible neural injury. IONM data provide an opportunity for intervention to prevent or minimize postoperative neurologic deficit. Current multimodality monitoring techniques permit intraoperative assessment of the functional integrity of afferent dorsal sensory spinal cord tracts, efferent ventral spinal cord tracts, and nerve roots. Combined use of these techniques is useful during complex spinal surgery because these monitoring modalities provide important complementary information to the surgery team. Intraoperative neurophysiologic monitoring should be used during spinal surgery when information regarding spinal cord and nerve root function is desired. The appropriate diagnostic modality for the proposed surgical intervention should be utilized at the discretion of the surgeon.

15. Non-invasive electrical bone growth stimulators may be considered:

a. as an adjunct to spinal fusion surgery for those at high risk for pseudoarthrosis, including one or more of the following fusion failure risk factors:

- i. one or more previous failed spinal fusion(s);
- ii. grade II or worse spondylolisthesis;
- iii. fusion to be performed at more than one level;
- iv. presence of other risk factors that may contribute to non-healing:

- (a). current smoking;
- (b). diabetes;
- (c). renal disease;
- (d). other metabolic diseases where bone healing is likely to be compromised (e.g.: significant osteoporosis);
- (e). active alcoholism;
- (f). morbid obesity BMI >40;

b. as treatment for individuals with failed spinal fusion. Failed spinal fusion is defined as a spinal fusion that has not healed at a minimum of six months after the original surgery, as evidenced by serial x-rays over a course of three months during the latter portion of the six month period;

c. no strict criteria for device removal are suggested in the literature. Implanted devices are generally removed only when the patient complains of discomfort, when there is device malfunction, or to allow for future ability to use MRI. Removal of batteries is not recommended unless there is a device malfunction or other complication.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1203.1.

HISTORICAL NOTE: Promulgated by the Louisiana Workforce Commission, Office of Workers Compensation Administration, LR 37:1676 (June 2011), amended by the Louisiana Workforce Commission, Office of Workers Compensation, LR 40:1151 (June 2014).

Chapter 21. Pain Medical Treatment Guidelines

Subchapter A. Chronic Pain Disorder Medical Treatment Guidelines

§2103. General Guideline Principles

A. - A.1. ...

2. Education. Education of the patient and family, as well as the employer, insurer, policy makers and the community should be the primary emphasis in the treatment

of workers' compensation injuries. Currently, practitioners often think of education last, after medications, manual therapy, and surgery. Practitioners must develop and implement an effective strategy and skills to educate patients, employers, insurance systems, policy makers, and the community as a whole. An education-based paradigm should always start with inexpensive communication providing reassuring information to the patient. More in-depth education currently exists within a treatment regime employing functional restorative and innovative programs of prevention and rehabilitation. No treatment plan is complete without addressing issues of individual and/or group patient education as a means of facilitating self-management of symptoms and prevention.

3. - 5.

6. Positive Patient Response. Positive results are defined primarily as functional gains that can be objectively measured. Standard measurement tools, including outcome measures, should be used.

a. Objective functional gains include, but are not limited to, positional tolerances, range-of-motion (ROM), strength, and endurance, activities of daily living, cognition, psychological behavior, and efficiency/velocity measures that can be quantified. Subjective reports of pain and function should be considered and given relative weight when the pain has anatomic and physiologic correlation. Anatomic correlation must be based on objective findings.

7. Re-Evaluation of Treatment Every Three to Four Weeks. If a given treatment or modality is not producing positive results within three to four weeks, the treatment should be either modified or discontinued. Reconsideration of diagnosis should also occur in the event of poor response to a seemingly rational intervention.

8. Surgical Interventions. Surgery should be contemplated within the context of expected improvement of functional outcome and not purely for the purpose of pain relief. The concept of "cure" with respect to surgical treatment by itself is generally a misnomer. All operative interventions must be based upon positive correlation of clinical findings, clinical course, and diagnostic tests. A comprehensive assimilation of these factors must lead to a specific diagnosis with positive identification of pathologic conditions. The decision and recommendation for operative treatment, and the appropriate informed consent should be made by the operating surgeon. Prior to surgical intervention, the patient and treating physician should identify functional operative goals and the likelihood of achieving improved ability to perform activities of daily living or work activities and the patient should agree to comply with the pre- and post-operative treatment plan and home exercise requirements. The patient should understand the length of partial and full disability expected post-operatively.

9. Pharmacy-Louisiana Law and Regulation. All prescribing will be done in accordance with the laws of the state of Louisiana as they pertain respectively to each individual licensee, including, but not limited to: Louisiana State Board of Medical Examiners regulations governing medications used in the treatment of non-cancer-related chronic or intractable pain; Louisiana Board of Pharmacy Prescription Monitoring Program; Louisiana Department of Health and Hospitals licensing and certification standards for

pain management clinics; other laws and regulations affecting the prescribing and dispensing of medications in the state of Louisiana.

10. Six Month-Time Frame. The prognosis drops precipitously for returning an injured worker to work once he/she has been temporarily totally disabled for more than six months. The emphasis within these guidelines is to move patients along a continuum of care and return-to-work within a six-month time frame, whenever possible. It is important to note that time frames may not be pertinent to injuries that do not involve work-time loss or are not occupationally related.

11. Return to Work. Return to work is therapeutic, assuming the work is not likely to aggravate the basic problem or increase long-term pain. The practitioner must provide specific written physical limitations. If a practitioner releases a patient at a level of function lower than their previous job position, the practitioner must provide physical limitations and abilities and job modifications. A patient should never be released to simply "sedentary" or "light duty." The following physical limitations should be considered and modified as recommended: lifting, pushing, pulling, crouching, walking, using stairs, climbing ladders, bending at the waist, awkward and/or sustained postures, tolerance for sitting or standing, hot and cold environments, data entry and other repetitive motion tasks, sustained grip, tool usage and vibration factors. Even if there is residual chronic pain, return-to-work is not necessarily contraindicated. The practitioner should understand all of the physical demands of the patient's job position before returning the patient to full duty and should request clarification of the patient's job duties. Clarification should be obtained from the employer or, if necessary, including, but not limited to, an occupational medicine physician, occupational health nurse, physical therapist, occupational therapist, vocational rehabilitation specialist, or an industrial hygienist.

12. Delayed Recovery. Strongly consider a psychological evaluation, if not previously provided, as well as initiating interdisciplinary rehabilitation treatment and vocational goal setting, for those patients who are failing to make expected progress 6 to 12 weeks after an injury. The OWCA recognizes that 3 to 10 percent of all industrially injured patients will not recover within the timelines outlined in this document despite optimal care. Such individuals may require treatments beyond the limits discussed within this document, but such treatment will require clear documentation by the authorized treating practitioner focusing on objective functional gains afforded by further treatment and impact upon prognosis.

13. Guideline Recommendations and Inclusion of Medical Evidence. Guidelines are recommendations based on available evidence and/or consensus recommendations. When possible, guideline recommendations will note the level of evidence supporting the treatment recommendation. When interpreting medical evidence statements in the guideline, the following apply to the strength of recommendation.

Strong	Level 1 Evidence	We Recommend
Moderate	Level 2 and Level 3 Evidence	We Suggest
Weak	Level 4 Evidence	Treatment is an Option
Inconclusive	Evidence is Either Insufficient or Conflicting	

a. Consensus guidelines are generated by a professional organization that the guidelines are intended to serve. A committee of specialists and experts are selected by the organization to create an unbiased, vetted recommendation for the treatment of specific issues within the realm of their expertise. All recommendations in the guideline are considered to represent reasonable care in appropriately selected cases, regardless of the level of evidence or consensus statement attached to it. Those procedures considered inappropriate, unreasonable, or unnecessary are designated in the guideline as “not recommended.”

14. Repealed.

B. The remainder of this document should be interpreted within the parameters of these guideline principles that may lead to more optimal medical and functional outcomes for injured workers.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1203.1.

HISTORICAL NOTE: Promulgated by the Louisiana Workforce Commission, Office of Workers Compensation Administration, LR 37:1631 (June 2011), amended by the Louisiana Workforce Commission, Office of Workers Compensation, LR 40:1155 (June 2014).

Subchapter B. Complex Regional Pain Syndrome

§2119. General Guideline Principles

A. - A.1. ...

2. Education. Education of the patient and family, as well as the employer, insurer, policy makers and the community should be the primary emphasis in the treatment of workers' compensation injuries. Currently, practitioners often think of education last, after medications, manual therapy, and surgery. Practitioners must develop and implement an effective strategy and skills to educate patients, employers, insurance systems, policy makers, and the community as a whole. An education-based paradigm should always start with inexpensive communication providing reassuring information to the patient. More in-depth education currently exists within a treatment regime employing functional restorative and innovative programs of prevention and rehabilitation. No treatment plan is complete without addressing issues of individual and/or group patient education as a means of facilitating self-management of symptoms and prevention.

3. - 5.

6. Positive Patient Response. Positive results are defined primarily as functional gains that can be objectively measured. Standard measurement tools, including outcome measures, should be used.

a. Objective functional gains include, but are not limited to, positional tolerances, range-of-motion (ROM), strength, and endurance, activities of daily living, cognition, psychological behavior, and efficiency/velocity measures that can be quantified. Subjective reports of pain and function should be considered and given relative weight when the pain has anatomic and physiologic correlation. Anatomic correlation must be based on objective findings.

7. Re-Evaluation of Treatment Every Three to Four Weeks. If a given treatment or modality is not producing positive results within three to four weeks, the treatment should be either modified or discontinued. Reconsideration of diagnosis should also occur in the event of poor response to a seemingly rational intervention.

8. Surgical Interventions. Surgery should be contemplated within the context of expected improvement of functional outcome and not purely for the purpose of pain relief. The concept of “cure” with respect to surgical treatment by itself is generally a misnomer. All operative interventions must be based upon positive correlation of clinical findings, clinical course, and diagnostic tests. A comprehensive assimilation of these factors must lead to a specific diagnosis with positive identification of pathologic conditions. The decision and recommendation for operative treatment, and the appropriate informed consent should be made by the operating surgeon. Prior to surgical intervention, the patient and treating physician should identify functional operative goals and the likelihood of achieving improved ability to perform activities of daily living or work activities and the patient should agree to comply with the pre- and post-operative treatment plan and home exercise requirements. The patient should understand the length of partial and full disability expected post-operatively.

9. Pharmacy-Louisiana Law and Regulation. All prescribing will be done in accordance with the laws of the state of Louisiana as they pertain respectively to each individual licensee, including, but not limited to: Louisiana State Board of Medical Examiners regulations governing medications used in the treatment of non-cancer-related chronic or intractable pain; Louisiana Board of Pharmacy Prescription Monitoring Program; Louisiana Department of Health and Hospitals licensing and certification standards for pain management clinics; other laws and regulations affecting the prescribing and dispensing of medications in the state of Louisiana.

10. Six Month-Time Frame. The prognosis drops precipitously for returning an injured worker to work once he/she has been temporarily totally disabled for more than six months. The emphasis within these guidelines is to move patients along a continuum of care and return-to-work within a six-month time frame, whenever possible. It is important to note that time frames may not be pertinent to injuries that do not involve work-time loss or are not occupationally related.

11. Return To Work. Return to work is therapeutic, assuming the work is not likely to aggravate the basic problem or increase long-term pain. The practitioner must provide specific written physical limitations. If a practitioner releases a patient at a level of function lower than their previous job position, the practitioner must provide physical limitations and abilities and job modifications. A patient should never be released to simply “sedentary” or “light duty.” The following physical limitations should be considered and modified as recommended: lifting, pushing, pulling, crouching, walking, using stairs, climbing ladders, bending at the waist, awkward and/or sustained postures, tolerance for sitting or standing, hot and cold environments, data entry and other repetitive motion tasks, sustained grip, tool usage and vibration factors. Even if there is residual chronic pain, return-to-work is not necessarily contraindicated. The practitioner should understand all of the physical demands of the patient's job position before returning the patient to full duty and should request clarification of the patient's job duties. Clarification should be obtained from the employer or, if necessary, including, but not limited to, an occupational medicine physician,

occupational health nurse, physical therapist, occupational therapist, vocational rehabilitation specialist, or an industrial hygienist.

12. Delayed Recovery. Strongly consider a psychological evaluation, if not previously provided, as well as initiating interdisciplinary rehabilitation treatment and vocational goal setting, for those patients who are failing to make expected progress 6 to 12 weeks after an injury. The OWCA recognizes that 3 to 10 percent of all industrially injured patients will not recover within the timelines outlined in this document despite optimal care. Such individuals may require treatments beyond the limits discussed within this document, but such treatment will require clear documentation by the authorized treating practitioner focusing on objective functional gains afforded by further treatment and impact upon prognosis.

13. Guideline Recommendations and Inclusion of Medical Evidence. Guidelines are recommendations based on available evidence and/or consensus recommendations. When possible, guideline recommendations will note the level of evidence supporting the treatment recommendation. When interpreting medical evidence statements in the guideline, the following apply to the strength of recommendation.

Strong	Level 1 Evidence	We Recommend
Moderate	Level 2 and Level 3 Evidence	We Suggest
Weak	Level 4 Evidence	Treatment is an Option
Inconclusive	Evidence is Either Insufficient or Conflicting	

a. Consensus guidelines are generated by a professional organization that the guidelines are intended to serve. A committee of specialists and experts are selected by the organization to create an unbiased, vetted recommendation for the treatment of specific issues within the realm of their expertise. All recommendations in the guideline are considered to represent reasonable care in appropriately selected cases, regardless of the level of evidence or consensus statement attached to it. Those procedures considered inappropriate, unreasonable, or unnecessary are designated in the guideline as “not recommended.”

14. Repealed.

B. The remainder of this document should be interpreted within the parameters of these guideline principles that may lead to more optimal medical and functional outcomes for injured workers.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1203.1.

HISTORICAL NOTE: Promulgated by the Louisiana Workforce Commission, Office of Workers Compensation Administration, LR 37:1631 (June 2011), amended by the Louisiana Workforce Commission, Office of Workers Compensation, LR 40:1157 (June 2014).

Chapter 22. Neurological and Neuromuscular Disorder Medical Treatment Guidelines
Subchapter A. Carpal Tunnel Syndrome (CTS) Medical Treatment Guidelines

§2203. General Guideline Principles

A. - A.1. ...

2. Education. Education of the patient and family, as well as the employer, insurer, policy makers and the community should be the primary emphasis in the treatment

of workers' compensation injuries. Currently, practitioners often think of education last, after medications, manual therapy, and surgery. Practitioners must develop and implement an effective strategy and skills to educate patients, employers, insurance systems, policy makers, and the community as a whole. An education-based paradigm should always start with inexpensive communication providing reassuring information to the patient. More in-depth education currently exists within a treatment regime employing functional restorative and innovative programs of prevention and rehabilitation. No treatment plan is complete without addressing issues of individual and/or group patient education as a means of facilitating self-management of symptoms and prevention.

3. - 5.

6. Positive Patient Response. Positive results are defined primarily as functional gains that can be objectively measured. Standard measurement tools, including outcome measures, should be used.

a. Objective functional gains include, but are not limited to, positional tolerances, range-of-motion (ROM), strength, and endurance, activities of daily living, cognition, psychological behavior, and efficiency/velocity measures that can be quantified. Subjective reports of pain and function should be considered and given relative weight when the pain has anatomic and physiologic correlation. Anatomic correlation must be based on objective findings.

7. Re-Evaluation of Treatment Every Three to Four Weeks. If a given treatment or modality is not producing positive results within three to four weeks, the treatment should be either modified or discontinued. Reconsideration of diagnosis should also occur in the event of poor response to a seemingly rational intervention.

8. Surgical Interventions. Surgery should be contemplated within the context of expected improvement of functional outcome and not purely for the purpose of pain relief. The concept of "cure" with respect to surgical treatment by itself is generally a misnomer. All operative interventions must be based upon positive correlation of clinical findings, clinical course, and diagnostic tests. A comprehensive assimilation of these factors must lead to a specific diagnosis with positive identification of pathologic conditions. The decision and recommendation for operative treatment, and the appropriate informed consent should be made by the operating surgeon. Prior to surgical intervention, the patient and treating physician should identify functional operative goals and the likelihood of achieving improved ability to perform activities of daily living or work activities and the patient should agree to comply with the pre- and post-operative treatment plan and home exercise requirements. The patient should understand the length of partial and full disability expected post-operatively.

9. Pharmacy-Louisiana Law and Regulation. All prescribing will be done in accordance with the laws of the state of Louisiana as they pertain respectively to each individual licensee, including, but not limited to: Louisiana State Board of Medical Examiners regulations governing medications used in the treatment of non-cancer-related chronic or intractable pain; Louisiana Board of Pharmacy Prescription Monitoring Program; Louisiana Department of Health and Hospitals licensing and certification standards for

pain management clinics; other laws and regulations affecting the prescribing and dispensing of medications in the state of Louisiana.

10. Six Month-Time Frame. The prognosis drops precipitously for returning an injured worker to work once he/she has been temporarily totally disabled for more than six months. The emphasis within these guidelines is to move patients along a continuum of care and return-to-work within a six-month time frame, whenever possible. It is important to note that time frames may not be pertinent to injuries that do not involve work-time loss or are not occupationally related.

11. Return To Work. Return to work is therapeutic, assuming the work is not likely to aggravate the basic problem or increase long-term pain. The practitioner must provide specific written physical limitations. If a practitioner releases a patient at a level of function lower than their previous job position, the practitioner must provide physical limitations and abilities and job modifications. A patient should never be released to simply “sedentary” or “light duty.” The following physical limitations should be considered and modified as recommended: lifting, pushing, pulling, crouching, walking, using stairs, climbing ladders, bending at the waist, awkward and/or sustained postures, tolerance for sitting or standing, hot and cold environments, data entry and other repetitive motion tasks, sustained grip, tool usage and vibration factors. Even if there is residual chronic pain, return-to-work is not necessarily contraindicated. The practitioner should understand all of the physical demands of the patient’s job position before returning the patient to full duty and should request clarification of the patient’s job duties. Clarification should be obtained from the employer or, if necessary, including, but not limited to, an occupational medicine physician, occupational health nurse, physical therapist, occupational therapist, vocational rehabilitation specialist, or an industrial hygienist.

12. Delayed Recovery. Strongly consider a psychological evaluation, if not previously provided, as well as initiating interdisciplinary rehabilitation treatment and vocational goal setting, for those patients who are failing to make expected progress 6 to 12 weeks after an injury. The OWCA recognizes that 3 to 10 percent of all industrially injured patients will not recover within the timelines outlined in this document despite optimal care. Such individuals may require treatments beyond the limits discussed within this document, but such treatment will require clear documentation by the authorized treating practitioner focusing on objective functional gains afforded by further treatment and impact upon prognosis.

13. Guideline Recommendations and Inclusion of Medical Evidence. Guidelines are recommendations based on available evidence and/or consensus recommendations. When possible, guideline recommendations will note the level of evidence supporting the treatment recommendation. When interpreting medical evidence statements in the guideline, the following apply to the strength of recommendation.

Strong	Level 1 Evidence	We Recommend
Moderate	Level 2 and Level 3 Evidence	We Suggest
Weak	Level 4 Evidence	Treatment is an Option
Inconclusive	Evidence is Either Insufficient or Conflicting	

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14. Repealed.

B. The remainder of this document should be interpreted within the parameters of these guideline principles that may lead to more optimal medical and functional outcomes for injured workers.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1203.1.

HISTORICAL NOTE: Promulgated by the Louisiana Workforce Commission, Office of Workers Compensation Administration, LR 37:1631 (June 2011), amended by the Louisiana Workforce Commission, Office of Workers Compensation, LR 40:1158 (June 2014).

Subchapter B. Thoracic Outlet Syndrome §2217. General Guidelines Principles

A. - A.1. ...

2. Education. Education of the patient and family, as well as the employer, insurer, policy makers and the community should be the primary emphasis in the treatment of workers’ compensation injuries. Currently, practitioners often think of education last, after medications, manual therapy, and surgery. Practitioners must develop and implement an effective strategy and skills to educate patients, employers, insurance systems, policy makers, and the community as a whole. An education-based paradigm should always start with inexpensive communication providing reassuring information to the patient. More in-depth education currently exists within a treatment regime employing functional restorative and innovative programs of prevention and rehabilitation. No treatment plan is complete without addressing issues of individual and/or group patient education as a means of facilitating self-management of symptoms and prevention.

3. - 5.

6. Positive Patient Response. Positive results are defined primarily as functional gains that can be objectively measured. Standard measurement tools, including outcome measures, should be used.

a. Objective functional gains include, but are not limited to, positional tolerances, range-of-motion (ROM), strength, and endurance, activities of daily living, cognition, psychological behavior, and efficiency/velocity measures that can be quantified. Subjective reports of pain and function should be considered and given relative weight when the pain has anatomic and physiologic correlation. Anatomic correlation must be based on objective findings.

7. Re-Evaluation of Treatment Every Three to Four Weeks. If a given treatment or modality is not producing positive results within three to four weeks, the treatment should be either modified or discontinued. Reconsideration of diagnosis should also occur in the event of poor response to a seemingly rational intervention.

8. Surgical Interventions. Surgery should be contemplated within the context of expected improvement of functional outcome and not purely for the purpose of pain relief. The concept of "cure" with respect to surgical treatment by itself is generally a misnomer. All operative interventions must be based upon positive correlation of clinical findings, clinical course, and diagnostic tests. A comprehensive assimilation of these factors must lead to a specific diagnosis with positive identification of pathologic conditions. The decision and recommendation for operative treatment, and the appropriate informed consent should be made by the operating surgeon. Prior to surgical intervention, the patient and treating physician should identify functional operative goals and the likelihood of achieving improved ability to perform activities of daily living or work activities and the patient should agree to comply with the pre- and post-operative treatment plan and home exercise requirements. The patient should understand the length of partial and full disability expected post-operatively.

9. Pharmacy-Louisiana Law and Regulation. All prescribing will be done in accordance with the laws of the state of Louisiana as they pertain respectively to each individual licensee, including, but not limited to: Louisiana State Board of Medical Examiners regulations governing medications used in the treatment of non-cancer-related chronic or intractable pain; Louisiana Board of Pharmacy Prescription Monitoring Program; Louisiana Department of Health and Hospitals licensing and certification standards for pain management clinics; other laws and regulations affecting the prescribing and dispensing of medications in the state of Louisiana.

10. Six Month-Time Frame. The prognosis drops precipitously for returning an injured worker to work once he/she has been temporarily totally disabled for more than six months. The emphasis within these guidelines is to move patients along a continuum of care and return-to-work within a six-month time frame, whenever possible. It is important to note that time frames may not be pertinent to injuries that do not involve work-time loss or are not occupationally related.

11. Return To Work. Return to work is therapeutic, assuming the work is not likely to aggravate the basic problem or increase long-term pain. The practitioner must provide specific written physical limitations. If a practitioner releases a patient at a level of function lower than their previous job position, the practitioner must provide physical limitations and abilities and job modifications. A patient should never be released to simply "sedentary" or "light duty." The following physical limitations should be considered and modified as recommended: lifting, pushing, pulling, crouching, walking, using stairs, climbing ladders, bending at the waist, awkward and/or sustained postures, tolerance for sitting or standing, hot and cold environments, data entry and other repetitive motion tasks, sustained grip, tool usage and vibration factors. Even if there is residual chronic pain, return-to-work is not necessarily contraindicated. The practitioner should understand all of the physical demands of the patient's job position before returning the patient to full duty and should request clarification of the patient's job duties. Clarification should be obtained from the employer or, if necessary, including, but not limited to, an occupational medicine physician,

occupational health nurse, physical therapist, occupational therapist, vocational rehabilitation specialist, or an industrial hygienist.

12. Delayed Recovery. Strongly consider a psychological evaluation, if not previously provided, as well as initiating interdisciplinary rehabilitation treatment and vocational goal setting, for those patients who are failing to make expected progress 6 to 12 weeks after an injury. The OWCA recognizes that 3 to 10 percent of all industrially injured patients will not recover within the timelines outlined in this document despite optimal care. Such individuals may require treatments beyond the limits discussed within this document, but such treatment will require clear documentation by the authorized treating practitioner focusing on objective functional gains afforded by further treatment and impact upon prognosis.

13. Guideline Recommendations and Inclusion of Medical Evidence. Guidelines are recommendations based on available evidence and/or consensus recommendations. When possible, guideline recommendations will note the level of evidence supporting the treatment recommendation. When interpreting medical evidence statements in the guideline, the following apply to the strength of recommendation.

Strong	Level 1 Evidence	We Recommend
Moderate	Level 2 and Level 3 Evidence	We Suggest
Weak	Level 4 Evidence	Treatment is an Option
Inconclusive	Evidence is Either Insufficient or Conflicting	

a. Consensus guidelines are generated by a professional organization that the guidelines are intended to serve. A committee of specialists and experts are selected by the organization to create an unbiased, vetted recommendation for the treatment of specific issues within the realm of their expertise. All recommendations in the guideline are considered to represent reasonable care in appropriately selected cases, regardless of the level of evidence or consensus statement attached to it. Those procedures considered inappropriate, unreasonable, or unnecessary are designated in the guideline as "not recommended."

14. Repealed.

B. The remainder of this document should be interpreted within the parameters of these guideline principles that may lead to more optimal medical and functional outcomes for injured workers.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1203.1.

HISTORICAL NOTE: Promulgated by the Louisiana Workforce Commission, Office of Workers Compensation Administration, LR 37:1631 (June 2011), amended by the Louisiana Workforce Commission, Office of Workers Compensation, LR 40:1159 (June 2014).

Chapter 23. Upper and Lower Extremities Medical Treatment Guidelines

Subchapter A. Lower Extremities

§2303. General Guidelines Principles

A. - A.1. ...

2. Education. Education of the patient and family, as well as the employer, insurer, policy makers and the community should be the primary emphasis in the treatment of workers' compensation injuries. Currently, practitioners

often think of education last, after medications, manual therapy, and surgery. Practitioners must develop and implement an effective strategy and skills to educate patients, employers, insurance systems, policy makers, and the community as a whole. An education-based paradigm should always start with inexpensive communication providing reassuring information to the patient. More in-depth education currently exists within a treatment regime employing functional restorative and innovative programs of prevention and rehabilitation. No treatment plan is complete without addressing issues of individual and/or group patient education as a means of facilitating self-management of symptoms and prevention.

3. - 5.

6. Positive Patient Response. Positive results are defined primarily as functional gains that can be objectively measured. Standard measurement tools, including outcome measures, should be used.

a. Objective functional gains include, but are not limited to, positional tolerances, range-of-motion (ROM), strength, and endurance, activities of daily living, cognition, psychological behavior, and efficiency/velocity measures that can be quantified. Subjective reports of pain and function should be considered and given relative weight when the pain has anatomic and physiologic correlation. Anatomic correlation must be based on objective findings.

7. Re-Evaluation of Treatment Every Three to Four Weeks. If a given treatment or modality is not producing positive results within three to four weeks, the treatment should be either modified or discontinued. Reconsideration of diagnosis should also occur in the event of poor response to a seemingly rational intervention.

8. Surgical Interventions. Surgery should be contemplated within the context of expected improvement of functional outcome and not purely for the purpose of pain relief. The concept of "cure" with respect to surgical treatment by itself is generally a misnomer. All operative interventions must be based upon positive correlation of clinical findings, clinical course, and diagnostic tests. A comprehensive assimilation of these factors must lead to a specific diagnosis with positive identification of pathologic conditions. The decision and recommendation for operative treatment, and the appropriate informed consent should be made by the operating surgeon. Prior to surgical intervention, the patient and treating physician should identify functional operative goals and the likelihood of achieving improved ability to perform activities of daily living or work activities and the patient should agree to comply with the pre- and post-operative treatment plan and home exercise requirements. The patient should understand the length of partial and full disability expected post-operatively.

9. Pharmacy-Louisiana Law and Regulation. All prescribing will be done in accordance with the laws of the state of Louisiana as they pertain respectively to each individual licensee, including, but not limited to: Louisiana State Board of Medical Examiners regulations governing medications used in the treatment of non-cancer-related chronic or intractable pain; Louisiana Board of Pharmacy Prescription Monitoring Program; Louisiana Department of Health and Hospitals licensing and certification standards for pain management clinics; other laws and regulations

affecting the prescribing and dispensing of medications in the state of Louisiana.

10. Six Month-Time Frame. The prognosis drops precipitously for returning an injured worker to work once he/she has been temporarily totally disabled for more than six months. The emphasis within these guidelines is to move patients along a continuum of care and return-to-work within a six-month time frame, whenever possible. It is important to note that time frames may not be pertinent to injuries that do not involve work-time loss or are not occupationally related.

11. Return To Work. Return to work is therapeutic, assuming the work is not likely to aggravate the basic problem or increase long-term pain. The practitioner must provide specific written physical limitations. If a practitioner releases a patient at a level of function lower than their previous job position, the practitioner must provide physical limitations and abilities and job modifications. A patient should never be released to simply "sedentary" or "light duty." The following physical limitations should be considered and modified as recommended: lifting, pushing, pulling, crouching, walking, using stairs, climbing ladders, bending at the waist, awkward and/or sustained postures, tolerance for sitting or standing, hot and cold environments, data entry and other repetitive motion tasks, sustained grip, tool usage and vibration factors. Even if there is residual chronic pain, return-to-work is not necessarily contraindicated. The practitioner should understand all of the physical demands of the patient's job position before returning the patient to full duty and should request clarification of the patient's job duties. Clarification should be obtained from the employer or, if necessary, including, but not limited to, an occupational medicine physician, occupational health nurse, physical therapist, occupational therapist, vocational rehabilitation specialist, or an industrial hygienist.

12. Delayed Recovery. Strongly consider a psychological evaluation, if not previously provided, as well as initiating interdisciplinary rehabilitation treatment and vocational goal setting, for those patients who are failing to make expected progress 6 to 12 weeks after an injury. The OWCA recognizes that 3 to 10 percent of all industrially injured patients will not recover within the timelines outlined in this document despite optimal care. Such individuals may require treatments beyond the limits discussed within this document, but such treatment will require clear documentation by the authorized treating practitioner focusing on objective functional gains afforded by further treatment and impact upon prognosis.

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Strong	Level 1 Evidence	We Recommend
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Weak	Level 4 Evidence	Treatment is an Option
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14. Repealed.

B. The remainder of this document should be interpreted within the parameters of these guideline principles that may lead to more optimal medical and functional outcomes for injured workers.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1203.1.

HISTORICAL NOTE: Promulgated by the Louisiana Workforce Commission, Office of Workers Compensation Administration, LR 37:1631 (June 2011), amended by the Louisiana Workforce Commission, Office of Workers Compensation, LR 40:1160 (June 2014).

Subchapter B. Shoulder Injury Medical Treatment Guidelines

§2317. General Guideline Principles

A. - A.1. ...

2. Education. Education of the patient and family, as well as the employer, insurer, policy makers and the community should be the primary emphasis in the treatment of workers' compensation injuries. Currently, practitioners often think of education last, after medications, manual therapy, and surgery. Practitioners must develop and implement an effective strategy and skills to educate patients, employers, insurance systems, policy makers, and the community as a whole. An education-based paradigm should always start with inexpensive communication providing reassuring information to the patient. More in-depth education currently exists within a treatment regime employing functional restorative and innovative programs of prevention and rehabilitation. No treatment plan is complete without addressing issues of individual and/or group patient education as a means of facilitating self-management of symptoms and prevention.

3. - 5.

6. Positive Patient Response. Positive results are defined primarily as functional gains that can be objectively measured. Standard measurement tools, including outcome measures, should be used.

a. Objective functional gains include, but are not limited to, positional tolerances, range-of-motion (ROM), strength, and endurance, activities of daily living, cognition, psychological behavior, and efficiency/velocity measures that can be quantified. Subjective reports of pain and function should be considered and given relative weight when the pain has anatomic and physiologic correlation. Anatomic correlation must be based on objective findings.

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of diagnosis should also occur in the event of poor response to a seemingly rational intervention.

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12. Delayed Recovery. Strongly consider a psychological evaluation, if not previously provided, as well as initiating interdisciplinary rehabilitation treatment and vocational goal setting, for those patients who are failing to make expected progress 6 to 12 weeks after an injury. The OWCA recognizes that 3 to 10 percent of all industrially injured patients will not recover within the timelines outlined in this document despite optimal care. Such individuals may require treatments beyond the limits discussed within this document, but such treatment will require clear documentation by the authorized treating practitioner focusing on objective functional gains afforded by further treatment and impact upon prognosis.

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14. Repealed.

B. The remainder of this document should be interpreted within the parameters of these guideline principles that may lead to more optimal medical and functional outcomes for injured workers.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1203.1.

HISTORICAL NOTE: Promulgated by the Louisiana Workforce Commission, Office of Workers Compensation Administration, LR 37:1631 (June 2011), amended by the Louisiana Workforce Commission, Office of Workers Compensation, LR 40:1162 (June 2014).

Curt Eysink
Executive Director

1406#028

RULE

Workforce Commission Office of Workers' Compensation

Utilization Review Procedures (LAC 40:I.2715)

In accordance with R.S. 49:950 et seq., the Louisiana Workforce Commission, Office of Workers' Compensation, pursuant to the authority vested in the director of the Office of Workers' Compensation by R.S. 23:1310.1 and in accordance with applicable provisions of the Administrative Provisions Act, has amended LAC 40:I.2715.

The amendments alter the existing medical treatment schedule authorization and dispute resolution rules (“UR rules”). The amendments add specific provisions regarding approval of a defined number of evaluation and management office visits in an otherwise compensable claim. The amendments also add a provision where the carrier/self-insured employer may only approval with modification active therapeutic exercise for no less than the “time to produce and effect” found in the applicable section of the medical treatment guidelines in an otherwise compensable claim, provided the request does not result in care beyond the “frequency” and “maximum duration” listed in the applicable section. These current updates to the already improved process, will further improve medical outcomes resulting in injured workers returning to gainful employment more quickly.

Title 40

LABOR AND EMPLOYMENT

Part I. Workers' Compensation Administration

Subpart 2. Medical Guidelines

Chapter 27. Utilization Review Procedures

§2715. Medical Treatment Schedule Authorization and Dispute Resolution

A. - B.3.c.

d. Except as provided pursuant to D.2, all requests for authorization of care beyond the statutory non-emergency monetary limit of \$750 are to be presented to the carrier/self-insured employer. In accordance with these Utilization Review Rules, the carrier/self-insured employer or a utilization review company acting on its behalf shall determine if such request is in accordance with the medical treatment schedule. If the request is denied or approved with modification and the health care provider determines to request a variance from the medical director, then a LWC-WC-1009 shall be filed as provided in Subsection G of this Section.

B.3.e. - C.3.b. ...

D. Submission and Process for Request for Authorization

1. Except as provided pursuant to D.2., to initiate the request for authorization of care beyond the statutory non-emergency medical care monetary limit of \$750 per health care provider, the health care provider shall submit LWC-WC-1010 along with the required information of this Section by fax or email to the carrier/self insured employer.

2. Evaluation and Management Visits

a. The medical treatment schedule provides that a timely routine evaluation and management office visit with

the treating physician is required for documentation of functional improvement resulting from previously authorized medical care, service and treatment. A LWC-WC-1010 shall be required to initiate the request for authorization of the first routine evaluation and management office visit that occurs beyond the statutory non-emergency medical care monetary limit of \$750 per health care provider. If such routine evaluation and management office visit is approved as medically necessary, a LWC-WC-1010 shall not be required for any subsequent routine evaluation and management office visits with the employee's treating physician within the first year of the accident date not to exceed 12 visits. Any routine evaluation and management office visit that occurred prior to the first submission of a LWC-WC-1010 shall count towards the 12 visits to occur within one year of the accident date. A LWC-WC-1010 shall be required for a routine evaluation and management office visit after the twelfth visit or after one year from date of accident. If approved, an LWC-WC-1010 shall only be required on every fourth routine evaluation and management office visit thereafter. The carrier/self-insured employer may authorize more office visits over a defined period of time.

b. A routine evaluation and management office visit is limited to new and established patient evaluation and management office/outpatient visits, which includes the following Current Procedural Terminology Codes: 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, and 99215.

c. Any medical care, services, or treatment performed at such routine evaluation and management office visit that will be billed as anything other than a routine evaluation and management office visit code shall require pre approval with a request for authorization on a form LWC-WC-1010. Nothing contained in Subparagraph D.2.a of this Section shall prevent the carrier/self insured employer from denying one of the 12 routine evaluation and management office visits to occur within the first year of the accident date for reasons other than medical necessity to include but not be limited to causation, compensability, and medical relatedness. After the first 12 routine evaluation and management office visits or after one year from the date of accident, the carrier/self insured employer may deny as not medically necessary any request for a routine evaluation and management office visit.

3. Authorization for Active Therapeutic Exercise

a. If the carrier/self insured employer determines on an otherwise compensable claim that modifications to a request for authorization on LWC-WC-1010 for active therapeutic exercise is necessary in order for the request for authorization to be in accordance with the medical treatment

schedule, said request shall not be approved with modification for a number of treatments less than the minimum "time to produce effect" found in the applicable portion of the medical treatment schedule.

b. Notwithstanding the provisions of Subparagraph 3.a., the carrier/self-insured employer may approve with modification a request for active therapeutic exercise below the minimum "time to produce effect" found in the applicable portion of the medical treatment schedule if the carrier/self-insured employer has already approved active therapeutic exercise beyond the "frequency" and "maximum duration" found in the applicable portion of the medical treatment schedule.

4. The carrier/self-insured employer shall provide to the OWC a fax number and/or email address to be used for purposes of these rules and particularly for LWC-WC-1010 and 1010A. If the fax number and/or email address provided is for a utilization review company contracted with the carrier/self-insured employer, then the carrier/self-insured employer shall provide the name of the utilization review company to the OWC. All carrier/self-insured employer fax numbers and/or email addresses provided to the OWC will be posted on the office's website at www.laworks.net. If the fax number or e-mail address is for a contracted utilization review company, then the OWC will also post on the web the name of the utilization review company. When requesting authorization and sending the LWC-WC-1010 and 1010A, the health care provider shall use the fax number and/or email address found on the OWC website.

5. Pursuant to R.S. 23:1203.1, the five business days to act on the request for authorization does not begin for the carrier/self-insured employer until the information of Subsection C and LWC-WC-1010 is received. In the absence of the submission of such information, any denial of further non-emergency care by the carrier/self-insured employer is prima facie, not arbitrary and capricious.

E. - O.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1203.1.

HISTORICAL NOTE: Promulgated by the Department of Employment and Training, Office of Workers' Compensation, LR 17:263 (March 1991), repromulgated LR 17:653 (July 1991), repromulgated LR 18:257 (March 1992), amended by the Louisiana Workforce Commission, Office of Workers' Compensation, LR 38:1030 (April 2012), repromulgated LR 38:1287 (May 2012), amended LR 38:3255 (December 2012), LR 40:1163 (June 2014).

Curt Eysink
Executive Director

1406#029

Notices of Intent

NOTICE OF INTENT

Department of Agriculture and Forestry Office of Agricultural and Environmental Sciences Structural Pest Control Commission

Hydraulic Injection (LAC 7:XXV.141)

Under the enabling authority of R.S. 3:3366, and in accordance with the Administrative Procedure Act, R.S. 49:950 et seq., the Department of Agriculture and Forestry, Office of Agricultural and Environmental Sciences, and the Structural Pest Control Commission intend to adopt these rules and regulations for the implementation of hydraulic injection as an approved method of trench and treat for minimum specifications for termite control work.

This proposed action will amend the current minimum specifications for termite control work for requirements for trench and treat to include hydraulic injection, an alternative method of termite control adopted by the Structural Pest Control Commission. Hydraulic injection is a high pressure unit that may be used in conjunction with an approved termiticide while performing a perimeter treatment.

Requirements for trench and treat are currently in place for termite control work. This proposed action permits hydraulic injection to be used in lieu of trench and treat. The unit will be made available by the manufacturer for an annual rental rate. Hydraulic injection of termiticide treatment will be an alternative method for perimeter treatments for termite control in Louisiana and will be a strictly voluntary method.

Title 7

AGRICULTURE AND ANIMALS

Part XXV. Structural Pest Control

Chapter 1. Structural Pest Control Commission

§141. Minimum Specifications for Termite Control Work

A. - B.4. ...

5. In lieu of trench and treat, a high precision hydraulic injection unit may be used in conjunction with an approved termiticide that requires the hydraulic injection unit's use.

C. - C.8.b. ...

c. In lieu of trench and treat, a high precision hydraulic injection unit may be used in conjunction with an approved termiticide that requires the hydraulic injection unit's use. Hydraulic injection shall be injected every 6 inches around the pier to form a continuous treatment zone.

C.9. - D.1.b. ...

c. In lieu of trench and treat, a high precision hydraulic injection unit may be used in conjunction with an approved termiticide that requires the hydraulic injection unit's use. Hydraulic injection shall be injected every 6 inches around the pier to form a continuous treatment zone.

D.2. - E.1.b. ...

c. In lieu of trench and treat, a high precision hydraulic injection unit may be used in conjunction with an

approved termiticide that requires the hydraulic injection unit's use. Hydraulic injection shall be injected every 6 inches around the pier to form a continuous treatment zone.

E.2. - K.7.e. ...

f. In lieu of trench and treat, a high precision hydraulic injection unit may be used in conjunction with an approved termiticide that requires the hydraulic injection unit's use. Hydraulic injection shall be injected every 6 inches around the pier to form a continuous treatment zone.

8. - 8.b. ...

c. In lieu of trench and treat, a high precision hydraulic injection unit may be used in conjunction with an approved termiticide that requires the hydraulic injection unit's use. Hydraulic injection shall be injected every 6 inches around the pier to form a continuous treatment zone.

K.9. - L.1.c.iii. ...

d. In lieu of trench and treat, a high precision hydraulic injection unit may be used in conjunction with an approved termiticide that requires the hydraulic injection unit's use. Hydraulic injection shall be injected every 6 inches around the pier to form a continuous treatment zone.

2. - 2.a. ...

b. In lieu of trench and treat, a high precision hydraulic injection unit may be used in conjunction with an approved termiticide that requires the hydraulic injection unit's use. Hydraulic injection shall be injected every 6 inches around the pier to form a continuous treatment zone.

L.3. - M.2.a. ...

b. Rod under or drill through any slab(s) adjoining or abutting the slab and treat all areas beneath adjoining or abutting slab(s) as per label and labeling instructions. When any slab(s) is drilled, the holes shall be no more than 18 inches (unless label requires closer distance) apart along the above stated areas.

c. In lieu of trench and treat, a high precision hydraulic injection unit may be used in conjunction with an approved termiticide that requires the hydraulic injection unit's use. Hydraulic injection shall be injected every 6 inches around the pier to form a continuous treatment zone.

3. - 9. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:3366.

HISTORICAL NOTE: Promulgated by the Department of Agriculture, Structural Pest Control Commission, LR 11:330 (April 1985), amended by the Department of Agriculture and Forestry, Structural Pest Control Commission, LR 15:958 (November 1989), LR 20:644 (June 1994), LR 21:931 (September 1995), LR 23:1285 (October 1997), LR 25:235 (February 1999), LR 25:1620 (September 1999), LR 26:2437 (November 2000), LR 27:1180 (August 2001), LR 29:1063 (July 2003), LR 30:1145 (June 2004), repromulgated LR 30:1614 (August 2004), amended LR 35:207 (February 2009), LR 35:1469 (August 2009), repromulgated LR 35:1872 (September 2009), amended, LR 37:286 (January 2011), amended by the Department of Agriculture and Forestry, Office of Agricultural and Environmental Sciences, Structural Pest Control Commission, LR 39:301 (February 2013), amended by the Department of Agriculture and Forestry, Office of Agricultural and Environmental Sciences, Structural Pest Control Commission, LR 39:1413 (June 2013), LR 40:

Family Impact Statement

It is anticipated that the proposed action will have no significant effect on the:

1. stability of the family;
2. authority and rights of parents regarding the education and supervision of their children;
3. functioning of the family;
4. family earnings and family budget;
5. behavior and personal responsibility of children; or
6. ability of the family or a local government to perform the function as contained in the proposed action.

Poverty Impact Statement

It is anticipated that the proposed action will have no significant effect on:

1. household income, assets, and financial security;
2. early childhood or educational development;
3. employment and workforce development;
4. taxes and tax credits; or
5. child and dependent care, housing, health care, nutrition, transportation, and utilities assistance.

Small Business Statement

It is anticipated that the proposed action will not have a significant adverse impact on small businesses as defined in the Regulatory Flexibility Act. The agency, consistent with health, safety, environmental and economic factors has considered and, where possible, utilized regulatory methods in drafting the proposed action to accomplish the objectives of applicable statutes while minimizing any anticipated adverse impact on small businesses.

Provider Impact Statement

The proposed Rule should not have any known or foreseeable impact on providers as defined by HCR 170 of the 2014 Regular Legislative Session. In particular, there should be no known or foreseeable effect on:

1. the staffing level requirements or qualifications required to provide the same level of service;
2. the total direct and indirect effect on the cost to the providers to provide the same level of service; or
3. the overall effect on the ability of the provider to provide the same level of service.

Public Comments

Interested persons may submit written comments, data, opinions, and arguments regarding the proposed action. Written submissions are to be directed to Kevin Wofford, Director of Pesticide and Environmental Programs, Department of Agriculture and Forestry; telephone (225) 925-3763; fax # (225) 925-3760; mailing address, P.O. Box 3596, Baton Rouge, LA 70821. The written submissions must be received no later than 4 p.m. on July 25, 2014. No preamble regarding these proposed regulations is available.

Mike Strain, DVM
Commissioner

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES RULE TITLE: Hydraulic Injection

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

The proposed action is not anticipated to have a direct material effect on state or local governmental unit expenditures. The proposed action makes changes to rules and regulations to

include hydraulic injection for termite control work as an alternative method for perimeter treatments for termite control in Louisiana. Hydraulic injection is a high-pressure unit that may be used in conjunction with an approved termiticide while performing a perimeter treatment.

Requirements for trench and treat are currently in place for termite control work. This proposed action permits hydraulic injection to be used in lieu of trench and treat. The unit will be made available by the manufacturer for an annual rental rate. Hydraulic injection of termiticide treatment will be an alternative method for perimeter treatments for termite control in Louisiana and will be a strictly voluntary method.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

The proposed action is not anticipated to have a direct material effect on state or local governmental revenues.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

The proposed action is not anticipated to have any costs and/or economic benefit to directly affected persons or nongovernmental groups. The Department of Agriculture has indicated that the difference in costs between the options is unknown at this time.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

The proposed action is not anticipated to have a direct material effect on competition or employment.

Dane Morgan
Assistant Commissioner
1406#087

Evan Brasseaux
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

Department of Children and Family Services Division of Programs Licensing Section

Licensing Class "A" and "B" Regulations for Child Care Centers (LAC 67:III.Chapter 73)

The Department of Children and Family Services (DCFS), Division of Programs, Licensing Section, in accordance with provisions of the Administrative Procedure Act, R.S. 49:953(A), proposes to amend LAC 67:III, Subpart 21, Child Care Licensing, Chapter 73, Sections 7302, 7317, 7355, and 7372.

The department finds it necessary to adopt this Rule to correct the unintended consequences on the child care industry that may have resulted from the inadvertent change to the naptime supervision requirements and the implementation of a retroactive timeframe for which a fine may be imposed.

This action was made effective by an Emergency Rule dated and effective March 12, 2014.

Title 67

SOCIAL SERVICES

Part III. Economic Stability

Subpart 21. Child Care Licensing

Chapter 73. Day Care Centers

Subchapter A. Licensing Class "A" Regulations for Child Care Centers

§7302. Authority

A. - I.2. ...

3. In assessing a fine, any violation of one or more of the above categories which occur during any 24-month period after the adoption of this Section shall be counted in determining whether multiple violations have occurred. For purposes of establishing a history of non-compliance, any violation of one or more of the above categories which occur during any 24-month period shall be counted in determining whether multiple violations have occurred.

I.4.a. - J.4. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:1401 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987), amended by the Department of Social Services, Office of the Secretary, Bureau of Licensing, LR 20:450 (April 1994), LR 24:2345 (December 1998), LR 29:1107 (July 2003), repromulgated by the Department of Social Services, Office of Family Support, LR 33:2755 (December 2007), amended LR 36:332 (February 2010), LR 36:847 (April 2010), amended by the Department of Children and Family Services, Division of Programs, LR 37:811 (March 2011), amended by the Department of Children and Family Services, Division of Programs, Licensing Section, LR 39:66 (January 2013), LR 40:243 (February 2014), effective March 1, 2014, LR 40:

§7317. Supervision

A. - D. ...

E. Children ages one year and above may be grouped together at rest time with one staff in each room supervising the resting children. If two rooms share a common doorway, one staff may supervise the resting children. If the view of the staff supervising the children is obstructed by an object such as a low shelving unit, children shall be checked by sight by staff continually circulating among the resting children.

F. - H. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:1401 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987), amended by the Department of Social Services, Office of the Secretary, Bureau of Licensing, LR 20:450 (April 1994), LR 24:2345 (December 1998), LR 29:1116 (July 2003), repromulgated by the Department of Social Services, Office of Family Support, LR 33:2764 (December 2007), amended by the Department of Children and Family Services, Division of Programs, Licensing Section, LR 40:252 (February 2014), effective March 1, 2014, LR 40:

Subchapter B. Licensing Class "B" Regulations for Child Care Centers

§7355. Authority

A. - I.2. ...

3. In assessing a fine, any violation of one or more of the above categories which occur during any 24-month period after the adoption of this Section shall be counted in determining whether multiple violations have occurred. For purposes of establishing a history of non-compliance, any violation of one or more of the above categories which occur during any 24-month period shall be counted in determining whether multiple violations have occurred.

I.4.a - J.4. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:1401 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987), amended by

the Department of Social Services, Office of the Secretary, LR 18:970 (September 1992), LR 26:1635 (August 2000), repromulgated by the Department of Social Services, Office of Family Support, LR 33:2770 (December 2007), amended LR 36:333 (February 2010), LR 36:849 (April 2010), amended by the Department of Children and Family Services, Division of Programs, Licensing Section, LR 39:66 (January 2013), LR 40:254 (February 2014), effective March 1, 2014, LR 40:

§7372. Supervision

A. - D. ...

E. Children ages one year and above may be grouped together at rest time with one staff in each room supervising the resting children. If two rooms share a common doorway, one staff may supervise the resting children. If the view of the staff supervising the children is obstructed by an object such as a low shelving unit, children shall be checked by sight by staff continually circulating among the resting children.

F. - H. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:1430 et seq.

HISTORICAL NOTE: Promulgated by the Department of Children and Family Services, Division of Programs, Licensing Section, LR 40:263 (February 2014), effective March 1, 2014, amended LR 40:

Family Impact Statement

1. What effect will this Rule have on the stability of the family? There will be no effect on the stability of the family.

2. What effect will this have on the authority and rights of persons regarding the education and supervision of their children? This Rule is to correct the unintended consequences on the child care industry that may have resulted from the inadvertent change to the naptime supervision requirements and the implementation of the retroactive timeframe for which a fine may be imposed.

3. What effect will this have on the functioning of the family? There will be no effect on the functioning of the family.

4. What effect will this have on family earnings and family budget? There will be no effect on family earnings and the family budget.

5. What effect will this have on the behavior and personal responsibility of children? This Rule will have no effect on the behavior and personal responsibility of children.

6. Is the family or local government able to perform the function as contained in this proposed rule? No, this is strictly an agency function.

Poverty Impact Statement

The proposed rulemaking will have no impact on poverty as described in R.S. 49:973.

Small Business Statement

The proposed Rule will have no adverse impact on small businesses as defined in the Regulatory Flexibility Act.

Provider Impact Statement

1. There is no effect on the staffing level requirements or qualifications to provide the same level of service.

2. There is no direct cost to the provider for providing the same level of service. If the provider does not provide the level of service as required by regulations, then a fine may be assessed in accordance with R.S. 46:1430.

3. There is no overall effect on the provider to provide the same level of service.

Public Comments

All interested persons may submit written comments through July 28, 2014, to Lisa Andry, Deputy Assistant Secretary, Department of Children and Family Services, P.O. Box 94065, Baton Rouge, LA, 70804-9065.

Public Hearing

A public hearing on the proposed rule will be held on July 28, 2014 at the Department of Children and Family Services, Iberville Building, 627 North Fourth Street, Seminar Room 1-127, Baton Rouge, LA beginning at 9 a.m. All interested persons will be afforded an opportunity to submit data, views, or arguments, orally or in writing, at said hearing. Individuals with disabilities who require special services should contact the Bureau of Appeals at least seven working days in advance of the hearing. For assistance, call (225) 342-4120 (voice and TDD).

Suzy Sonnier
Secretary

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES

RULE TITLE: Licensing Class "A" and "B" Regulations for Child Care Centers

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

This rule proposes to amend LAC 67:III, Subpart 21 Child Care Licensing, Chapter 73 Day Care Centers, Sections 7302, 7317, 7355, and 7372. The proposed rule changes the naptime supervision requirements and the timeframe for which a fine may be imposed on child care facilities.

The only cost associated with this proposed rule is the cost of publishing rulemaking which is estimated to be approximately \$1,476 (Federal) in Fiscal Year 2013-2014. This is a one-time cost that is routinely included in the department's budget.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

The department cannot determine the number of child care facilities that will be assessed civil fines as a result of violating the new supervision requirement in this proposed rule. In accordance with LA R.S. 46:1430 that established the Child Care Licensing Trust Fund, monies generated from the civil fines shall be credited to this fund and appropriated for the education and training of employees, staff, or other personnel of child care facilities.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

This proposed rule amends naptime supervision requirements of child care providers. Failure by a provider to meet published, established standards with regard to child/staff ratio, supervision, criminal background clearances, state central registry disclosure, and/or critical incident reporting may result in a fee of not more than \$250 dollars per day being assessed, not to exceed \$2,000 in a 12 month period.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

There is no estimated impact on competition or employment.

Etta Harris
Undersecretary
1406#085

Evan Basseaux
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

Department of Children and Family Services Economic Stability Section

Family Independence Temporary Assistance Program (FITAP) and Strategies to Empower People (STEP) Program (LAC 67:III.1213, 1229 and Chapter 57)

In accordance with the provisions of the Administrative Procedure Act R.S. 49:953(A), the Department of Children and Family Services (DCFS) proposes to amend LAC 67:III, Subpart 2, Family Independence Temporary Assistance Program (FITAP), Chapter 12, Subchapter A, Section 1213 and Subchapter B, Section 1229; and Subpart 16, Strategies to Empower People (STEP) Program, Chapter 57, Subchapter A, Sections 5703, 5705, and 5707, Subchapter B, Sections 5709, 5713, 5715, and 5717, and Subchapter C, Sections 5719, 5721, 5723, 5725, 5727, and 5729.

Sections 1213 and 1229 are being amended to provide clarification of program requirements.

Sections 5703, 5705, 5707, 5709, 5713, 5715, 5717, 5719, 5721, 5723, 5725, and 5729 are being amended to provide clarification of administration of the program, of availability, coordination, and provision of employment services for work-eligible FITAP recipients, and of program requirements. Section 5727 is being repealed.

Pursuant to Louisiana's Temporary Assistance for Needy Families (TANF) Block Grant, the department considers these amendments necessary to address changes in revised statute as amended by Act 285 of the 2013 Regular Session, to add clarification, and to facilitate the expenditure of TANF funds.

Title 67

SOCIAL SERVICES

Part III. Economic Stability

Subpart 2. Family Independence Temporary Assistance Program

Chapter 12. Application, Eligibility, and Furnishing Assistance

Subchapter A. Application, Determination of Eligibility, and Furnishing Assistance

§1213. Domestic Violence

A. The secretary shall waive, for as long as necessary, pursuant to a determination of good cause, any public assistance program requirement that will create obstacles for a victim of domestic violence to escape a domestic violence situation, including but not limited to, time limits on receipt of assistance; work, training, or educational requirements; limitations on TANF assistance to noncitizens; child support or paternity establishment cooperation requirements; residency requirements; and any other program requirements which will create obstacles for such victim to escape violence or penalize that victim for past, present, and potential for abuse. However, a victim of domestic violence shall develop a plan that specifies the necessary actions, goals, and services that may enable the victim to become free of a domestic violence situation.

B. - C.5. ...

AUTHORITY NOTE: Promulgated in accordance with 42 U.S.C. 601 et seq., R.S. 36:474 and R.S. 46:231.1.B, Act 58, 2003 Reg. Session.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Family Support, LR 25:2447 (December 1999), amended LR 30:494 (March 2004), amended by the Department of Children and Family Services, Economic Stability Section, LR 40:

Subchapter B. Conditions of Eligibility

§1229. Income

A. - A.32. ...

B. Need Standards Deduction. This deduction as described in §1229.F.3.b is applied to the income of an alien sponsor when determining eligibility and benefits of an alien.

1. The need standards are as follows.

Size of Household	Current Need Standard
1	\$245
2	472
3	658
4	809
5	955
6	1,089
7	1,217
8	1,347
9	1,471
10	1,595
11	1,731
12	1,870
13	2,005
14	2,146
15	2,291
16	2,444
17	2,564
18	2,727

B.2. - E. ...

F. Income of Alien Sponsors

1. - 1.b. ...

2. The department has opted not to apply the deeming rule of 42 U.S.C. 608 in determining the eligibility and benefits of non-213A aliens.

3. The gross countable income of a sponsor and the sponsor's spouse shall be deemed to be the unearned income of an alien minus the following deductions:

- a. 20 percent of the total earned income not to exceed \$175;
- b. The appropriate need standard amount for the sponsor, spouse, and any other persons living in the home whom the sponsor claims or could claim as a dependent for federal income tax purposes;
- c. Total amounts the sponsor or spouse pays to anyone not living in the household but whom the sponsor or spouse claims or could claim as a dependent for federal income tax purposes; and
- d. Total verified alimony or child support the sponsor or spouse pays to persons not living in the household.

G. ...

AUTHORITY NOTE: Promulgated in accordance with 42 U.S.C. 601 et seq. and 10602(c), R.S. 36:474, R.S. 46:231.1.B., R.S. 46:231.2, P.L. 108-447, Act 16, 2005 Reg. Session, 7 CFR 273.2, (j).

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Family Support, LR 25:2449 (December 1999), amended LR 26:1342 (June 2000), LR 26:2831 (December 2000), LR 31:2956 (November 2005), LR 32:1616 (September 2006), LR 32:1912 (October 2006), LR 34:2678 (December 2008),

amended by the Department of Children and Family Services, Economic Stability and Self-Sufficiency Section, LR 36:2524 (November 2010), amended by the Department of Children and Family Services, Economic Stability Section, LR 40:

Subpart 16. Strategies to Empower People (STEP) Program

Chapter 57. Strategies to Empower People (STEP) Program

Subchapter A. Designation and Authority of State Agency

§5703. Program Administration

A. The Department of Children and Family Services (DCFS) shall develop, implement, and administer STEP as the employment program for work-eligible recipients of the Family Independence Temporary Assistance Program (FITAP) in accordance with the provisions of the Federal Welfare Reform Act and make available to eligible FITAP recipients the allowable work, training, and education activities of the STEP Program.

B. Prior to receipt of FITAP, a work-eligible participant shall be notified in writing of program expectations and participant responsibilities. When possible, notification may be delivered via e-mail or other electronic means, and notification delivered in this manner shall be deemed to satisfy the written notification requirement established in this Chapter.

C. DCFS shall collaborate with the Louisiana Workforce Commission (LWC) to identify and coordinate employment services for the program. Employment services shall be delivered pursuant to performance-based contracts between the department and LWC, other government agencies, or any community partner.

D. ...

E. The secretary shall provide workers' compensation and liability insurance coverage for participants engaged in work experience or community service activities.

AUTHORITY NOTE: Promulgated in accordance with P.L. 104-193, R.S. 46:231, R.S. 46:460, and Act 58, 2003 Reg. Session.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Family Support, LR 30:497 (March 2004), amended by the Department of Children and Family Services, Economic Stability Section, LR 40:

§5705. Definitions

Family Assessment—consists of an initial employability assessment and a comprehensive assessment if needed:

1. initial employability assessment is designed to determine the applicant's level of employability, immediate needs, and family circumstances during the application process;

2. comprehensive assessment is conducted once the applicant is certified for eligibility if needed and may include but is not limited to workplace literacy, basic skills and educational attainment, interests and aptitude related to employment, barriers to employment, need for education, supportive services such as child care and transportation, and other supportive services. Specialized assessments can occur for issues that arise after an initial assessment has been completed and could include substance abuse, domestic violence, mental health screening, or others as determined by the department.

Family Success Agreement (FSA)—the mutually developed contract between a Family Independence Temporary Assistance Program (FITAP) recipient, on behalf

of their family, and the department that sets forth mutual and time-bound responsibilities, expectations, activities, and goals designed to transition the family from receipt of FITAP to self-sufficiency.

Family Transition Assessment (FTA)—Repealed.

* * *

Temporary Exception—Repealed.

* * *

AUTHORITY NOTE: Promulgated in accordance with P.L. 104-193, R.S. 46:231, R.S. 46:460, and Act 58, 2003 Reg. Session; Act 110, 2004 Reg. Session.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Family Support, LR 30:497 (March 2004), amended LR 31:103 (January 2005), amended by the Department of Children and Family Services, Economic Stability Section, LR 40:

§5707. Domestic Violence

A. The secretary shall waive, for as long as necessary, pursuant to a determination of good cause, any public assistance program requirement that will create obstacles for a victim of domestic violence to escape a domestic violence situation, including but not limited to time limits on receipt of assistance, work, training or educational requirements, limitations on TANF requirements, residency requirements, and any other program requirements which will create obstacles for such victim to escape violence or penalize that victim for past, present, and potential for abuse. However, a victim of domestic violence shall develop a plan that specifies the necessary actions, goals, and services that may enable the victim to become free of a domestic violence situation.

AUTHORITY NOTE: Promulgated in accordance with P.L. 104-193, R.S. 46:231, R.S. 46:460, and Act 58, 2003 Reg. Session.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Family Support, LR 30:498 (March 2004), amended by the Department of Children and Family Services, Economic Stability Section, LR 40:

Subchapter B. Participation Requirements

§5709. School Attendance

A. Work-eligible FITAP recipients, in order to ensure appropriate child development, educational attainment, and school attendance for each minor child included in the assistance unit, shall agree in the family success agreement (FSA) to actively participate in their child's education through parent-teacher conferences, homework assistance, or other activities.

B. ...

AUTHORITY NOTE: Promulgated in accordance with P.L. 104-193, R.S. 46:231, R.S. 46:460, and Act 58, 2003 Reg. Session.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Family Support, LR 30:498 (March 2004), amended by the Department of Children and Family Services, Economic Stability Section, LR 40:

§5713. Work Activities

A. Work-eligible recipients shall participate in appropriate work activities for the minimum number of hours specified by federal law as agreed upon in the FSA. Appropriate work activities may include but are not limited to:

1. subsidized or unsubsidized employment;
2. unpaid work experience;
3. on-the-job training;
4. job search;
5. job readiness;

6. vocational education;
7. attendance in secondary school for those individuals who have not graduated from high school;
8. participation in GED or basic skills training;
9. employment-related education;
10. job skills training;
11. community service; and
12. the provision of child care to an individual who is participating in community service.

B. ...

AUTHORITY NOTE: Promulgated in accordance with P.L. 104-193, R.S. 46:231, R.S. 46:460, and Act 58, 2003 Reg. Session.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Family Support, LR 30:498 (March 2004), amended by the Department of Children and Family Services, Economic Stability Section, LR 40:

§5715. Good Cause

A. A work-eligible applicant or recipient of cash assistance shall immediately participate in work activities for the minimum number of hours per week required by federal law unless one of the following good cause reasons applies:

1. Appropriate child care is unavailable within a reasonable distance from the participant's home or worksite after efforts have been made, and assistance has been offered, to secure child care.

2. Appropriate transportation is:

- a. unavailable and the participant's home or worksite are not within a reasonable walking distance, or
- b. available but is cost prohibitive.

3. Situations Related to Domestic Violence. Any participant that receives a good cause exception related to domestic violence shall complete a plan that specifies the necessary actions, goals, and services that may enable the victim to become free of the violence.

4. Situations related to the treatment of a mental or physical illness, including substance abuse treatment, where there is verification that participation in required activities would impair a treatment plan of a mental health or medical professional.

5. Temporary, short-term illness, or the temporary care of a family member who is ill, as documented by a medical professional.

6. Temporary emergency crisis, such as homelessness, fire, accident, dislocation due to natural causes, hurricane, flood, or similar circumstances that can be substantiated.

B. Participants who are granted good cause shall be informed that this time is counted against their federal 60-month time limit and state 24-month time limit for receipt of cash assistance.

C. When good cause is granted, the basis for good cause shall be re-evaluated every six months to determine if good cause continues to exist.

AUTHORITY NOTE: Promulgated in accordance with P.L. 104-193, R.S. 46:231, R.S. 46:460, and Act 58, 2003 Reg. Session; Act 110 and Act 675, 2004 Reg. Session.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Family Support, LR 30:498 (March 2004), amended LR 31:103 (January 2005), amended by the Department of Children and Family Services, Economic Stability Section, LR 40:

§5717. Sanctions

A. Sanctions shall be used as a last resort to inform participants that they have not met the expectations set forth

in the FSA. Participants shall be sanctioned for the following violations:

1. failure of a work-eligible, minor parent with a child who has not yet received a high school diploma or its equivalent, to attend school or related education classes designed to obtain a high school diploma or its equivalent;

2. failure of a public assistance recipient who is pregnant or has a child under age one to attend parenting education and other training conducive to the unique needs of new parents;

3. failure of work-eligible families to meet the required employment and education activities for the minimum number of hours without good cause, as specified in the FSA; or

4. failure of work-eligible families to meet other requirements such as but not limited to immunization, cooperation with support enforcement services, compliance with substance abuse screening, testing, treatment, etc., as specified in the FSA.

B. - B.3. ...

AUTHORITY NOTE: Promulgated in accordance with P.L. 104-193, R.S. 46:231, R.S. 46:460, and Act 58, 2003 Reg. Session.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Family Support, LR 30:499 (March 2004), amended by the Department of Children and Family Services, Economic Stability Section, LR 40:

Subchapter C. STEP Program Process

§5719. Family Assessment

A. A family assessment shall be completed on all FITAP/STEP applicants in order to assist the worker in identifying family strengths, weaknesses, opportunities and barriers as well as determining programs that the applicants will need to become self-sufficient.

B. The family assessment may be created, sent, signed, or stored by electronic means.

AUTHORITY NOTE: Promulgated in accordance with P.L. 104-193, R.S. 46:231, R.S. 46:460, and Act 58, 2003 Reg. Session.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Family Support, LR 30:499 (March 2004), amended by the Department of Children and Family Services, Economic Stability Section, LR 40:

§5721. Job Readiness

A. A work-eligible applicant of FITAP shall register for work with the Louisiana Workforce Commission (LWC). Registration for work shall be documented as a condition for certification of eligibility for FITAP. The applicant shall receive an initial employability assessment designed to determine their level of employability, immediate needs, and family circumstances.

B. DCFS will ensure job readiness services are provided through other state partners or through performance-based contracts.

AUTHORITY NOTE: Promulgated in accordance with P.L. 104-193, R.S. 46:231, R.S. 46:460, and Act 58, 2003 Reg. Session.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Family Support, LR 30:499 (March 2004), amended by the Department of Children and Family Services, Economic Stability Section, LR 40:

§5723. Comprehensive Assessment

A. Once the applicant is certified for eligibility, a comprehensive assessment shall be conducted if needed and may include but is not limited to workplace literacy, basic

skills and educational attainment, interests and aptitude related to employment, barriers to employment, need for education, supportive services such as child care and transportation, and other supportive services.

B. ...

AUTHORITY NOTE: Promulgated in accordance with P.L. 104-193, R.S. 46:231, R.S. 46:460, and Act 58, 2003 Reg. Session.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Family Support, LR 30:499 (March 2004), amended by the Department of Children and Family Services, Economic Stability Section, LR 40:

§5725. Family Success Agreement (FSA)

A. Upon determination of eligibility and after completion of the comprehensive assessment if needed, work-eligible participants shall enter into a contractual agreement, known as the family success agreement (FSA), with the department. The FSA will specify:

1. the client's time-bound goals, responsibilities, and work activity participation; and

2. the department's obligation to provide necessary supportive services, assessments, notifications, information, and case management.

B. The FSA shall be updated at least every six months or as the client's needs, goals, barriers, and family circumstances change. It shall be the responsibility of the participant to inform the department or its representative of these changes.

C. The family success agreement may be created, sent, signed, or stored by electronic means. The electronic version of the Family Success Agreement is known as the Case Plan.

AUTHORITY NOTE: Promulgated in accordance with P.L. 104-193, R.S. 46:231, R.S. 46:460, and Act 58, 2003 Reg. Session.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Family Support, LR 30:500 (March 2004), amended by the Department of Children and Family Services, Economic Stability Section, LR 40:

§5727. Family Transition Assessment

Repealed.

AUTHORITY NOTE: Promulgated in accordance with P.L. 104-193, R.S. 46:231, R.S. 46:460, and Act 58, 2003 Reg. Session; Act 110 and Act 675, 2004 Reg. Session.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Family Support, LR 30:500 (March 2004), amended LR 31:103 (January 2005), LR 33:1686 (August 2007), repealed by the Department of Children and Family Services, LR 40:

§5729. Support Services

A. - A.7. ...

B. Support services may be provided to:

1. persons participating in the family assessment;

2. persons referred by the department to other activities, such as drug counseling, prior to their participation in a work activity;

B.3. - C.2. ...

D. The department shall inform participants of available supportive services as part of the initial family assessment and shall integrate the provision of any necessary supportive services to the family success agreement developed and signed by the department and the participant.

AUTHORITY NOTE: Promulgated in accordance with P.L. 104-193, R.S. 46:231, R.S. 46:460, and Act 58, 2003 Reg. Session, ACYF-IM-CC-05-03.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Family Support, LR 30:500 (March 2004), amended LR 32:2098 (November 2006), amended by the Department of Children and Family Services, Economic Stability and Self-Sufficiency Section, LR 38:1391 (June 2012), LR 40:

Family Impact Statement

1. What effect will this Rule have on the stability of the family? This Rule will have no impact on the family's stability.

2. What effect will this have on the authority and rights of persons regarding the education and supervision of their children? This Rule will have no effect on the authority and rights of persons regarding the education and supervision of their children.

3. What effect will this have on the functioning of the family? This Rule will have no negative effect on the functioning of the family.

4. What effect will this have on family earnings and family budget? This Rule will have no effect on family earnings or family budget.

5. What effect will this have on the behavior and personal responsibility of children? This Rule will have no effect on the behavior and personal responsibility of children.

6. Is the family or local government able to perform the function as contained in this proposed Rule? No, these functions are department functions.

Poverty Impact Statement

The proposed rulemaking will have no impact on poverty as described in R.S. 49:973.

Small Business Statement

The proposed Rule will have no adverse impact on small businesses as defined in the Regulatory Flexibility Act.

Provider Impact Statement

The department has considered the impact of the proposed rule on providers and organizations that provide services for individuals with development disabilities. It is estimated that the proposed action will have no adverse fiscal impact regarding staffing requirements or qualifications, the total cost to the provider, or the overall effect on the provider's ability to provide the same level of service.

Public Comments

All interested persons may submit written comments through July 29, 2014, to Lisa Andry, Deputy Assistant Secretary of Programs, Department of Children and Family Services, P.O. Box 94065, Baton Rouge, LA 70804-9065.

Public Hearing

A public hearing on the proposed Rule will be held on July 29, 2014 at the Department of Children and Family Services, Iberville Building, 627 North Fourth Street, Seminar Room 1-127, Baton Rouge, LA, beginning at 9 a.m. All interested persons will be afforded an opportunity to submit data, views, or arguments, orally or in writing, at said hearing. Individuals with disabilities who require special services should contact the Bureau of Appeals at least seven working days in advance of the hearing. For assistance, call (225) 342-4120 (voice and TDD).

Suzy Sonnier
Secretary

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES

RULE TITLE: Family Independence Temporary Assistance Program (FITAP) and Strategies to Empower People (STEP) Program

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

This rule proposes to amend LAC 67:III, Subpart 2 Family Independence Temporary Assistance Program (FITAP), Chapter 12, Subchapter A, Section 1213 and Subchapter B, Section 1229; and Subpart 16 Strategies to Empower People (STEP) Program, Chapter 57, Subchapter A, Sections 5703, 5705, and 5707, Subchapter B, Sections 5709, 5713, 5715, and 5717, and Subchapter C, Sections 5719, 5721, 5723, 5725, 5727, and 5729. The proposed action stipulates that the secretary of the Department of Children and Family Services (DCFS) has authority to amend these sections to address changes in revised statute as amended by Act 285 of the 2013 Regular Session, to add clarification, and to facilitate the expenditure of TANF funds.

The proposed rule clarifies Sections 5703, 5705, 5707, 5709, 5713, 5715, 5717, 5719, 5721, 5723, 5725, and 5729 on the administration of the STEP program, provision of employment services for work-eligible FITAP recipients, and program requirements. Also, the proposed rule repeals Section 5727.

The only cost associated with this proposed rule is the cost of publishing rulemaking. It is anticipated that \$2,460 (Federal) will be expended in SFY 13-14 for the state's administrative expense for promulgation of this proposed rule and the final rule.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

Implementation of this proposed rule will have no effect on revenue collections of state or local governmental units.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

Implementation of this proposed rule will have no cost or economic benefit to directly affected persons or non-governmental groups. None of these changes impact individuals or recipients of the FITAP or STEP programs.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

This proposed rule will not have an impact on competition and employment for low-income families.

Suzy Sonnier
Secretary
1406#084

Evan Brasseaux
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

Department of Civil Service Board of Ethics

Food and Drink Limit (LAC 52:I.1703)

In accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., notice is hereby given that the Department of Civil Service, Louisiana Board of Ethics, has initiated rulemaking procedures to make amendments to the Rules for the Board of Ethics to bring the Rules into compliance with current statutory provisions and Section 1115.1C of the *Code of Governmental Ethics*.

**Title 52
ETHICS**

Part I. Board of Ethics

Chapter 17. Code of Governmental Ethics

§1703. Food and Drink Limit

A. In accordance with R.S. 42:1115.1(C), beginning on July 1, 2014, the limit for food, drink or refreshments provided in R.S. 42:1115.1(A) and (B) is \$58.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:1115.1.

HISTORICAL NOTE: Promulgated by the Department of Civil Service, Board of Ethics, LR 36:304 (February 2010), amended LR 36:1466 (July 2010), LR 38:1951 (August 2012), LR 39:3062 (November 2013), LR 40:

Family Impact Statement

The proposed Rule changes have no impact on family formation, stability or autonomy, as described in R.S. 49:972.

Poverty Impact Statement

The proposed Rule changes have no impact on poverty, as described in R.S. 49:972.

Provider Impact Statement

The proposed Rule should not have any known or foreseeable impact on providers as defined by HCR 170 of 2014 Regular Legislative Session.

Public Comments

Interested persons may direct their comments to Kathleen M. Allen, Louisiana Board of Ethics, P.O. Box 4368, Baton Rouge, LA 70821, telephone (225) 219-5600, until 4:45 p.m. on July 10, 2014.

Kathleen M. Allen
Ethics Administrator

**FISCAL AND ECONOMIC IMPACT STATEMENT
FOR ADMINISTRATIVE RULES
RULE TITLE: Food and Drink Limit**

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

The estimated cost to implement this Rule, which sets forth the amended monetary limit on the receipt of food and drink by a public servant and public employee, is \$168 in FY 14-15, which accounts for the cost to publish the Notice of Intent and the rule in the *Louisiana Register*. The proposed administrative Rule raises the monetary limit on the receipt of food and drink from \$57 to \$58 in FY 15.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

The proposed Rule will have no anticipated effect on revenue collections of state or local governmental units.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

The proposed action will affect all public employees and public servants by setting a monetary limit on the receipt of food and drink.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

The proposed Rule change will have no anticipated effect on competition and employment.

Kristy Gary
Deputy Ethics Administrator
1406#046

Evan Brasseaux
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

**Department of Culture, Recreation, and Tourism
Office of Cultural Development
Division of Historic Preservation**

Application Fees for the State
Commercial Tax Credit Program
(LAC 25:I.Chapter 13)

The Department of Culture, Recreation and Tourism, Office of Cultural Development, Division of Historic Preservation, in accordance with R.S. 47:6019 and with the Administrative Procedure Act, R.S. 49:950 et seq., hereby adopts LAC 25:I.1301-03, State Commercial Tax Credit for Historic Buildings.

The purpose of this regulation is to define a sliding scale fee structure for State Commercial Tax Credit applications submitted to the Division of Historic Preservation. The proposed regulation sets forth the fee schedule, discusses definitions relating to the fee structure, and provides the circumstances under which a fee must be submitted.

Title 25

CULTURAL RESOURCES

Part I. Office of Cultural Development

Chapter 13. State Commercial Tax Credit for Historic Buildings

§1301. Definitions

A. The following definitions shall apply for purposes of this Chapter, unless specifically defined otherwise.

Application—the three-part State Commercial Tax Credit for Historic Buildings application, which consists of: Part 1—Certification of Contributing Status; Part 2—Proposed Work Description; and, Part 3—Request for Project Certification.

Credit Amount—the dollar amount of credit earned.

Division—the Louisiana Division of Historic Preservation.

Qualified Rehabilitation Expenditures (QREs)—eligible costs and expenses as defined in section 47c(2)(A) of the *Internal Revenue Code* of 1986, as amended.

Rehabilitation—the process of returning a property to a state of utility, through repair or alteration, which makes possible an efficient contemporary use while preserving those aspects of the building, its site, and environment that are significant to its historic, architectural, and cultural values, as determined by the division.

AUTHORITY NOTE: Promulgated in accordance with Revised Statute 47:6019.

HISTORICAL NOTE: Promulgated by the Department of Culture, Recreation, and Tourism, Office of Cultural Development, Division of Historic Preservation, LR 40:

§1303. Fees

A. The Division of Historic Preservation shall charge an application fee for each rehabilitation project that is submitted. Application fees for a single rehabilitation project are as indicated.

Qualified Rehabilitation Expenditures (QREs)	Part 2 Fee, based on estimated QREs	Part 3 Fee, based on actual QREs
Up to \$100,000	\$250	None
\$100,001 - \$500,000	\$250	1.5% of credit amount, minus Part 2 fee

Qualified Rehabilitation Expenditures (QREs)	Part 2 Fee, based on estimated QREs	Part 3 Fee, based on actual QREs
\$500,001 - \$1 million	\$500	1.5% of credit amount, minus Part 2 fee
\$1,000,001 - \$3 million	\$1000	1.5% of credit amount, minus Part 2 fee
\$3,000,001 - \$6 million	\$2000	1.5% of credit amount, minus Part 2 fee (\$15,000 cap)
\$6,000,001 - \$15 million	\$3500	1.5% of credit amount, minus Part 2 fee (\$15,000 cap)
\$15,000,001 +	\$5,000	1.5% of credit amount, minus Part 2 fee (\$15,000 cap)

B. A decision will not be issued on an application until the appropriate remittance is received, in a method determined by the division.

C. Fees are nonrefundable.

AUTHORITY NOTE: Promulgated in accordance with Revised Statute 47:6019.

HISTORICAL NOTE: Promulgated by the Department of Culture, Recreation, and Tourism, Office of Cultural Development, Division of Historic Preservation, LR 40:

Family Impact Statement

1. What effect will this Rule have on the stability of the family? This proposed Rule will have no impact on the stability of the family.

2. What effect will this have on the authority and rights of persons regarding the education and supervision of their children? This proposed Rule will have no effect on the authority and rights of persons regarding the education and supervision of their children.

3. What effect will this have on the functioning of the family? This proposed Rule will have no effect on the function of the family.

4. What effect will this have on family earnings and family budget? This proposed Rule will have no effect on the family's earnings or budget.

5. What effect will this have on the behavior and personal responsibility of children? This proposed Rule will have no effect on the behavior and personal responsibility of children.

6. Is the family or local government able to perform the function as contained in this proposed Rule? No, these functions are department functions.

Poverty Impact Statement

The proposed Rule will have no impact on poverty as described in R.S. 49:6019.

Small Business Statement

The proposed Rule will have no adverse impact on small businesses as defined in the Regulatory Flexibility Act.

Provider Impact Statement

The proposed Rule should not have any known or foreseeable impact on providers as defined by HCR 170 of the 2014 Regular Legislative Session. In particular, there should be no known or foreseeable effect on:

1. the effect on the staffing level requirements or qualifications required to provide the same level of service;

2. the total direct and indirect effect on the cost to the providers to provide the same level of service; or

3. the overall effect on the ability of the provider to provide the same level of service.

Public Comments

All interested persons may submit written comments through July 24, 2014, to Alison Saunders, Tax Incentives Director, Division of Historic Preservation, Office of Cultural Development, Department of Culture, Recreation and Tourism, P.O. Box 44247, Baton Rouge, LA 70804 or via email to asaunders@crt.la.gov.

Public Hearing

A public hearing to receive comments on the Notice of Intent will be held on July 25, 2014 at 10 a.m. at the Division of Historic Preservation, 1051 North Third Street, Baton Rouge, LA 70802.

Pamela Breaux
Assistant Secretary

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES

RULE TITLE: Application Fees for the State Commercial Tax Credit Program

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

Pursuant to HB 824 of the 2014 Regular Legislative Session the implementation of the rule is anticipated to result in no additional cost or savings to the state or local governmental units. The minor administrative cost of operations will be absorbed by the Office of Cultural Development within the Department of Culture, Recreation, and Tourism.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

Pursuant to HB 824 of the 2014 Regular Legislative Session, increasing the application fee from \$250 to a sliding scale is anticipated to result in increased revenues of \$192,000 more than current collection in FY 15 and \$431,500 more than the current fee structure for FY 16. Subsequent fiscal year revenues are based on an average annual increase of 44.6% in applications requested since the inception of the tax credit. There is no projected effect at the local government level.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

The proposed rule will result in participating nongovernmental entities paying greater application fees to participate in the program. Currently, the Office of Cultural Development charges a \$250 review fee per application (R.S. 47:6019), regardless of the size of the project. The proposed sliding scale will be based on a percentage of the tax credits earned by each taxpayer, keeping the fee paid in direct proportion to the benefit received. The fees range from \$250 to \$15,000 per application.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

The change to the fee structure is expected to have little or no effect on competition and employment.

Charles R. Davis
Deputy Secretary
1406#088

Gregory V. Albrecht
Chief Economist
Legislative Fiscal Office

NOTICE OF INTENT

Board of Elementary and Secondary Education

Bulletin 741—Louisiana Handbook for
School Administrators (LAC 28: CXV.2318)

In accordance with R.S. 49:950 et seq., the Administrative Procedure Act, notice is hereby given that the Board of Elementary and Secondary Education approved for advertisement revisions to *Bulletin 741—Louisiana Handbook for School Administrators*: §2318. The College Diploma. The proposed policy revisions delete unnecessary policy language.

Title 28 EDUCATION

Part CXV. Bulletin 741—Louisiana Handbook for School Administrators

Chapter 23. Curriculum and Instruction

Subchapter A. Standards and Curricula

§2318. The College Diploma

- A. - C.2.j. ...
- k. - k.iv. Repealed.
- 3. - 6.a.vi. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:7, R.S. 17:24.4, R.S. 17:183.2, and R.S. 17: 395.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 31:1291 (June 2005), amended LR 31:2211 (September 2005), LR 31:3070 (December 2005), LR 31:3072 (December 2005), LR 32:1414 (August 2006), LR 33:429 (March 2007), LR 33:432 (March 2007), LR 33:2050 (October 2007), LR 33:2354 (November 2007), LR 33:2601 (December 2007), LR 34:1607 (August 2008), LR 36:1486 (July 2010), LR 37:547 (February 2011), LR 37:1128 (April 2011), LR 37:2129 (July 2011), LR 37:2132 (July 2011), LR 37:3193 (November 2011), LR 38:754, 761 (March 2012), LR 38:1001 (April 2012), LR 38:1584 (July 2012), LR 40:

Family Impact Statement

In accordance with section 953 and 974 of title 49 of the Louisiana Revised Statutes, there is hereby submitted a Family Impact Statement on the Rule proposed for adoption, repeal or amendment. All Family Impact Statements shall be kept on file in the state board office which has adopted, amended, or repealed a Rule in accordance with the applicable provisions of the law relating to public records.

1. Will the proposed Rule affect the stability of the family? No.
2. Will the proposed Rule affect the authority and rights of parents regarding the education and supervision of their children? No.
3. Will the proposed Rule affect the functioning of the family? No.
4. Will the proposed Rule affect family earnings and family budget? No.
5. Will the proposed Rule affect the behavior and personal responsibility of children? No.
6. Is the family or a local government able to perform the function as contained in the proposed Rule? Yes.

Poverty Impact Statement

In accordance with section 973 of title 49 of the Louisiana Revised Statutes, there is hereby submitted a Poverty Impact

Statement on the Rule proposed for adoption, amendment, or repeal. All Poverty Impact Statements shall be in writing and kept on file in the state agency which has adopted, amended, or repealed a Rule in accordance with the applicable provisions of the law relating to public records. For the purposes of this section, the word “poverty” means living at or below 100 percent of the federal poverty line.

1. Will the proposed Rule affect the household income, assets, and financial security? No.
2. Will the proposed Rule affect early childhood development and preschool through postsecondary education development? Yes.
3. Will the proposed Rule affect employment and workforce development? No.
4. Will the proposed Rule affect taxes and tax credits? No.
5. Will the proposed Rule affect child and dependent care, housing, health care, nutrition, transportation, and utilities assistance? No.

Provider Impact Statement

The proposed Rule should not have any known or foreseeable impact on providers as defined by HCR 170 of 2014 Regular Legislative Session. In particular, there should be no known or foreseeable effect on:

1. the effect on the staffing level requirements or qualifications required to provide the same level of service;
2. the total direct and indirect effect on the cost to the providers to provide the same level of service; or
3. the overall effect on the ability of the provider to provide the same level of service.

Small Business Statement

The impact of the proposed Rule on small businesses as defined in the Regulatory Flexibility Act has been considered. It is estimated that the proposed action is not expected to have a significant adverse impact on small businesses. The agency, consistent with health, safety, environmental and economic welfare factors has considered and, where possible, utilized regulatory methods in the drafting of the proposed rule that will accomplish the objectives of applicable statutes while minimizing the adverse impact of the proposed rule on small businesses.

Public Comments

Interested persons may submit written comments via the U.S. Mail until 4:30 p.m., July 9, 2014, to Heather Cope, Board of Elementary and Secondary Education, Box 94064, Capitol Station, Baton Rouge, LA 70804-9064.

Heather Cope
Executive Director

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES

RULE TITLE: Bulletin 741—Louisiana Handbook for School Administrators

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

The proposed policy revisions do not impact costs for state or local governmental units.

NOTICE OF INTENT

Board of Elementary and Secondary Education

Bulletin 746—Louisiana Standards for State Certification of School Personnel (LAC 28:CXXXI.243)

In accordance with R.S. 49:950 et seq., the Administrative Procedure Act, notice is hereby given that the Board of Elementary and Secondary Education approved for advertisement revisions to *Bulletin 746—Louisiana Standards for State Certification of School Personnel*: §243, PRAXIS Exams and Scores. The proposed policy will allow the adoption of new Praxis exams required for Louisiana teacher licensure.

Title 28

EDUCATION

**Part CXXXI. Bulletin 746— Louisiana Standards for State Certification of School Personnel
Chapter 2. Louisiana Educator Preparation Programs**

Subchapter D. Testing Required for Licensure Areas §243. PRAXIS Exams and Scores

A. - A.2. ...

The proposed policy revision removes a list of courses for the New Orleans Center of Creative Arts (NOCCA). In January 2014, the Board of Elementary and Secondary Education (BESE) approved the course equivalents for the Louisiana School for Math, Science, and the Arts (LSMSA). Both the LSMSA and NOCCA courses are BESE-approved course equivalents and are not considered alternate graduation requirements. For this reason, it is unnecessary to list the courses in policy.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

This policy will have no effect on revenue collections of state or local governmental units.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

There will be no estimated cost and/or economic benefit to directly affected persons or non-governmental groups.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

This policy will have no determinable effect on competition and employment.

Beth Scioneaux
Deputy Superintendent
1406#027

Evan Brasseaux
Staff Director
Legislative Fiscal Office

B. Content and Pedagogy Requirements

Certification Area	Name of Praxis Test	Content Exam Score	Pedagogy: Principles of Learning & Teaching		
			PLT K-6 (#0622 or 5622)	PLT 5-9 (#0623 or 5623)	PLT 7-12 (#0624 or 5624)
Early Childhood PK-3	Elementary Content Knowledge (0014 or 5014)	150	PLT: Early Childhood 0621 or 5621 (Score 157)		
Grades 1-5	Elementary Content Knowledge (0014 or 5014)	150	160	---	---
Grades 4-8 Mathematics	Middle School Mathematics (0069) Prior to 1/1/14	148	---	160	---
	Middle School Mathematics (5169) Effective 1/1/14	165			
Grades 4-8 Science	Middle School Science (0439) Prior to 6/8/14	150	---	160	---
	Middle School Science (5440) Effective 6/8/14	150			
Grades 4-8 Social Studies	Middle School Social Studies (0089 or 5089)	149	---	160	---
Grades 4-8 English/ Language Arts	Middle School English/Language Arts (0049 or 5049) Prior to 1/1/14	160	---	160	---
	Middle School English (5047) Effective 1/1/14	164			

C. Certification Areas

1. Grades 6-12 Certification

Grades 6-12 Certification Areas					
		Score			PLT 7-12
Agriculture	Agriculture (0700) Prior to 6/8/14	510	---	---	157
	Agriculture (5701) Effective 6/8/14	147			
Biology	Biology: Content Knowledge (0235 or 5235)	150	---	---	157
Business	Business Education: Content Knowledge (0101 or 5101)	154	---	---	157
Chemistry	Chemistry: Content Knowledge (0245 or 5245)	151			157
Chinese	Chinese (Mandarin): World Language (5665)	164	PLT7-12 (Score 157) until 6/30/13; After 6/30/13 World Languages Pedagogy 0841 (Score 158)		
English	English Language, Literature, and Composition: Content Knowledge (0041 or 5041) Pedagogy (0043) Prior to 1/1/14	160 130	---	---	157
	English Language Arts: Content and Analysis (5039) Effective 1/1/14	168			
Family and Consumer Sciences	Family and Consumer Sciences (0121 or 5121) Prior to 6/8/14	141	---	---	157
	Family and Consumer Sciences (5122) Effective 6/8/14	153			
French	French: World Language (5174)	157	PLT7-12 (Score 157) until 6/30/13; After 6/30/13 World Languages Pedagogy 0841 (Score 158)		
General Science	General Science: Content Knowledge (0435 or 5435)	156	---	---	157
German	German: World Language (5183)	157	PLT7-12 (Score 157) until 6/30/13; After 6/30/13 World Languages Pedagogy 0841 (Score 158)		
Mathematics	Mathematics: Content Knowledge (0061 or 5061) Effective 6/1/10-12/31/13	135	---	---	157
	Mathematics: Content Knowledge (5161) Effective 1/1/14	160			
Physics	Physics: Content Knowledge (0265 or 5265)	141			157
Social Studies	Social Studies: Content and Interpretation (0086 or 5086)	160	---	---	157
Spanish	Spanish: World Language (5195)	157	PLT7-12 (Score 157) until 6/30/13; After 6/30/13 World languages Pedagogy 0841 (Score 158)		
Speech	Speech Communications (0221 or 5221)	146	---	---	157
Technology Education	Technology Education (0051 or 5051)	159	---	---	157
Computer Science Earth Science Environmental Science Journalism Latin Marketing	At this time, a content area exam is not required for certification in Louisiana.	---	---	---	157

2. All-Level K-12 Certification

All-Level K-12 Certification Areas						
		Score	PLT K-6		PLT 5-9	PLT 7-12
Grades K-12 Art	Art: Content Knowledge (0134 or 5134)	159	160	or	160	157
Grades K-12 Dance	None Available**	---	160		160	157
Grades K-12 Foreign Languages	Chinese (Mandarin): World Language (5665)	164	PLT K-6 (Score 160) or PLT 5-9 (Score 160) or PL7-12 (Score 157) until 6/30/13; After 6/30/13 World Languages Pedagogy 0841 (Score 158)			
	French: World Language (5174)	157				
	German: World Language (5183)	157				
	Spanish: World Language (5195)	157				
Grades K-12 Music	Music: Content Knowledge (0113 or 5113)	151	160	or	160	157
Grades K-12 Health and Physical Education	Phys. Education: Content Knowledge (0091 or 5091) Prior to 6/8/14	146	160		160	157
	Health and Physical Education (5857) Effective 6/8/14	160				

**At this time, a content area exam is not required for certification in Louisiana.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:6 (A)(10), (11), and (15), R.S. 17:7(6), R.S. 17:10, R.S. 17:22(6), R.S. 17:391.1-391.10, and R.S. 17:411.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 32:1833 (October 2006), amended LR 36:485 and 488 (March 2010), LR 36:2265 (October 2010), LR 37:551 (February 2011), repromulgated LR 37:556 (February 2011), amended LR 37:3210 (November 2011), LR 39:1461 (June 2013), LR 40:277 (February 2014), LR 40:

Family Impact Statement

In accordance with Section 953 and 974 of Title 49 of the Louisiana Revised Statutes, there is hereby submitted a Family Impact Statement on the Rule proposed for adoption, repeal or amendment. All Family Impact Statements shall be kept on file in the state board office which has adopted, amended, or repealed a Rule in accordance with the applicable provisions of the law relating to public records.

1. Will the proposed Rule affect the stability of the family? No.
2. Will the proposed Rule affect the authority and rights of parents regarding the education and supervision of their children? No.
3. Will the proposed Rule affect the functioning of the family? No.
4. Will the proposed Rule affect family earnings and family budget? No.
5. Will the proposed Rule affect the behavior and personal responsibility of children? No.
6. Is the family or a local government able to perform the function as contained in the proposed Rule? Yes.

Poverty Impact Statement

In accordance with Section 973 of Title 49 of the Louisiana Revised Statutes, there is hereby submitted a Poverty Impact Statement on the Rule proposed for adoption, amendment, or repeal. All Poverty Impact Statements shall be in writing and kept on file in the state agency which has adopted, amended, or repealed a Rule in accordance with the applicable provisions of the law relating to public records. For the purposes of this Section, the word "poverty" means living at or below one hundred percent of the federal poverty line.

1. Will the proposed Rule affect the household income, assets, and financial security? No.
2. Will the proposed Rule affect early childhood development and preschool through postsecondary education development? Yes.
3. Will the proposed Rule affect employment and workforce development? No.
4. Will the proposed Rule affect taxes and tax credits? No.
5. Will the proposed Rule affect child and dependent care, housing, health care, nutrition, transportation, and utilities assistance? No.

Provider Impact Statement

The proposed Rule should not have any known or foreseeable impact on providers as defined by HCR 170 of 2014 Regular Legislative Session. In particular, there should be no known or foreseeable effect on:

1. the effect on the staffing level requirements or qualifications required to provide the same level of service;
2. the total direct and indirect effect on the cost to the providers to provide the same level of service; or
3. the overall effect on the ability of the provider to provide the same level of service.

Small Business Statement

The impact of the proposed Rule on small businesses as defined in the Regulatory Flexibility Act has been considered. It is estimated that the proposed action is not expected to have a significant adverse impact on small businesses. The agency, consistent with health, safety, environmental and economic welfare factors has considered and, where possible, utilized regulatory methods in the drafting of the proposed Rule that will accomplish the objectives of applicable statutes while minimizing the adverse impact of the proposed Rule on small businesses.

Public Comments

Interested persons may submit written comments via the U.S. Mail until 4:30 p.m., July 9, 2014, to Heather Cope, Board of Elementary and Secondary Education, P.O. Box 94064, Capitol Station, Baton Rouge, LA 70804-9064.

Heather Cope
Executive Director

**FISCAL AND ECONOMIC IMPACT STATEMENT
FOR ADMINISTRATIVE RULES
RULE TITLE: Bulletin 746—Louisiana Standards for
State Certification of School Personnel**

- I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)
The proposed policy will have no effect on state or local governmental units. The proposed policy changes revise the existing Praxis exams that are currently administered and required for teacher licensure. Praxis exams are regenerated on a five-year cycle or on an as-needed basis.
- II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)
This policy will have no effect on revenue collections of state or local governmental units.
- III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)
There will be no estimated cost and/or economic benefit to directly affected persons or non-governmental groups.
- IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)
This policy will have no effect on competition and employment.

Beth Scioneaux
Deputy Superintendent
1406#026

Evan Brasseaux
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

Board of Elementary and Secondary Education

Bulletin 741 (Nonpublic)—Louisiana Handbook for Nonpublic School Administrators (LAC 28:LXXIX.2102, 2109, and Chapter 23)

In accordance with R.S. 49:950 et seq., the Administrative Procedure Act, notice is hereby given that the Board of Elementary and Secondary Education approved for advertisement revisions to Bulletin 741 (Nonpublic)—Louisiana Handbook for Nonpublic School Administrators: §121, Emergency Planning and Procedures; §2109, High School Graduation Requirements; §2305, Art; §2313, English; §2317, Foreign Languages; §2319, Health and Physical Education; §2323, Mathematics; §2325, Music; §2329, Science; §2331, Social Studies; and §2337, Theatre Arts. The proposed policy revisions align the high school courses required for the college diploma with the courses required for TOPS as listed in Act 359 of the 2013 Regular Session of the Legislature.

Title 28

EDUCATION

Part LXXIX. Bulletin 741 (Nonpublic)—Louisiana Handbook for Nonpublic School Administrators—Programs of Study

Chapter 21. Curriculum and Instruction

Subchapter A. General

§2102. Carnegie Credit and Credit Flexibility

A. - D. ...

E. Students meeting the requirements for Carnegie credit based on proficiency shall have the course title, the year proficiency was demonstrated, grade earned, and the unit of credit earned entered on their transcript.

1. School systems shall determine whether to award the letter grade earned on the proficiency assessment(s) or a P (pass) when a student demonstrates proficiency.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:6(A)(10), (11), and (15), R.S. 17:7(6), R.S. 17:10, and R.S. 17:22(6).

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 39:1444 (June 2013), amended LR 40:276 (February 2014), LR 40:

Subchapter C. Secondary Schools

§2109. High School Graduation Requirements

A. For incoming freshmen in 2009-2010 and beyond, the 24 units required for graduation shall include 16 required units and 8 elective units for the Louisiana Basic Core Curriculum, or 21 required units and 3 elective units for the Louisiana Core 4 Curriculum.

B. Beginning with incoming freshmen in 2009-2010, all ninth graders will be enrolled in the Louisiana Core 4 Curriculum.

1. After the student has attended high school for a minimum of two years, as determined by the school, the student, the student's parent, guardian, or custodian may request that the student be exempt from completing the Louisiana Core 4 Curriculum.

2. The following conditions shall be satisfied for consideration of the exemption of a student from completing the Louisiana Core 4 Curriculum.

a. The student, the student's parent, guardian, or custodian and the school counselor (or other staff member who assists students in course selection) shall meet to discuss the student's progress and determine what is in the student's best interest for the continuation of his educational pursuit and future educational plan.

b. During the meeting, the student's parent, guardian, or custodian shall determine whether the student will achieve greater educational benefits by continuing the Louisiana Core 4 Curriculum or completing the Louisiana Core Curriculum.

c. The student's parent, guardian, or custodian shall sign and file with the school a written statement asserting their consent to the student graduating without completing the Louisiana Core 4 Curriculum and acknowledging that one consequence of not completing the Louisiana Core 4 Curriculum may be ineligibility to enroll in into a Louisiana four-year public college or university. The statement will then be approved upon the signature of the principal or the principal's designee.

3. The student in the Louisiana Core Curriculum may return to the Louisiana Core 4 Curriculum, in consultation with the student's parent, guardian, or custodian and the school counselor (or other staff member who assists students in course selection).

4. After a student who is 18 years of age or older has attended high school for two years, as determined by the school, the student may request to be exempt from completing the Louisiana Core 4 Curriculum by satisfying the conditions cited in Subparagraph 2.c with the exception of the requirement for the participation of the parent, guardian, or custodian, given that the parent/guardian has been notified.

C. For incoming freshmen in 2009-2010 through 2013-2014 who are completing the Louisiana Core 4 Curriculum, the minimum course requirements shall be the following:

1. English—4 units, shall be English I, II, III, and IV;

2. mathematics—4 units, shall be:

a. algebra I (1 unit) or algebra I-Pt. 2;

b. geometry;

c. algebra II;

d. the remaining unit shall come from the following: financial mathematics, math essentials, advanced mathematics-pre-calculus, advanced mathematics-functions and statistics, pre-calculus, calculus, probability and statistics, discrete mathematics, AP Calculus BC, or a locally-initiated elective approved by BESE as a math substitute;

3. science—4 units, shall be:

a. biology;

b. chemistry;

c. 2 units from the following courses: physical science, integrated science, physics I, physics of technology I, aerospace science, biology II, chemistry II, earth science, environmental science, physics II, physics of technology II, agriscience II, anatomy and physiology, or a locally initiated elective approved by BESE as a science substitute;

i. students may not take both integrated science and physical science.

ii. agriscience I is a prerequisite for agriscience II and is an elective course;

4. social studies—4 units, shall be:
 - a. 1 unit of civics or AP American government, or 1/2 unit of civics or AP American Government and 1/2 unit of free enterprise;
 - b. 1 unit of U.S. history;
 - c. 1 unit from the following: world history, world geography, western civilization, or AP European history;
 - d. 1 unit from the following: world history, world geography, western civilization, AP European history, law studies, psychology, sociology, African American studies, economics, world religions, history of religion, or religion I, II, III, or IV;
5. health and physical education—2 units;
6. foreign language—2 units, shall be 2 units from the same foreign language or two speech courses;
7. arts—1 unit, shall be one unit of art (§2305), dance (§2309), media arts (§2324), music (§2325), theatre, or fine arts survey;

NOTE: Students may satisfy this requirement by earning half credits in two different arts courses.

8. electives—3 units;
 9. total—24 units.
- D. For incoming freshmen in 2009-2010 and beyond who are completing the Louisiana Basic Core Curriculum, the minimum course requirements for graduation shall be the following.

1. English—4 units, shall be English I, II, III, and IV or senior applications in English.
2. Mathematics—4 units, shall be:
 - a. algebra I (1 unit) or algebra I-pt. 1 and algebra I-pt. 2 (2 units);
 - b. geometry;
 - c. the remaining units shall come from the following:
 - i. algebra II;
 - ii. financial mathematics;
 - iii. math essentials;
 - iv. advanced mathematics-pre-calculus;
 - v. advanced mathematics-functions and statistics;
 - vi. pre-calculus;
 - vii. calculus;
 - viii. probability and statistics;
 - ix. discrete mathematics; or
 - x. a locally initiated elective approved by BESE as a math substitute.

3. Science—3 units, shall be:
 - a. biology;
 - b. 1 unit from the following physical science cluster:
 - i. physical science;
 - ii. integrated science;
 - iii. chemistry I;
 - iv. physics I;
 - v. physics of technology I;
 - c. 1 unit from the following courses:
 - i. aerospace science;
 - ii. biology II;
 - iii. chemistry II;
 - iv. earth science;
 - v. environmental science;
 - vi. physics II;
 - vii. physics of technology II;

- viii. agriscience II;
- ix. anatomy and physiology;
- x. an additional course from the physical science cluster; or
- xi. a locally initiated elective approved by BESE as a science substitute.

(a). Students may not take both integrated science and physical science.

(b). Agriscience I is a prerequisite for agriscience II and is an elective course.

4. Social Studies—3 units, shall be:
 - a. 1 unit of civics and/or AP American government, or 1/2 unit of civics or AP American government and 1/2 unit of free enterprise;
 - b. 1 unit of U.S. history;
 - c. 1 unit from the following: world history, world geography, western civilization, or AP European history.
5. Health and physical education—2 units.
6. Electives—8 units.
7. Total—24 units.

E. For incoming freshmen in 2014-2015 and beyond who are completing the Louisiana Core 4 Curriculum, the minimum course requirements shall be the following.

1. English—4 units:
 - a. English I;
 - b. English II;
 - c. one of the following:
 - i. English III;
 - ii. AP English language arts and composition;
 - iii. English III IB;
 - d. one of the following:
 - i. English IV;
 - ii. AP English literature and composition;
 - iii. English IV IB.
2. Mathematics
 - a. algebra I;
 - b. geometry;
 - c. algebra II;

NOTE: Integrated Mathematics I, II, and III may be substituted for the Algebra I, Geometry, and Algebra II sequence.

- d. one of the following:
 - i. algebra III;
 - ii. advanced math—functions and statistics;
 - iii. advanced math—pre-calculus;
 - iv. pre-calculus;
 - v. math methods I IB (mathematical studies SL);
 - vi. calculus;
 - vii. AP calculus AB;
 - viii. math methods II IB;
 - ix. AP calculus BC;
 - x. AP statistics;
 - xi. IB further mathematics HL;
 - xii. IB mathematics HL.
3. Science—4 units:
 - a. biology I;
 - b. chemistry I;
 - c. 2 units chosen from the following:
 - i. earth science;
 - ii. environmental science;
 - iii. physical science;

- iv. agriscience II—the elective course agriscience I is a pre-requisite;
 - v. one of:
 - (a). chemistry II;
 - (b). AP chemistry;
 - (c). IB chemistry II;
 - vi. one of:
 - (a). AP physics C: electricity and magnetism;
 - (b). AP physics C: mechanics;
 - (c). IB physics II;
 - vii. AP physics I and AP physics II;
 - viii. one of:
 - (a). biology II;
 - (b). AP biology;
 - (c). IB biology II.
4. Social Studies—4 units:
- a. 1 unit chosen from:
 - i. U.S. history;
 - ii. AP U.S. history;
 - iii. IB U.S. history;
 - b. 1 unit chosen from:
 - i. 1 unit of civics with a section on free enterprise; or
 - ii. 1/2 unit of:
 - (a). government; or
 - (b). AP U.S. government and politics: comparative; or
 - (c). AP U.S. government and politics: United States; and
 - iii. 1/2 unit of:
 - (a). economics;
 - (b). AP macroeconomics; or
 - (c). AP microeconomics;
 - b. 2 units chosen from:
 - i. one of:
 - (a). European history;
 - (b). AP European history; or
 - (c). western civilization;
 - ii. one of:
 - (a). world geography;
 - (b). AP human geography; or
 - (c). IB geography; or
 - iii. one of:
 - (a). world history;
 - (b). AP world history;
 - (c). world history IB;
 - iv. history of religion;
 - v. IB economics.
5. Foreign language—2 units:
- a. 2 units from the same language.
6. Art—1 unit chosen from the following:
- a. art (§2333);
 - b. music (§2355);
 - c. dance (§2337);
 - d. theatre (§2369);
 - e. speech III and IV—one unit combined;
 - f. fine arts survey.
7. Health and physical education—2 units.

8. Electives—3 units.

9. Total—24 units.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:6(A)(10), (11), and (15), R.S. 17:7(6), R.S. 17:10, R.S. 17:22(6), R.S. 17:391.1-391.10, and R.S. 44:411.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 29:2351 (November 2003), amended LR 30:2776 (December 2004), LR 31:3081 (December 2005), LR 34:2099 (October 2008), LR 36:2849 (December 2010), LR 37:2142, 2144 (July 2011), repromulgated LR 37:2390 (August 2011), amended LR 37:2597 (September 2011), LR 38:769 (March 2012), LR 38:1008 (April 2012), LR 39:1444 (June 2013), LR 40:

§2305. Art

A. Art course offerings shall be as follows.

Course Title	Unit(s)
Art I, II, III, IV	1 each
AP Art Studio 3-D Design	1
AP Art History	1
Fine Arts Survey	1
AP Studio Art: 2-D Design	1
AP Studio Art: 3-D Design	1
AP Studio Art: Drawing	1
Art Design III IB	1
Art Design IV IB	1

B. Fine Arts Survey (Art). Fine arts survey shall be taught by a qualified art teacher and the other semester by a qualified music teacher. If one or both of these teachers is not available, the principal is authorized to select the most qualified teacher, preferably one with a strong liberal arts or humanities background.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:6 (A)(10), (11), (15); R.S. 17:7(6); R.S. 17:10; R.S. 17:22(6); R.S. 17:391.1-391.10; R.S. 17:411.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 29:2353 (November 2003), amended LR 31:3085 (December 2005), LR 37:2143 (July 2011), LR 40:

§2313. English

A. The English course offerings shall be as follows.

Course Title(s)	Units
English I, II, III, and IV	1 each
Business English (for incoming freshmen prior to 2008-2009)	1
Senior Applications in English	1
Reading I	1
Reading II	1
English as a Second Language (ESL) I, II, III, and IV	1 each
AP English Language Arts and Composition	1
AP English Literature and Composition	1
English III IB	1
English IV IB	1

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:6(A)(10), (11), and (15), R.S. 17:7(6), R.S. 17:10, R.S. 17:22(6), R.S. 17:391.1-391.10, and R.S. 44:411.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 29:2353 (November 2003), amended LR 31:3085 (December 2005), LR 34:2101 (October 2008), LR 39:1448 (June 2013), LR 40:

§2317. Foreign Languages

A. The foreign language course offerings shall be as follows.

Course Title	Unit(s)
Chinese I, II, III, IV	1 each
French I, II, III, IV, V	1 each
German I, II, III, IV, V	1 each
Greek I, II, III, IV	1 each
Hebrew I, II, III, IV	1 each
Italian I, II, III, IV, V	1 each
Latin I, II, III, IV, V	1 each
Russian I, II, III, IV, V	1 each
Spanish I, II, III, IV, V	1 each
Japanese I, II, III, IV	1 each
Hebrew I, II, III, IV	1 each
Arabic I, II, III, IV	1 each
AP Chinese Language and Culture	1
AP French Language and Culture	1
AP German Language and Culture	1
AP Italian Language and Culture	1
AP Japanese Language and Culture	1
AP Latin	1
AP Spanish Language and Culture	1
French IV IB	1
French V IB	1
Spanish IV IB	1
Spanish V IB	1

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:6 (A)(10), (11), (15), R.S. 17:7(6); R.S. 17:10; R.S. 17:22(6); R.S. 17:391.1-391.10; R.S. 17:411.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 29:2354 (November 2003), amended LR 31:3086 (December 2005), LR 38:770 (March 2012), LR 40:

§2319. Health and Physical Education

A. Two units of Health and Physical Education shall be required for graduation. They shall be Health and Physical Education I and Health and Physical Education II, or Adapted Physical Education for eligible special education students. The Health and Physical Education course offerings shall be as follows.

B. The physical education course offerings shall be as follows.

Course Title(s)	Units
Adapted Health and Physical Education I, II, III, IV	1 each
Health and Physical Education I, II, III, IV	1 each
Marching Band	1/2
Cheering	1/2
Extracurricular Sports	1/2
Dance Team	1/2

1. It is recommended that physical education I and II be taught in the ninth and tenth grades.

2. A minimum of 30 hours of health instruction shall be taught in each of the two required health and physical education units.

3. Cardiopulmonary resuscitation (CPR) is required.

B. No more than four units of health and physical education shall be allowed for meeting high school graduation requirements.

C. In schools having approved Junior Reserve Officer Training Corps (R.O.T.C.) training, credits may, at the option of the local school board, be substituted for the required credits in health and physical education, including required hours in health instruction.

D. Marching band, cheering, extracurricular sports, and dance team may be substituted for physical education II credit and shall:

1. include a minimum of 100 minutes of physical activity per week,

2. encourage the benefits of a physically active lifestyle, and

3. include a minimum of 15 hours of Health Instruction per each one-half unit that may be taught in conjunction with the activity or separately.

E. Students shall be exempted from the requirements in health and physical education for medical reasons only; however, the minimum number of credits required for graduation shall remain 24.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:6(A)(10), (11), and (15), R.S. 17:7(6), R.S. 17:10, R.S. 17:22(6), R.S. 17:391.1-391.10, and R.S. 44:411.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 29:2354 (November 2003), amended LR 31:3086 (December 2005), LR 39:1448 (June 2013), LR 40:

§2323. Mathematics

A. The mathematics course offerings shall be as follows:

Course Title	Unit(s)
Advanced Mathematics I	1
Advanced Mathematics II	1
Algebra I	1
Algebra I-Part I	1
Algebra I-Part II	1
Algebra II	1
Calculus	1
Discrete Mathematics	1
Financial Mathematics	1
Geometry	1
Integrated Mathematics I	1
Integrated Mathematics II	1
Integrated Mathematics III	1
Pre-Calculus	1
Probability and Statistics	1
Math Essentials	1
AP Calculus BC	1
AP Calculus AB	1
AP Statistics	1
Math Methods I IB (Mathematical Studies SL)	1
Math Methods II IB (Mathematics SL)	1
IB Further Mathematics HL	1
IB Mathematics HL	1

B. Financial mathematics may be taught by the Business Education Department.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:6(A)(10), (11), and (15), R.S. 17:7(6), R.S. 17:10, R.S. 17:22(6), R.S. 17:391.1-391.1, and; R.S. 44:411.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 29:2354 (November 2003), amended LR 30:2776 (December 2004), LR 31:3086 (December 2005), LR 34:2101 (October 2008), LR 36:2849 (December 2010), LR 38:771 (March 2012), LR 39:1449 (June 2013), LR 40:

§2325. Music

A. Music course offerings shall be as follows.

Course Title	Unit(s)
Beginning Band	1
Beginning Choir	1
Beginning Orchestra	1
Guitar Class	1
Intermediate Band	1
Intermediate Choir	1
Intermediate Orchestra	1
Jazz Ensemble	1
Music Theory I, II	1 each
Piano class	1
Sectional Rehearsal	1
Studio Piano, I, II, III	1 each
Advanced Band	1
Advanced Choir	1
Advanced Orchestra	1
Applied Music	1
Small Vocal Ensemble	1
Wind Ensemble	1
Sectional Rehearsal	1
Studio Strings I, II, III	1 each
Music and Media	1
Music and Technology	1
AP Music Theory	1
Music I IB	1
Music II IB	1
Marching Band	1/2

B. Advanced choir, advanced band, advanced orchestra, intermediate choir, intermediate band, intermediate orchestra, studio strings III, sectional rehearsal, small vocal ensemble, wind ensemble, applied music, jazz ensemble, and studio piano III are performance classes with new literature each year; they may be repeated more than once.

C. Refer to §2741 for credit for private piano and studio strings instruction.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:6 (A)(10), (11), (15); R.S. 17:7(6); R.S. 17:10; R.S. 17:22(6); R.S. 17:391.1-391.10; R.S. 44:411.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 29:2355 (November 2003), amended LR 31:3087 (December 2005), LR 39:1449 (June 2013), LR 40:

§2329. Science

A. The science course offerings shall be as follows.

Course Title	Unit(s)
Aerospace Science	1
Agriscience II	1
Anatomy and Physiology	1
Biology I, II	1 each
Chemistry I, II	1 each
Earth Science	1
Environmental Science	1
Integrated Science	1
Physical Science	1
Physics I, II	1 each
Physics for Technology I, II	1 each
AP Chemistry	1
IB Chemistry II	1
AP Environmental Science	1
IB Environmental Systems	1
AP Physics B	1
IB Physics I	1
AP Physics: Electricity and Magnetism	1
AP Physics C: Mechanics	1

Course Title	Unit(s)
IB Physics II	1
AP Physics I and II	1/2
AP Biology	1
IB Biology II	1

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:6 (A)(10), (11), and (15), R.S. 17:7(6), R.S. 17:10, R.S. 17:22(6), R.S. 17:391.1-391.10, and R.S. 44:411.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 29:2355 (November 2003), amended LR 31:3087 (December 2005), LR 34:2101 (October 2008), LR 39:1450 (June 2013), LR 40:

§2331. Social Studies

A. Social studies course offerings shall be as follows.

Course Title	Unit(s)
African American Studies	1
American Government	1
U.S. History	1
Civics	1 (or 1/2)
Economics	1
Free Enterprise System	1/2
Law Studies	1
Psychology	1
Sociology	1
Western Civilization	1
World Geography	1
World History	1
AP European History	1
AP US History	1
IB US History	1
AP US Government and Politics: Comparative	1/2
AP US Government and Politics: United States	1/2
AP Macroeconomics	1/2
AP Microeconomics	1/2
AP Human Geography	1
IB Geography	1
AP World History	1
World History IB	1
IB Economics	1

B. One unit of religious studies (§2335) may be used as the fourth social studies course required for the Louisiana Core 4 curriculum.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:6 (A)(10), (11), and (15), R.S. 17:7(6), R.S. 17:10, R.S. 17:22(6), R.S. 17:391.1-391.10, and R.S. 44:411.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 29:2356 (November 2003), amended LR 31:3088 (December 2005), LR 34:2102 (October 2008), LR 37:2144 (July 2011), LR 37:2598 (September 2011), LR 38:771 (March 2012), LR 39:1450 (June 2013), LR 40:

§2337. Theatre Arts

A. The theatre arts course offerings shall be as follows.

Course Title(s)	Units
Theatre I, II, III, IV	1 each
Technical Theatre	1
Theater Design and Technology	1
Talented Theatre I, II, III, IV	1 each
Film Study I IB	1
Film Study II IB	1
Theatre I IB	1

B. Theatre II, III, and IV are performance classes with new literature each year; they may be repeated more than once.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:7; R.S. 17:24.4.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 29:2356 (November 2003), amended LR 31:3088 (December 2005), LR 37:2144 (July 2011), LR 40:

Family Impact Statement

In accordance with Section 953 and 974 of Title 49 of the Louisiana Revised Statutes, there is hereby submitted a Family Impact Statement on the Rule proposed for adoption, repeal or amendment. All Family Impact Statements shall be kept on file in the state board office which has adopted, amended, or repealed a Rule in accordance with the applicable provisions of the law relating to public records.

1. Will the proposed Rule affect the stability of the family? No.
2. Will the proposed Rule affect the authority and rights of parents regarding the education and supervision of their children? No.
3. Will the proposed Rule affect the functioning of the family? No.
4. Will the proposed Rule affect family earnings and family budget? No.
5. Will the proposed Rule affect the behavior and personal responsibility of children? No.
6. Is the family or a local government able to perform the function as contained in the proposed Rule? Yes.

Poverty Impact Statement

In accordance with Section 973 of Title 49 of the Louisiana Revised Statutes, there is hereby submitted a Poverty Impact Statement on the Rule proposed for adoption, amendment, or repeal. All Poverty Impact Statements shall be in writing and kept on file in the state agency which has adopted, amended, or repealed a Rule in accordance with the applicable provisions of the law relating to public records. For the purposes of this Section, the word "poverty" means living at or below one hundred percent of the federal poverty line.

1. Will the proposed Rule affect the household income, assets, and financial security? No.
2. Will the proposed Rule affect early childhood development and preschool through postsecondary education development? Yes.
3. Will the proposed Rule affect employment and workforce development? No.
4. Will the proposed Rule affect taxes and tax credits? No.
5. Will the proposed Rule affect child and dependent care, housing, health care, nutrition, transportation, and utilities assistance? No.

Small Business Statement

The impact of the proposed Rule on small businesses as defined in the Regulatory Flexibility Act has been considered. It is estimated that the proposed action is not expected to have a significant adverse impact on small businesses. The agency, consistent with health, safety, environmental and economic welfare factors has considered and, where possible, utilized regulatory methods in the drafting of the proposed Rule that will accomplish the objectives of applicable statutes while minimizing the adverse impact of the proposed Rule on small businesses.

Provider Impact Statement

The proposed Rule should not have any known or foreseeable impact on providers as defined by HCR 170 of 2014 Regular Legislative Session. In particular, there should be no known or foreseeable effect on:

1. the effect on the staffing level requirements or qualifications required to provide the same level of service;
2. the total direct and indirect effect on the cost to the providers to provide the same level of service; or
3. the overall effect on the ability of the provider to provide the same level of service.

Public Comments

Interested persons may submit written comments via the U.S. Mail until 4:30 p.m., July 9, 2014, to Heather Cope, Board of Elementary and Secondary Education, Box 94064, Capitol Station, Baton Rouge, LA 70804-9064.

Heather Cope
Executive Director

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES

RULE TITLE: Bulletin 741 (Nonpublic)—Louisiana Handbook for Nonpublic School Administrators

- I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)
The proposed policy will have no effect on state or local governmental units.
The proposed policy revisions align the high school courses required for the Louisiana Core 4 diploma with the courses required for TOPS as listed in Act 359 of the 2013 Regular Session of the Legislature.
- II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)
This policy will have no effect on revenue collections of state or local governmental units.
- III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)
There will be no estimated cost and/or economic benefit to directly affected persons or non-governmental groups.
- IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)
This policy will have no effect on competition and employment.

Beth Scioneaux
Deputy Superintendent
1406#025

Evan Brasseaux
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

Department of Education Board of Regents

Minimum Cancellation and Refund Policy;
School Catalog; Forms (LAC 28:III.901 and 2301)

In accordance with the Administrative Procedure Act, R.S. 17:3141 et seq., notice is hereby given that the Board of Regents is amending the rules and regulations to LAC 28:III, Proprietary Schools, by codifying current practices and

procedures into administrative law to assist in the oversight of licensed Louisiana proprietary schools.

Title 28

EDUCATION

Part III. Proprietary Schools

Chapter 9. Proprietary Schools Applications

§901. Initial License or Change of Ownership License Procedures

A. Refer to the PSC-14 Form, Proprietary Schools License Requirements Checklist. Enclose one original application in a binder, with tabs of the applicable items as listed on the PSC-14.

B. Louisiana Minimum Cancellation and Refund Policy

1. Three-Business-Day Cancellation. All monies paid by a student shall be refunded if requested within three business days after signing an enrollment agreement and making an initial payment.

2. Cancellation after the Three-Business-Day Cancellation Period but Before Commencement of Classes by the Student. If tuition or fees are collected in advance of entrance, and if the student does not begin classes, not more than a \$150 registration fee shall be retained by the institution. Appropriate refunds shall be made within 30 days of the start of the quarter, term, or semester.

3. For programs less than 300 clock hours, the withdrawal after commencement of classes refund policy shall be:

a. after a student has completed less than 15 percent of the program, the institution shall refund at least 80 percent of the tuition, less the registration fee, thereafter;

b. after a student has completed less than one fourth of the program, the institution shall refund at least 70 percent of the tuition, less the registration fee, thereafter;

c. after a student has completed one fourth, but less than one half of the program, the institution shall refund at least 45 percent of the tuition, less the registration fee, thereafter;

d. after a student has completed one half or more of the program, the institution may retain 100 percent of the stated program price.

4. Any unused portion of the book fee will be refunded.

5. For programs 300 clock hours or longer, the withdrawal after commencement of classes refund policy shall be:

a. during the first week of the program, the institution shall refund at least 90 percent of the tuition, less the registration fee, thereafter;

b. during the next three weeks of the program, the institution shall refund at least 75 percent of the tuition, less the registration fee, thereafter;

c. during the first 25 percent of the program, the institution shall refund at least 55 percent of the tuition, less the registration fee, thereafter;

d. during the second 25 percent of the program, the institution shall refund at least 30 percent of the tuition, less the registration fee, thereafter;

e. during the third and fourth 25 percent of the program, the institution shall retain 100 percent of the stated program price. Percentages of the program completion are to be computed on the basis of clock hour. For programs longer than one year (12 calendar months) in length, 100 percent of

the stated program price attributable to the period beyond the first year will be refunded when the student withdraws during the prior period.

6. Any unused portion of the book fee will be refunded.

C. Items to be Included in School Catalog

1. A prospective student is entitled to sufficient data to make an informed decision on training opportunities and institutions. A school is therefore obligated to provide sufficiently detailed information in advance of enrollment to enable prospective students to clearly understand their opportunities, limitations, and obligations.

2. Each school shall prepare and make available a typed and bound publication which is readily identifiable as a catalog and each student shall receive a copy. This catalog shall be designed and written to convey accurate information on the school. It shall avoid false, misleading, or exaggerated statements.

3. The following items shall be listed in the catalog:

a. the name, address, phone number, email, and fax of school;

b. the date of publication;

c. a statement of institutional philosophy;

d. licensure statement;

e. the admission requirements and procedures;

f. the educational objectives of each program offering, including the name, nature, and level of occupations for which training is provided;

g. a detailed program outline for each program of study that includes subject abbreviations and numbers, subject titles, the number of clock and/or credit hours of instruction in lecture, lab, and/or clinical/externship, and the length of time in weeks or months normally required for completion;

h. the subject descriptions for each program of study;

i. a brief description of the school's physical facilities, equipment to be used in class, and the maximum class size;

j. the school policies relative to tardiness, absences, make-up work, conduct, termination, re-entry, and other rules and regulations of the school;

k. the grading system, including a definition of ratings;

l. the required levels of performance for graduation;

m. a statement of certificates, diplomas, or degrees awarded upon graduation;

n. a statement of student charges related to enrollment: registration fee, tuition, book fee, lab fee, and any other charges for which a student will be responsible;

o. a statement of the cancellation and refund policy of the school;

p. a detailed and explicit description of the extent and nature of job placement assistance that is available to graduates, if any;

q. specifics describing the availability of residential housing, vocational counseling services, scholarships, and the extent of other services available to students, if any;

r. a school calendar including holidays and other dates of importance;

s. the school's student complaint procedure;

t. any other facts concerning the school and its programs of instruction.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:3141.4, R.S. 17:3141.5.

HISTORICAL NOTE: Promulgated by the Department of Education, Board of Regents, LR 33:1862 (September 2007), amended by the Department of Education, Board of Regents, Proprietary School Section, LR 40:

Chapter 23. Forms

§2301. Proprietary Schools Licensure Forms

A. The following forms have been adopted by the Commission.

1. PSC-1 Proprietary School Application. The applicant shall complete the following items of the PSC-1 form:

- a. name and contact information of institution;
- b. method of instruction;
- c. accreditation;
- d. classification of school;
- e. owner name and contact information;
- f. programmatic information; and
- g. instructional staff.

2. PSC-2 Notarized Commitment Statement. The applicant shall complete the following items of the PSC-2 form:

- a. name of institution;
- b. name of owner(s);
- c. name and contact information of statutory agent;
- d. signature and title of school official; and
- e. name, signature, and seal of notary.

3. PSC-3 Surety Bond for Certificate of Registration. The applicant shall complete the following items of the PSC-3 form:

- a. bond number;
- b. name and location of principal;
- c. name of surety and state of organization;
- d. name of principal;
- e. signature and title of school official;
- f. attorney-in-fact; and
- g. name, address, and phone number of insurance or bonding agency.

4. PSC-4 Application for Solicitor Permit. The applicant shall complete the following items of the PSC-4 form:

- a. name and contact information of applicant;
- b. employment history;
- c. education;
- d. required references;
- e. attestation of applicant's criminal history;
- f. signature of applicant;
- g. signature and seal of notary; and
- h. employer's certificate.

5. PSC-5 Surety Bond for Solicitor's Permit. The applicant shall complete the following items of the PSC-5 form:

- a. bond number;
- b. name and location of principal;
- c. name of surety and state of organization;
- d. name, signature, and title of principal;
- e. attorney-in-fact; and
- f. name, address, and phone number of insurance or bonding agency.

6. PSC-6 Blanket Bond for Solicitor(s) Permit. The applicant shall complete the following items of the PSC-6 form:

- a. bond number;
- b. name and location of proprietary school;
- c. name of surety and state of organization;
- d. bond coverage amount;
- e. name of principal;
- f. signature and title of school official;
- g. attorney-in-fact; and
- h. name, address, and phone number of insurance or bonding agency.

7. PSC-9 Personnel Affidavit. The applicant shall complete the following items of the PSC-9 form:

- a. name and contact information of applicant;
- b. proposed date of employment;
- c. name and address of proprietary school;
- d. position;
- e. subjects to be taught;
- f. employment history;
- g. education;
- h. required references;
- i. signature of applicant;
- j. places of residence for the past five years;
- k. attestation of applicant's criminal history; and
- l. signature and seal of notary.

8. PSC-11 Application for Associate in Occupational Studies Degree. The applicant shall complete the following items of the PSC-11 form:

- a. title of associate in occupational studies degree proposal;
- b. name and location of proprietary school;
- c. name and address of institution;
- d. signature and title of school official; and
- e. name, signature, and seal of notary.

9. PSC-12 Annual Renewal Fee Affidavit. The applicant shall complete the following items of the PSC-12 form:

- a. name and location of proprietary school;
- b. attestation of the dates of the previous business year and the gross tuition collected;
- c. number of students enrolled in the previous business year;
- d. number of students graduated in the previous business year;
- e. signature and title of school official;
- f. name, signature, and seal of notary; and
- g. enrollment data.

10. PSC-13 Annual Student Protection Fee. The applicant shall complete the following items of the PSC-13 form.

- a. name and location of proprietary school;
- b. attestation of the dates of the previous business year and the gross tuition collected;
- c. signature and title of school official; and
- d. name, signature, and seal of notary.

11. PSC-14 Proprietary School License Requirements Checklist. The applicant shall complete the following items of the PSC-14 form:

- a. PSC-1 form;
- b. PSC-2 form;

c. copy of documents from the Office of the Secretary of State validating legal structure and any other documentation as required;

d. current audited balance sheet of the school prepared by an independent CPA licensed in the state of Louisiana;

e. inventory list of equipment available for each course of study;

f. copies of all enrollment contracts or agreements with a minimum cancellation and refund policy that has been approved by the commission;

g. copies of all circulars, brochures, bulletins, certificates, diplomas, and advertising copy for all media;

h. copy of school catalog;

i. PSC-3 form;

j. copy of bill of sale (for change of ownership applications only);

k. PSC-6 or PSC-5 form;

l. license fee;

m. student protection fund fee;

n. solicitor fee;

o. PSC-4;

p. PSC-9;

q. copy of detailed program outline and subject descriptions for each program of study;

r. copy of fee schedule for each program of study;

s. narrative geographic description of school location;

t. copy of certificate of occupancy;

u. PSC-17 form; and

v. business plan.

12. PSC-15 Student Claim Form. The applicant shall complete the following items of the PSC-15 form:

a. name and contact information of claimant;

b. name and contact information of next of kin;

c. name and address of school claim filed against;

d. course of instruction;

e. student's enrollment status at time of closure;

f. dates of attendance;

g. graduation status;

h. claimant's attendance status within 90 days of school closure;

i. reason for leaving/withdrawing;

j. method of payment to school;

k. name and address lender if applicable;

l. claimant's signature and social security number; and

m. date of claim.

13. PSC-17 Initial License Tuition Refund Affidavit. The applicant shall complete the following items of the PSC-17 form:

a. legal structure of school;

b. name of proprietary school and/or name of corporation and state of incorporation;

c. signature of owner(s) and/or name and signature of corporate secretary; and

d. name, signature, and seal of notary;

14. PSC-18 License Renewal Tuition Refund Affidavit. The applicant shall complete the following items of the PSC-18 form:

a. legal structure of school;

b. name of proprietary school and/or name of corporation and state of incorporation;

c. attestation of payable tuition refunds;

d. signature of owner(s) and/or name and signature of corporate secretary; and

e. name, signature, and seal of notary;

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:3141.3(E), R.S. 17:3141.3(D)(2).

HISTORICAL NOTE: Promulgated amended by the Department of Education, Board of Regents, Proprietary School Section, LR 40:

Family Impact Statement

In compliance with Act 1183 of the 1999 Regular Session of the Louisiana Legislature, the impact of this proposed Rule on the family has been considered. This proposed Rule has a positive impact on family functioning, stability, or autonomy as described in R.S. 49:972 by allowing waiver service recipients within active duty military families to return to Louisiana and have preferential assignment to available waiver opportunities.

Poverty Impact Statement

The proposed Rule should not have any known or foreseeable impact on any child, individual or family as defined by R.S. 49:973(B). In particular, there should be no known or foreseeable effect on:

1. the effect on household income, assets, and financial security;

2. the effect on early childhood development and preschool through postsecondary education development;

3. the effect on employment and workforce development;

4. the effect on taxes and tax credits;

5. the effect on child and dependent care, housing, health care, nutrition, transportation, and utilities assistance.

Provider Impact Statement

The proposed Rule should not have any known or foreseeable impact on providers as defined by HCR 170 of the 2014 Regular Legislative Session. In particular, there should be no known or foreseeable effect on:

1. the effect on the staffing level requirements or qualifications required to provide the same level of service;

2. the total direct and indirect effect on the cost to the provider to provide the same level or service; or

3. the overall effect on the ability of the provider to provide the same level of service.

Public Comments

Interested persons may submit written comments to Larry Tremblay, Deputy Commissioner for Planning, Research, and Academic Affairs, Louisiana Board of Regents, P.O. Box 3677, Baton Rouge, LA, 70821, by July 20, 2014. He is responsible for responding to inquiries regarding this proposed Rule.

Larry Tremblay
Deputy Commissioner

**FISCAL AND ECONOMIC IMPACT STATEMENT
FOR ADMINISTRATIVE RULES**

**RULE TITLE: Minimum Cancellation and
Refund Policy; School Catalog; Forms**

- I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENTAL UNITS (Summary)
There are no estimated implementation costs or savings to state or local governmental units as a result of these changes. There is no fiscal impact because the changes are technical in nature and do not fundamentally alter the regulation of proprietary schools in Louisiana.
- II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)
This rule update has no effect on revenue collections of state or local governmental units. The rule update included no changes to fees, fines, or other charges.
- III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)
This rule update has no costs and/or economic benefits to directly affected persons or non-governmental groups. The rule update included no changes to fees, fines, or other charges.
- IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)
This rule update has no effect on competition and employment.

Larry Tremblay
Deputy Commissioner
1406#047

Evan Brasseaux
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

**Tuition Trust Authority
Office of Student Financial Assistance**

START Saving Program (LAC 28:VI.315)

The Louisiana Tuition Trust Authority announces its intention to amend its START Saving Program rules (LSA-R.S. 17:3091 et seq.).

This rulemaking adds the applicable interest rates for the 2013 calendar year. (ST14153NI)

**Title 28
EDUCATION**

**Part VI. Student Financial Assistance—Higher
Education Savings**

Chapter 3. Education Savings Account

§315. Miscellaneous Provisions

A. - B.28. ...

29. For the year ending December 31, 2013, the Louisiana Education Tuition and Savings Fund earned an interest rate of 2.168 percent.

30. For the year ending December 31, 2013, the Savings Enhancement Fund earned an interest rate of 1.715 percent.

C. - S.2. ...

AUTHORITY NOTE: Promulgated in accordance with 17:3091-3099.2.

HISTORICAL NOTE: Promulgated by the Tuition Trust Authority, Office of Student Financial Assistance, LR 23:712 (June 1997), amended LR 24:1268 (July 1998), LR 25:1794 (October

1999), LR 26:2260 (October 2000), LR 27:37 (January 2001), LR 27:1222 (August 2001), LR 27:1876 (November 2001), LR 28:450 (March 2002), LR 28:777 (April 2002), LR 28:2334 (November 2002), LR 29:556 (April 2003), LR 30:786 (April 2004), LR 30:1169 (June 2004), LR 30:2302 (October 2004), LR 31:639 (March 2005), LR 32:1433 (August 2006), LR 32:2240 (December 2006), LR 33:443 (March 2007), LR 34:1885 (September 2008), LR 35:1492 (August 2009), LR 36:492 (March 2010), LR 36:2030 (September 2010), LR 38:1954 (August 2012), LR 39:2238 (August 2013), LR 40:

Family Impact Statement

The proposed Rule has no known impact on family formation, stability, or autonomy, as described in R.S. 49:972.

Poverty Impact Statement

The proposed rulemaking will have no impact on poverty as described in R.S. 49:973.

Small Business Statement

The proposed Rule will have no adverse impact on small businesses as described in R.S. 49:965.2 et seq.

Public Comments

Interested persons may submit written comments on the proposed changes (SG14153NI) until 4:30 p.m., July 10, 2014, to Sujuan Williams Boutté, Executive Director, Office of Student Financial Assistance, P.O. Box 91202, Baton Rouge, LA 70821-9202.

George Badge Eldredge
General Counsel

**FISCAL AND ECONOMIC IMPACT STATEMENT
FOR ADMINISTRATIVE RULES**

RULE TITLE: START Saving Program

- I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENTAL UNITS (Summary)
There are no estimated implementation costs or savings to state or local governmental units. This proposed change places in rule the actual earnings realized by START account owners who invested in the Louisiana Principal Protection investment option and the actual earnings realized on the investment of Earnings Enhancements. This increase in START funds belongs to the account owner (it is not state general fund money), and no expenditure of state general funds is required.
- II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)
Revenue collections of state and local governments will not be affected by the proposed changes.
- III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)
These changes adopt interest rates for deposits and earnings enhancements for the year ending December 31, 2013. START account holders earned slightly less than in the previous year.
- IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)
There are no anticipated effects on competition and employment resulting from these measures.

George Eldredge
General Counsel
1406#005

Evan Brasseaux
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

**Department of Environmental Quality
Office of the Secretary
Legal Division**

Ambient Air Quality (LAC 33:III.711 and 918)(AQ344ft)

Under the authority of the Environmental Quality Act, R.S. 30:2001 et seq., and in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., the secretary gives notice that rulemaking procedures have been initiated to amend the Air regulations, LAC 33:III.711 and 918 (Log #AQ344ft).

This Rule is identical to federal regulations found in 40 CFR 50.5; 50.11; 50.15; 50.16; 50.17; 50.18 and 78, which are applicable in Louisiana. For more information regarding the federal requirement, contact the Regulation Development Section at (225) 219-3985 or Box 4302, Baton Rouge, LA 70821-4302. No fiscal or economic impact will result from the Rule. This Rule will be promulgated in accordance with the procedures in R.S. 49:953(F)(3) and (4).

This Rule includes LAC 33:III, Chapter 7. Ambient Air Quality, 711. Table 1, 1a, and 2 Also included in this Rule is Chapter 9. General Regulations on Control of Emission and Emission Standards, 918.B, Table 6. These revisions update the National Ambient Air Quality Standards (NAAQS) for certain criteria pollutants (ozone, particular matter (2.5), nitrogen oxide, lead and sulfur dioxide) and the Louisiana designated nonattainment area for the sulfur dioxide standard.

The Clean Air Act (CAA) directs EPA to propose and promulgate primary and secondary NAAQS (section 109) and to designate areas following promulgation of a new or revised NAAQS (section 107). To reflect the most current federal revisions to the NAAQS and nonattainment designated area(s) as promulgated by EPA, Louisiana is adopting the updated standards and is specifically updating the nonattainment area as it relates to the 2010 sulfur dioxide standard.

This Rule is necessary to maintain equivalency with the federal regulations and/or standards and to enable Louisiana to carry out its duty as required under R.S. 30:2054 and the provisions of the CAA and State Implementation Plan (SIP) to implement, maintain and enforce the NAAQS in each affected region within the state. The basis and rationale for this Rule are to update the NAAQS and to specify the designated nonattainment area to mirror federal regulations as they apply to Louisiana's affected sources. This Rule meets an exception listed in R.S. 30:2019(D)(2) and R.S. 49:953(G)(3); therefore, no report regarding environmental/health benefits and social/economic costs is required.

**Title 33
ENVIRONMENTAL QUALITY
Part III. Air**

**Chapter 7. Ambient Air Quality
§711. Tables 1, 1a, 2—Air Quality**

A. Table 1. Primary Ambient Air Quality Standards

Air Contaminant	Maximum Permissible Concentration	
PM ₁₀	150 µg/m ³	(Maximum 24-hour concentration not to be exceeded more than once per year)
PM _{2.5}	12 µg/m ³	(Annual arithmetic mean, averaged over 3 years) The standard is met when the annual arithmetic mean concentration, as determined in accordance with appendix N of 40 CFR Part 50 is less than or equal to 12 µg/m ³ .
	35 µg/m ³	(24-hour, averaged over 3 years) The standard is met when the 98 th percentile 24-hour concentration, as determined in accordance with Appendix N of 40 CFR Part 50 is less than or equal to 35 µg/m ³ .
Sulfur Dioxide (SO ₂)	75 ppb daily maximum 1-hour concentration	The standard is met at an ambient air monitoring site when the 3-year average of the annual 99 th percentile of the daily maximum 1-hour average concentration is less than or equal to 75 ppb, as determined in accordance with 40 CFR Part 50 appendix T.
Carbon Monoxide (CO)	10,000 µg/m ³	or 9 ppm (Maximum 8-hour concentration not to be exceeded more than once per year)
	40,000 µg/m ³	or 35 ppm (Maximum 1-hour concentration not to be exceeded more than once per year)
Ozone	0.075 ppm daily maximum 8-hour average	The standard is met at an ambient air monitoring site when the 3-year average of the annual fourth highest daily maximum 8-hour average ozone concentrations is less than or equal to 0.075 ppm, as determined in accordance with 40 CFR Part 50, appendix P.
Nitrogen Dioxide (NO ₂)	53 ppb	(Annual arithmetic mean) The Standard is met when the annual arithmetic mean is less than or equal to 53 ppb, as determined in accordance with 40 CFR Part 50, appendix S.
	100 ppb	(1-hour average concentration) The standard is met when the 3-year average of the annual 98 th percentile of the daily maximum 1-hour average concentration is less than or equal to 100 ppb, as determined in accordance with 40 CFR Part 50, appendix S.
Lead	0.15 µg/m ³	(3-month rolling average) (The standard is met when the maximum arithmetic 3-month mean concentration for a 3-year period, as determined in accordance with appendix R of 40 CFR Part 50 is less than or equal to 0.15 µg/m ³ .

A.1. - 2. ...

B. Table 1a. Secondary Ambient Air Quality Standards

Air Contaminant	Maximum Permissible Concentration	
PM ₁₀	150 µg/m ³	(Maximum 24-hour concentration not to be exceeded more than once per year)

Air Contaminant	Maximum Permissible Concentration	
Sulfur Dioxide (SO ₂)	0.5 ppm	(3-hour average concentration not to be exceeded more than once per year)
PM _{2.5}	15.0 µg/m ³	(Annual arithmetic mean, averaged over 3 years) The standard is met when the annual arithmetic mean concentration, as determined in accordance with appendix N of 40 CFR Part 50 is less than or equal to 15 µg/m ³ .
	35 µg/m ³	(24-hour, averaged over 3 years) The standard is met when the 98 th percentile 24-hour concentration, as determined in accordance with appendix N of 40 CFR Part 50 is less than or equal to 35 µg/m ³ .
Carbon Monoxide (CO)	10,000 µg/m ³	or 9 ppm (Maximum 8-hour concentration not to be exceeded more than once per year)
	40,000 µg/m ³	or 35 ppm (Maximum 1-hour concentration not to be exceeded more than once per year)
Ozone	0.075 ppm daily maximum 8-hour average	The standard is met at an ambient air monitoring site when the 3-year average of the annual fourth highest daily maximum 8-hour average ozone concentrations is less than or equal to 0.075 ppm, as determined in accordance with 40 CFR Part 50, appendix P.
Nitrogen Dioxide (NO ₂)	100 µg/m ³	(0.053 ppm) (Annual arithmetic mean) The Standard is met when the annual arithmetic mean concentration in a calendar year is less than or equal to 0.053 ppm.
Lead	0.15 µg/m ³	(3-month rolling average) (The standard is met when the maximum arithmetic 3-month mean concentration for a 3-year period, as determined in accordance with appendix R of 40 CFR Part 50 is less than 0.15 µg/m ³ .

B.1. - 2 ...

C. Table 2. Ambient Air—Methods of Contaminant Measurement

Air Contaminant	Sampling Interval	Analytical Method
Carbon Monoxide	Continuous	Any method complying with reference or equivalent methods in Title 40, Code of Federal Regulations, Part 50, appendix C, and Part 53, Subpart B.
Nitrogen Dioxide	24 hours	Reference method based on appendix F to 40 CFR Part 50 or an equivalent method designated in accordance with 40 CFR Part 53.
Lead	24 hours	Reference method based on appendix G to 40 CFR Part 50 or an equivalent method designated in accordance with 40 CFR Part 53.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:2054.

HISTORICAL NOTE: Promulgated by the Department of Environmental Quality, Office of Air Quality and Nuclear Energy, Air Quality Division, LR 13:741 (December 1987), amended LR 14:348 (June 1988), amended by the Office of the Secretary, Legal Affairs Division, LR 32:1602 (September 2006), LR 34:433 (March 2008), amended by the Office of the Secretary, Legal Division, LR 40:

Chapter 9. General Regulations on Control of Emissions and Emission Standards
§918. Nonattainment Areas and Adjoining Parishes List

A. - B, Table 5. ...

Sulfur Dioxide (SO ₂) Nonattainment Areas and Adjoining Parishes	
Parish Code	Nonattainment Parish(es)
2500	St. Bernard
Parish Code	Adjoining Parishes to Nonattainment Areas
2140, 2240	Orleans and Plaquemines

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:2054.

HISTORICAL NOTE: Promulgated by the Department of Environmental Quality, Office of Air Quality and Nuclear Energy, Air Quality Division, LR 13:741 (December 1987), amended by the Office of Air Quality and Radiation Protection, Air Quality Division, LR 22:339 (May 1996), amended by the Office of Environmental Assessment, Environmental Planning Division, LR 26:2450 (November 2000), LR 29:2776 (December 2003), amended by the Office of the Secretary, Legal Affairs Division, LR 31:2438 (October 2005), LR 33:2083 (October 2007), LR 37:3221 (November 2011), amended by the Office of the Secretary, Legal Division, LR 40:

Family Impact Statement

This Rule has no known impact on family formation, stability, and autonomy as described in R.S. 49:972.

Poverty Impact Statement

This Rule has no known impact on poverty as described in R.S. 49:973.

Provider Impact Statement

This Rule has no known impact on providers as described in HCR 170 of 2014.

Public Comments

All interested persons are invited to submit written comments on the proposed regulation. Persons commenting should reference this proposed regulation by AQ344ft. Such comments must be received no later than July 29, 2014, at 4:30 p.m., and should be sent to Deidra Johnson, Attorney

Air Contaminant	Sampling Interval	Analytical Method
PM ₁₀	24 hours	Any method complying with reference method in Title 40, Code of Federal Regulations, Part 50, appendix J.
PM _{2.5}	24 hours	Reference method based on appendix L to 40 CFR Part 50 and designated in accordance with 40 CFR Part 53 or an equivalent method designated in accordance with 40 CFR Part 53.
Sulfur Dioxide	24 hours	Reference method based on appendix A-1 or A-2 to 40 CFR Part 50 or an equivalent method designated in accordance with 40 CFR Part 53.
	Continuous	Reference method based on appendix A-1 or A-2 to 40 CFR Part 50 or an equivalent method designated in accordance with 40 CFR Part 53.
Total Oxidants	Continuous	Reference method based on appendix D to 40 CFR Part 50 and designated in accordance with 40 CFR Part 53 or an equivalent method designated in accordance with 40 CFR Part 53.

Supervisor, Office of the Secretary, Legal Division, Box 4302, Baton Rouge, LA 70821-4302 or to fax (225) 219-4068 or by e-mail to deidra.johnson@la.gov. The comment period for this Rule ends on the same date as the public hearing. Copies of this proposed regulation can be purchased by contacting the DEQ Public Records Center at (225) 219-3168. Check or money order is required in advance for each copy of AQ344ft. This regulation is available on the Internet at www.deq.louisiana.gov/portal/tabid/1669/default.aspx.

This proposed regulation is available for inspection at the following DEQ office locations from 8 a.m. until 4:30 p.m.: 602 North Fifth Street, Baton Rouge, LA 70802; 1823 Highway 546, West Monroe, LA 71292; State Office Building, 1525 Fairfield Avenue, Shreveport, LA 71101; 1301 Gadwall Street, Lake Charles, LA 70615; 111 New Center Drive, Lafayette, LA 70508; 110 Barataria Street, Lockport, LA 70374; 201 Evans Road, Bldg. 4, Suite 420, New Orleans, LA 70123.

Public Hearing

A public hearing will be held on July 29, 2014, at 1:30 p.m. in the Galvez Building, Oliver Pollock Conference Room, 602 North Fifth Street, Baton Rouge, LA 70802. Interested persons are invited to attend and submit oral comments on the proposed amendments. Should individuals with a disability need an accommodation in order to participate, contact Deidra Johnson at the address given below or at (225) 219-3985. Two hours of free parking are allowed in the Galvez Garage with a validated parking ticket.

Herman Robinson, CPM
Executive Counsel

1406#016

NOTICE OF INTENT

Department of Environmental Quality Office of the Secretary Legal Division

Incorporation by Reference—LPDES Program (LAC 33:IX.4901 and 4903)(WQ089ft)

Under the authority of the Environmental Quality Act, R.S. 30:2001 et seq., and in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., the secretary gives notice that rulemaking procedures have been initiated to amend the Water Quality regulations, LAC 33:IX.4901 and 4903 (Log #WQ089ft).

This Rule is identical to federal regulations found in 40 CFR Part 136 and 40 CFR Chapter I, Subchapter N, parts 401 and 405-471, which are applicable in Louisiana. For more information regarding the federal requirement, contact the Regulation Development Section at (225) 219-3985 or P.O. Box 4302, Baton Rouge, LA 70821-4302. No fiscal or economic impact will result from the Rule. This Rule will be promulgated in accordance with the procedures in R.S. 49:953(F)(3) and (4).

This Rule is the annual incorporation by reference update of the water regulations. This Rule changes the reference dates found in 40 CFR Part 136 and 40 CFR Chapter I, Subchapter N, Parts 401, 405-471. LAC 33: IX, Chapter 49

incorporates the following portions of federal regulations into the Louisiana water quality regulations:

1. 40 CFR Part 136, Guidelines Establishing Test Procedures for the Analysis of Pollutants, July 1, 2012, in its entirety; and

2. 40 CFR Chapter I, Subchapter N, Effluent Guidelines and Standards, parts 401 and 405-471, July 1, 2012.

This action will incorporate the recently updated federal regulations into Louisiana's water quality regulations, increasing the enforceability of LPDES permits that include EPA-approved analytical methods and effluent limitations guidelines. The published edition of the 40 CFR is regularly updated on July 1 of every calendar year; therefore, this Rule will incorporate the date of July 1, 2013 in anticipation of the most recent publication, which will include the above referenced Rules. The basis and rationale for this Rule are to mirror the federal regulations. This Rule meets an exception listed in R.S. 30:2019(D)(2) and R.S. 49:953(G)(3); therefore, no report regarding environmental/health benefits and social/economic costs is required.

Title 33

ENVIRONMENTAL QUALITY

Part IX. Water Quality

Subpart 2. The Louisiana Pollutant Discharge Elimination System (LPDES) Program

Chapter 49. Incorporation by Reference

§4901. 40 CFR Part 136

A. 40 CFR Part 136, Guidelines Establishing Test Procedures for the Analysis of Pollutants, July 1, 2013, in its entirety, is hereby incorporated by reference.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:2001 et seq., and in particular Section 2074(B)(3) and (B)(4).

HISTORICAL NOTE: Promulgated by the Department of Environmental Quality, Office of Water Resources, LR 21:945 (September 1995), amended LR 23:958 (August 1997), amended by the Office of Environmental Assessment, Environmental Planning Division, LR 25:1467 (August 1999), LR 26:1609 (August 2000), LR 27:2231 (December 2001), LR 28:996 (May 2002), LR 29:700 (May 2003), repromulgated LR 30:232 (February 2004), amended LR 30:752 (April 2004), amended by the Office of Environmental Assessment, LR 31:920 (April 2005), amended by the Office of the Secretary, Legal Affairs Division, LR 32:604 (April 2006), LR 33:641 (April 2007), LR 34:867 (May 2008), LR 35:1110 (June 2009), LR 36:2275 (October 2010), amended by the Office of the Secretary, Legal Division, LR 38:2747 (November 2012), LR 40:

§4903. 40 CFR, Chapter I, Subchapter N

A. 40 CFR Chapter I, Subchapter N, Effluent Guidelines and Standards, Parts 401 and 405-471, July 1, 2013, are hereby incorporated by reference.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:2001 et seq., and in particular Section 2074(B)(3) and (B)(4).

HISTORICAL NOTE: Promulgated by the Department of Environmental Quality, Office of Water Resources, LR 21:945 (September 1995), amended LR 23:958 (August 1997), amended by the Office of Environmental Assessment, Environmental Planning Division, LR 25:1467 (August 1999), LR 26:1609 (August 2000), LR 27:2232 (December 2001), LR 28:996 (May 2002), LR 29:700 (May 2003), LR 29:1467 (August 2003), repromulgated LR 30:232 (February 2004), amended LR 30:752 (April 2004), amended by the Office of Environmental Assessment, LR 31:920 (April 2005), amended by the Office of the Secretary, Legal Affairs Division LR 32:604 (April 2006), LR 32:819 (May 2006), LR 33:641 (April 2007), LR 34:867 (May 2008), LR 35:654

(April 2009), LR 35:1110 (June 2009), LR 36:2275 (October 2010), amended by the Office of the Secretary, Legal Division, LR 38:2747 (November 2012), LR 40:

Family Impact Statement

This Rule has no known impact on family formation, stability, and autonomy as described in R.S. 49:972.

Poverty Impact Statement

This Rule has no known impact on poverty as described in R.S. 49:973.

Provider Impact Statement

This Rule has no known impact on providers as described in HCR 170 of 2014.

Public Comments

All interested persons are invited to submit written comments on the proposed regulation. Persons commenting should reference this proposed regulation by WQ089ft. Such comments must be received no later than July 29, 2014, at 4:30 p.m., and should be sent to Deidra Johnson, Attorney Supervisor, Office of the Secretary, Legal Division, P.O. Box 4302, Baton Rouge, LA 70821-4302 or to fax (225) 219-4068 or by e-mail to deidra.johnson@la.gov. The comment period for this Rule ends on the same date as the public hearing. Copies of this proposed regulation can be purchased by contacting the DEQ Public Records Center at (225) 219-3168. Check or money order is required in advance for each copy of WQ089ft. This regulation is available on the Internet at www.deq.louisiana.gov/portal/tabid/1669/default.aspx.

This proposed regulation is available for inspection at the following DEQ office locations from 8 a.m. until 4:30 p.m.: 602 North Fifth Street, Baton Rouge, LA 70802; 1823 Highway 546, West Monroe, LA 71292; State Office Building, 1525 Fairfield Avenue, Shreveport, LA 71101; 1301 Gadwall Street, Lake Charles, LA 70615; 111 New Center Drive, Lafayette, LA 70508; 110 Barataria Street, Lockport, LA 70374; 201 Evans Road, Bldg. 4, Suite 420, New Orleans, LA 70123.

Public Hearing

A public hearing will be held on July 29, 2014, at 1:30 p.m. in the Galvez Building, Oliver Pollock Conference Room, 602 North Fifth Street, Baton Rouge, LA 70802. Interested persons are invited to attend and submit oral comments on the proposed amendments. Should individuals with a disability need an accommodation in order to participate, contact Deidra Johnson at the address given below or at (225) 219-3985. Two hours of free parking are allowed in the Galvez Garage with a validated parking ticket.

Herman Robinson, CPM
Executive Counsel

1406#017

NOTICE OF INTENT

**Office of the Governor
Board of Tax Appeals**

Procedures for Out-of-State Attorneys,
Fee Schedule and Local Tax Division

The following are proposed administrative rules of the Board of Tax Appeals for the state of Louisiana. The jurisdiction of the board is authorized by R.S. 47:1407.

These rules are to be promulgated in accordance with R.S. 47:1413, which states: "In all other matters regarding the conduct of its hearings, the board may prescribe and promulgate rules and regulations not inconsistent with law or the provisions of this chapter, which rules and regulations when prescribed, adopted, and promulgated shall be binding upon parties litigant in any cause over which the jurisdiction of this board shall extend." The board reserves the right to amend, modify, waive or supplement these rules in the interest of justice.

**Rules and Regulations of Procedure and Proactive
Before the Louisiana Board of Tax Appeal
Part I.**

* * *

Rule 1.1: Attorneys Enrolling Pro Hac Vice

Attorneys appearing *pro hac vice* are instructed to comply with Rule XVII, Section 13 of the Rules of the Louisiana Supreme Court in advance of appearing in any hearing before the Board.

* * *

Rule 16: Filing Fees, Fees and Mileage of Witnesses:

I. The Board's filing fee schedule is as follows:

a) Initial Filing of Petitions:

Under \$10,000 in controversy (appealing an assessment):	\$ no filing fee
Under \$10,000 in controversy (other matters):	\$20
From \$10,000 to \$50,000 in controversy:	\$300
Over \$50,000 in controversy (and all local tax cases):	\$450

b) Additional and Supplemental Filings of Amendments, Motions, Oppositions, Memoranda, etc. (first 25 pages):

Under \$10,000 in controversy:	\$ no filing fee
From \$10,000 to \$50,000 in controversy:	\$20
Over \$50,000 in controversy (or local tax case):	\$40

c)(i) All Additional, and Supplemental Filings: \$2 per page over 25 pages

(ii) Local tax case Additional and Supplemental Filings: \$2 per page*

* This is an additional cost (ex. a total of \$4 per page over 25 pages)

d) Miscellaneous Filings and Requests

All paper exhibits:	\$2 per page
All non-paper exhibits (maps, cds, etc.)	\$5 each
Conformed or Certified Copies:	\$5
Judgment (with 1 certified copy):	\$20
Motion to Appear <i>Pro Hac Vice</i> :	\$250
Request for a Subpoena (applicant responsible for service):	\$20
Request to Approve Appeal Bond:	\$300

Unless otherwise stated in the case scheduling order, these miscellaneous fees shall not apply in any case with less

than \$10,000 in controversy, or to 25 or fewer total exhibit pages filed in any case.

e) Any Local collector who files as a petitioner pursuant to R.S. 47:337.101 shall pay any amounts payable by a taxpayer in a local tax case, except the initial filing fee shall be \$300.

f) The chairman, at his discretion, may reduce or waive any fee in the interest of justice.

II. Any witnesses subpoenaed, or whose deposition is taken under R.S. 47:1409, shall receive the same fees and mileage as witnesses in Louisiana District Courts. Such fees and mileage and the expenses of taking such deposition shall be paid as follows:

In the case of witnesses for the secretary, such payments shall be the responsibility of the Department of Revenue. In the case of any other witnesses, such payments shall be made, subject to review by the board, by the party at whose instance the witness appears or is deposed.

No witness, other than one for the Department of Revenue, may be required to testify in any proceeding before this board until he shall have been tendered the fees and mileage to which he is entitled. The board may only recognize a subpoena issued pursuant to R.S. 47:1408.

III. The board may, on its own motion, issue a Rule to Show Cause to any party concerning the non-payment of any cost or fee due to it pursuant to this Rule. Following a hearing on such Rule, notice for which has been served pursuant to R.S. 47:1411, the board may render Judgment declaring the cost or fee to be a delinquent debt and/or dismissing the party's petition.

The board may also consider a motion to tax costs in accordance with the rules of the *Louisiana Code of Civil Procedure* in the same manner as provided for in a civil case in a district court.

* * *

Part II. Waiver of Penalties

Rule 17:

At the discretion of the board, and as allowed by law, the board may approve penalty waivers submitted for its approval by the secretary of the Louisiana Department of Revenue.

* * *

Part IV. Board Operations

* * *

Rule 22. Administrative Fees and Costs

The board's administrative fees or costs are as follows:

A. The appellant is responsible for paying the stenographic fee for preparing a transcript, prepared by the board-approved stenographer at the rate of \$6.00 per page.

B. The board will furnish a copy of the transcript to the appellee at a cost of \$2.00 per page.

C. No transcripts or copies will be furnished until costs are paid in full by the party receiving same.

D. The appellant shall pay \$1.00 per page for a copy of the record sent to the District Court.

E. Any other copying requests from the Board shall be charged at the rate of \$1.00 per page.

F. The board may, for good cause, waive administrative fees and costs, except for the stenographic fees in Rule 22 (A).

Part V. Local Tax Division

Rule 23:

The rules of the board are hereby made applicable to the Local Tax Division, subject to the provisions of R.S. 47:1403 concerning the authority of the Hearing Judge of the Local Tax Division in relation to cases assigned to it by law.

For the purposes of a case in the Local Tax Division, "local collector" shall be substituted for the references in Rules 4 and 5 to the "secretary", and the name of the relevant Local collector's agency shall be substituted for the reference to the "Department of Revenue" in the sample caption.

Effective Date:

If adopted, these rules and regulations shall be effective August 1, 2014, pending approval from the Legislative Fiscal Office, and except as amended hereby, all other previously promulgated rules and regulations of the board shall remain in full force and effect, including those published in the *Louisiana Register*, Vol. 38, No. 7, commencing at page 1787, and in Vol. 39, No. 7, commencing at page 1766.

Family Impact Statement

There will be no family impact in regard to issues set forth in these rules.

Public Comments

Interested persons may submit written comments on these proposed Rule changes to Ann Faust, Secretary-Clerk, Louisiana State Board of Tax Appeals, 5615 Corporate Blvd., Ste. 600 B, Baton Rouge, LA, 70808. Written comments must be submitted to and received by the board within 20 days of the date of the publication of this notice.

Public Hearing

A public hearing will be held at 9 a.m. on July 10, 2014 at the board office at the above referenced address to receive any further comment

Judge Tony Graphia, (Ret.)
Chairman

1406#086

NOTICE OF INTENT

Department of Health and Hospitals Behavior Analyst Board

License Renewal Requirements
(LAC 46:VIII.Chapter 4)

In accordance with R.S. 49:950 et seq., the Administrative Procedure Act, notice is hereby given that the Department of Health and Hospitals, Behavior Analyst Board is creating a new Rule, LAC 46:VIII.Chapter 4, Renewal Requirements. This proposed Rule provides a procedure for licensees, certificants and registrants to renew their license, certificate or registration annually in accordance with Act 351 beginning December 2014.

Title 46
PROFESSIONAL AND OCCUPATIONAL
STANDARDS

Part VIII. Behavior Analysts

Chapter 4. License, Certification and Registration
Renewal Process

§401. Renewal Process

A. A licensed behavior analyst shall renew their current license every year by December 31 beginning in December 2014. The renewal period shall open in October and will close December 31 annually. The licensed behavior analyst must submit the required renewal forms, renewal fee and proof of fulfillment of all continuing education requirements as approved by the board.

B. A state certified assistant behavior analyst shall renew their current license every year by December 31 beginning in December 2014. The renewal period shall open in October and will close December 31 annually. The state certified assistant behavior analyst must submit the required renewal forms, renewal fee and proof of fulfillment of all continuing education requirements as approved by the board.

C. A licensed behavior analyst shall renew the registration of all registered line technicians under their supervision every year by December 31 beginning December 2014. The renewal period shall open in October and will close December 31 annually. The licensed behavior analyst in conjunction with the registered line technicians must complete the proper renewal forms accompanied with the renewal fee as determined by the board.

D. A license, certificate or registration may be valid for one year beginning January 1 through December 31 for each renewal period.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3709.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Behavior Analyst Board, LR 40:

§402. Noncompliance—Renewal Process

A. Noncompliance shall include, in part, incomplete forms, unsigned forms, failure to file all of the required renewal forms by December 31, failure to postmark the renewal package by December 31 and failure to report a sufficient number of acceptable continuing education credits as determined by the board.

B. If the license, certificate or registration is not renewed by the end of December, due notice having been given, the license, certificate, or registration shall be regarded as lapsed effective January 1. An individual shall not practice applied behavior analysis in Louisiana while the license is lapsed.

C. A lapsed license, certificate, or registration may be reinstated, at the approval of the board, if all applicable requirements have been met, along with payment of the renewal fee and a late filing fee.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3709.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Behavior Analyst Board, LR 40:

§403. Extensions/Exemptions—Renewal Process

A. The board may grant requests for renewal extensions or exemptions on a case-by-case basis. All requests must be made in writing, submitted via U.S. mail, to the board office and shall be reviewed at the next regularly scheduled board meeting.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3709.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Behavior Analyst Board, LR 40:

Family Impact Statement

The Behavior Analyst Board hereby issues this Family Impact Statement as set forth in R.S. 49:972. The proposed Rule and adoption of the Rule related to the license, certificate and renewal process is being implemented to guarantee the licensing authority can safeguard the public welfare of this state and will have no known foreseeable impact on the stability of the family; authority and rights of parents regarding the education and supervision of their children; functioning of the family; family earnings and family budget; behavior and personality responsibility of children; or the ability of the family or a local government to perform the function as contained in the proposed Rule.

Poverty Impact Statement

The proposed Rule creates a new rule, LAC 46:VIII. Chapter 4. The Rule should not have any known or foreseeable impact on any child, individual or family as defined by R.S. 49:973(B). In particular, there should be no known or foreseeable effect on:

1. the effect on household income, assets, and financial security;
2. the effect on early childhood development and preschool through postsecondary education development;
3. the effect on employment and workforce development;
4. the effect on taxes and tax credits;
5. the effect on child and dependent care, housing, health care, nutrition, transportation, and utilities assistance.

Provider Impact Statement

The proposed Rule should not have any known or foreseeable impact on providers as defined by HCR 170 of 2014 Regular Legislative Session. In particular, there should be no known or foreseeable effect on:

1. the effect on the staffing level requirements or qualifications required to provide the same level of service;
2. the total direct and indirect effect on the cost to the providers to provide the same level of service; or
3. the overall effect on the ability of the provider to provide the same level of service.

Public Comments

Interested persons may submit written comments to Kelly Parker, Executive Director, 8706 Jefferson Highway, Suite B, Baton Rouge, LA 70809. All comments must be submitted by 12 noon on July 10, 2014.

Kelly Parker
Executive Director

FISCAL AND ECONOMIC IMPACT STATEMENT
FOR ADMINISTRATIVE RULES

RULE TITLE: License Renewal Requirements

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

The proposed Rule codifies and establishes requirements enacted by Act 351 of the 2013 Legislative Session, effective August 1, 2013. Act 351 created the Louisiana Behavior Analyst Board and allowed for the establishment of licensure, certification, registration, continuing education and practice

requirements of behavior analysts, certified assistant behavior analysts and line technicians. This proposed Rule provides a procedure for licensees, certificants and registrants to renew their credentials annually beginning in December 2014. The estimated implementation cost for this Rule totals approximately \$600 in FY 14 and an ongoing annual cost of approximately \$500 in subsequent years. Those initial costs are related to publishing the proposed and final Rule in the *Louisiana Register*. The estimated annual cost for renewal supplies and office preparation for the processing of annual renewals is \$500 beginning in FY 15

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

This proposed Rule provides a procedure for licensees, certificants and registrants to renew their credentials annually beginning in December 2014 as established in Act 351. The fee schedule for renewal fees is projected to generate revenues of approximately \$50,550 SGR annually based on the current practicing population of 82 licensed behavior analysts, 7 assistant behavior analysts and 320 line technicians as of April 30, 2014.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

The proposed Rule will provide procedures for qualified individuals to renew their licensure, certification or registration. It also requires persons licensed, certified or registered under the provisions of Act 351 to be subject to the appropriate renewal fees found in Chapter 3, Section 305. Licensure and certification may provide economic benefits to individuals practicing in the field of behavioral analysis to the degree that such licensure bolsters public confidence in the area of practice.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

Individuals and businesses performing behavioral analysis services will require renewal of the licensure, certification or registration pursuant to Act 351 of the 2013 Legislative Session. Individuals failing to renew shall be unable to work in the field of behavior analysis. The impact on competition and employment statewide is unknown.

Kelly Parker
Executive Director
1406#045

Evan Brasseaux
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

**Department of Health and Hospitals
Behavior Analyst Board**

Supervision of Behavior Analysts (LAC 46:VIII.Chapter 5)

This Rule establishes the requirements for supervision of state certified assistant behavior analysts. This Rule outlines the supervising licensed behavior analysts responsibilities and those of the state certified assistant behavior analyst.

Title 46

**PROFESSIONAL AND OCCUPATIONAL
STANDARDS**

Part VIII. Behavior Analysts

**Chapter 5. Supervision Requirements for State
Certified Assistant Behavior Analysts
[SCABA]**

§501. Supervision—General

A. A state certified assistant behavior analyst [hereinafter referred to as "SCABA"] shall assist a licensed behavior

analyst [hereinafter referred to as "LBA"] in the delivery of applied behavior analysis in compliance with all state and federal statutes, regulations, and Rules.

B. The SCABA may only perform services under the direct supervision of a LBA as set forth in this Rule.

C. Supervision shall be an interactive process between the LBA and SCABA. It shall be more than peer review or co-signature.

D. There shall be a written supervisory agreement between the LBA and the SCABA that shall address:

1. the domains of competency within which services may be provided by the SCABA; and

2. the nature and frequency of the supervision of the practice of the LBA by the LBA.

E. A copy of the written supervisory agreement must be maintained by the LBA and the SCABA and made available to the board upon request.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3706-R.S. 37:3708.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Behavior Analysts Board, LR 40:

§502. Supervision Requirements

A. The manner of supervision shall depend on the treatment setting, patient/client caseload, and the competency of the SCABA. At a minimum, for full-time SCABAS, working at least 30 hours per week, a face-to-face supervisory meeting shall occur not less than once every four weeks, with each supervisory session lasting no less than one hour for full-time SCABAS. The qualifying supervision activities may include:

1. Direct, real-time observation of the SCABA implementing behavior analytic assessment and intervention procedures with clients in natural environments and/or training others to implement them, with feedback from the supervising LBA.

2. One-to-one real-time interactions between the supervising LBA and the SCABA to review and discuss assessment procedures, assessment outcomes, possible intervention procedures and materials, data collection procedures, intervention outcome data, modifications of intervention procedures, published research, ethical and professional standards and guidelines, professional development needs and opportunities, and relevant laws, regulations, and policies.

B. More frequent supervisory activities may be necessary as determined by the LBA or SCABA dependent on the level of expertise displayed by the SCABA, the practice setting, and/or the complexity of the patient/client caseload. These additional supervisory activities, however, do not qualify towards the once per month requirements. The non-qualifying additional supervision activities may include, but are not limited to:

1. real-time interactions between a supervising LBA and a group of SCABAS to review and discuss assessment and treatment plans and procedures, client assessment and progress data and reports, published research, ethical and professional standards and guidelines, professional development needs and opportunities, and relevant laws, regulations, and policies;

2. informal interactions between supervising LBAs and SCABAs via telephone, electronic mail, and other written communication.

C. Supervision requirements for part-time practice, less than 30 hours per week, may be modified at the discretion of the board upon approval of the submitted plan. Additional modifications of the format, frequency, or duration of supervision may be submitted for approval by the board.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3706-R.S. 37:3708.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Behavior Analysts Board, LR 40:

§503. Supervisor Responsibilities

A. Qualifying supervision shall ensure that the quality of the services provided by the SCABA to his employer and to consumers is in accordance with accepted standards, including the Guidelines for Responsible Conduct for Behavior Analysts and Professional Disciplinary and Ethical Standards for the Behavior Analyst Certification Board or other nation credentialing bodies as approved by the board.

B. Qualifying supervision shall guide the professional development of the SCABA in ways that improve the practitioner's knowledge and skills.

C. The LBA or the supervisor's alternate LBA designee must be available for immediate consultation with the assistant behavior analyst. The supervisor need not be physically present or on the premises at all times.

D. The LBA is ultimately responsible and accountable for client care and outcomes under his clinical supervision. The supervising LBA shall:

1. be licensed by the board as a LBA;
2. not be under restriction or discipline from any licensing board or jurisdiction;
3. not have more than 10 full-time-equivalent SCABAs under his/her supervision at one time without prior approval by the board;
4. provide at least one hour of face-to-face, direct supervision per month per each SCABA.
5. be responsible for all referrals of the patient/client;
6. be responsible for completing the patient's evaluation/assessment. The SCABA may contribute to the screening and/or evaluation process by gathering data, administering standardized tests, and reporting observations. The SCABA may not evaluate independently or initiate treatment before the supervising LBA's evaluation/assessment;
7. be responsible for developing and modifying the patient's treatment plan. The treatment plan must include goals, interventions, frequency, and duration of treatment. The SCABA may contribute to the preparation, implementation, and documentation of the treatment plan. The supervising behavior analyst shall be responsible for the outcome of the treatment plan and assigning of appropriate intervention plans to the SCABA within the competency level of the SCABA.

E. Be responsible for developing the patient's discharge plan. The SCABA may contribute to the preparation, implementation, and documentation of the discharge plan. The supervising LBA shall be responsible for the outcome of the discharge plan and assigning of appropriate tasks to the SCABA within the competency level of the SCABA.

F. Ensure that all patient/client documentation becomes a part of the permanent record.

G. Conduct at least one on-site observation per client per month.

H. The supervisor shall ensure that the SCABA provides applied behavior analysis as defined in R.S. 37:3702 appropriate to and consistent with his/her education, training, and experience.

I. Inform the board of the termination in a supervisory relationship within 30 days.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3706-R.S. 37:3708.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Behavior Analysts Board, LR 40:

§504. SCABA Responsibilities

A. The supervising LBA has the overall responsibility for providing the necessary supervision to protect the health and welfare of the patient/client receiving treatment from an SCABA. However, this does not absolve the SCABA from his/her professional responsibilities. The SCABA shall exercise sound judgment and provide adequate care in the performance of duties. The SCABA shall:

1. not initiate any patient/client treatment program or modification of said program until the behavior analyst has evaluated, established a treatment plan, and consulted with the LBA;
2. not perform an evaluation/assessment, but may assist in the data gathering process and administer specific assessments where clinical competency has been demonstrated, under the direction of the LBA;
3. not analyze or interpret evaluation data;
4. monitor the need for reassessment and report changes in status that might warrant reassessment or referral;
5. immediately suspend any treatment intervention that appears harmful to the patient/client and immediately notify the supervising LBA; and
6. ensure that all patient/client documentation prepared by the SCABA becomes a part of the permanent record;
7. meet these supervision requirements, even if they are not currently providing behavior analysis services. If not currently providing behavior analysis services, supervision from the supervising LBA may focus on guiding the development and maintenance of the SCABA's professional knowledge and skills and remaining current with the professional literature in the field;
8. inform the board of the termination in a supervisory relationship within 30 days.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3706-R.S. 37:3708.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Behavior Analysts Board, LR 40:

Family Impact Statement

The Behavior Analyst Board hereby issues this Family Impact Statement as set forth in R.S. 49:972. The proposed Rule and adoption of the Rule related to supervision of SCABAs is being implemented to guarantee the licensing authority can safeguard the public welfare of this state and will have no known foreseeable impact on the stability of the family; authority and rights of parents regarding the education and supervision of their children; functioning of the family; family earnings and family budget; behavior and personality responsibility of children; or the ability of the family or a local government to perform the function as contained in the proposed Rule.

Poverty Impact Statement

The proposed Rule creates a new Rule, LAC 46:VIII. Chapter 5. The Rule should not have any known or foreseeable impact on any child, individual or family as defined by R.S. 49:973(B). In particular, there should be no known or foreseeable effect on:

1. the effect on household income, assets, and financial security;
2. the effect on early childhood development and preschool through postsecondary education development;
3. the effect on employment and workforce development;
4. the effect on taxes and tax credits;
5. the effect on child and dependent care, housing, health care, nutrition, transportation, and utilities assistance.

Provider Impact Statement

The proposed Rule should not have any known or foreseeable impact on providers as defined by HCR 170 of 2014 Regular Legislative Session. In particular, there should be no known or foreseeable effect on:

1. the effect on the staffing level requirements or qualifications required to provide the same level of service;
2. the total direct and indirect effect on the cost to the providers to provide the same level of service; or
3. the overall effect on the ability of the provider to provide the same level of service.

Public Comments

Interested persons may submit written comments to Kelly Parker, Executive Director, 8706 Jefferson Highway, Suite B, Baton Rouge, LA 70809. All comments must be submitted by 12 noon on July 10, 2014.

Kelly Parker
Executive Director

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES

RULE TITLE: Supervision of Behavior Analysts

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

The proposed Rule will result in a one-time cost for the Louisiana Behavior Analyst Board of approximately \$700 in FY 15 to publish the proposed and final Rules in the *Louisiana Register*. The proposed Rule codifies and establishes requirements with regard to supervisory requirements between Licensed Behavior Analysts and State Certified Assistant Behavior Analysts as enacted by Act 351 of the 2013 Legislative Session, effective August 1, 2013. Act 351 created the Louisiana Behavior Analyst Board and allowed for certification of assistants under the title "State Certified Assistant Behavior Analysts" [hereinafter referred to as "SCABA"]. Pursuant to Act 351, a SCABA must work under the supervision of a Licensed Behavior Analyst licensed pursuant to Act 351 [hereinafter referred to as "LBA"].

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

There is no anticipated effect on revenue collections of state or local governmental units.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

The proposed Rule codifies supervisory requirements between LBAs and SCABAs as per current state law. There are no estimated costs or economic benefits to LBAs and SCABAs

as the proposed Rule simply sets up the framework of the prescribed supervisory relationship between the licensed and certified professions.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

The proposed Rule codifies supervisory requirements between LBAs and SCABAs as per current state law. There are no estimated effects on competition and employment.

Kelly Parker
Executive Director
1406#044

Evan Brasseaux
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

Department of Health and Hospitals Board of Dentistry

Oral Administration of Versed (LAC 46:XXXIII.1508)

In accordance with the applicable provisions of the Administrative Procedure Act, R.S. 49:950, et seq., the Dental Practice Act, R.S. 37:751 et seq., and particularly R.S. 37:760(8), notice is hereby given that the Department of Health and Hospitals, Board of Dentistry intends to amend LAC 46:XXXIII.1508.

The Louisiana State Board of Dentistry is amending LAC 46:XXXIII.1508 because it is unnecessary to require a working electrocardiograph and defibrillator when administering versed orally.

Title 46

PROFESSIONAL AND OCCUPATIONAL STANDARDS

Part XXXIII. Dental Health Profession

Chapter 15. Anesthesia/Analgesia Administration §1508. Oral Administration of Versed

A. Oral administration of Versed shall be performed on the dental premises only. Prescriptions for oral Versed intended for at-home pre-medication is prohibited. Further, all dental offices where oral Versed is administered shall be in compliance with LAC 46:XXXIII.1511 "Required Facilities, Personnel and Equipment for Sedation Procedures" as it pertains to the administration of moderate sedation with parenteral drugs.

AUTHORITY NOTE: Promulgated in accordance with R. S. 37:760(8) and R.S. 37:793.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Dentistry, LR 26:488 (March 2000), amended LR 40:

Family Impact Statement

There will be no family impact in regard to issues set forth in R.S. 49:972.

Poverty Statement

The proposed rulemaking will have no impact on poverty as described in R.S. 49:973.

Provider Impact Statement

The proposed rulemaking should not have any know or foreseeable impact on providers as defined by HCR 170 of 2014 Regular Legislative Session. In particular, there should be no known or foreseeable effect on:

1. the effect on the staffing level requirements or qualifications required to provide the same level of service;
2. the total direct and indirect effect of the cost to the providers to provide the same level of service; or

3. the overall effect on the ability of the provider to provide the same level of service.

Public Comment

Interested persons may submit written comments on this proposed Rule change to Arthur Hickham, Jr., Executive Director, Louisiana State Board of Dentistry, One Canal Place, Suite 2680, 365 Canal Street, New Orleans, LA 70130. Written comments must be submitted to and received by the board within 20 days of the date of the publication of this notice. A request pursuant to R.S. 49:953(A)(2) for oral presentation, argument, or public hearing must be made in writing and received by the board within 20 days of the date of the publication of this notice.

Public Hearing

A request pursuant to R.S. 49:953(A)(2) for oral presentation, argument, or public hearing must be in writing and received by the board within 20 days of the date of the publication of this notice.

Arthur Hickham, Jr.
Executive Director

**FISCAL AND ECONOMIC IMPACT STATEMENT
FOR ADMINISTRATIVE RULES**

RULE TITLE: Oral Administration of Versed

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

There will be a one-time cost to the Board of Dentistry of \$500 in FY 15 for publication of the proposed rule change in the State Register. There are no estimated costs or savings to state or local governmental units. The proposed rule change stipulates that the oral administration of Versed shall be in compliance with LAC 46:XXXII.1511 "Required Facilities, Personnel and Equipment for Sedation Procedures" as it pertains to the administration of moderate sedation with parenteral drugs.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

There will be no effect on revenue collections by the board as a result of the proposed rule.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

Any licensed dental practitioners in the State of Louisiana who administer Versed orally will be affected by this rule change. However, there are no estimated costs associated with the proposed rule change and it may result in cost savings for dental practitioners because it is not necessary for dentists who administer versed orally to purchase a working electrocardiograph and defibrillator. The LFO assumes this will generally lower cost-of-entry for new dentists or allow some dental practitioners to begin administering Versed orally who may have resisted in the past due to higher restrictions and requirements on deep sedation versus the newly classified moderate sedation category under the proposed rule change.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

There is no estimated effect on competition and employment as a result of the proposed rule change.

Arthur F. Hickman, Jr.
Executive Director
1406#090

Evan Brousseau
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

**Department of Health and Hospitals
Board of Nursing**

Fees for Registration and Licensure (LAC 46:XLVII.3341)

Notice is hereby given in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., and through the authority granted in R.S. 37:918, that the Louisiana State Board of Nursing (LSBN) proposes to amend Chapter 33 of its rules particular, by amending §3341 A.1-B.1. The proposed Rule for fee increases will be utilized for operating funds which will further the mission of the Louisiana State Board of Nursing. Top funding expenditures will address key operation issues and process improvements including: disaster preparedness, paperless systems, workforce planning and research through the Louisiana Center for Nursing, personnel costs and related benefits, caseload complexity in investigative and legal services, monitoring and recovery services through Recovery Nurse Program (RNP) and the LSBN's adoption and implementation of the National Council of State Boards of Nursing (NCSBN) evidence-based regulatory management system. With the current overall growth rate of three percent annually in the number of nurses served by the LSBN along with an increase in the number of criminally and drug related complaints, it is projected that LSBN's annual operational expenses will exceed the revenues currently generated. The fundamental purpose of the LSBN is to protect the public. The increased revenue generated from the modest increase in fees will impact the LSBN's ability to better serve the public.

Title 46

PROFESSIONAL AND OCCUPATION STANDARDS

Part XLVII. Nurses: Practical Nurses and Registered Nurses

Subpart 2. Registered Nurses

Chapter 33. General

Subchapter C. Registration and Registered Nurse Licensure

§3341. Fees for Registration and Licensure

A. Notwithstanding any provisions of this Chapter, the board shall collect in advance fees for licensure and administrative services as follows.

1. Licensure

- a. - b. ...
- c. enrollment application—\$50;
- d. RN renewal fee—\$100;
- e. RN late fee (plus renewal fee)—\$50;
- f. retired license fee (one-time fee)—\$100;
- g. - h. ...
- i. RN/APRN endorsement temporary permit

fee—\$100;

j. ...

k. APRN renewal fee—\$100;

l. APRN late fee (plus renewal fee)—\$50;

m. - n. ...

o. APRN prescriptive authority site change—\$50;

p. reinstatement of prescriptive authority privileges—\$100;

1.q. - 2.e. ...

B. Fees for Returned Items

1. The board shall collect a \$25 fee for returned items for payment of any of the fees discussed in LAC 46:XLVII.3341.A.

B.2. - C. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:918 and R.S. 37:927.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, LR 8:417 (August 1982), amended by the Department of Health and Hospitals, Board of Nursing, LR 14:533 (August 1988), LR 22:981 (October 1996), repromulgated LR 24:1293 (July 1998), amended LR 26:84 (January 2000), LR 30:2829 (December 2004), LR:31:2027 (August 2005), LR 36:1246 (June 2010), LR 37:3027 (October 2011), LR 40:

Family Impact Statement

1. What effect will this Rule have on the stability of the family? The proposed Rule should have no effect on the stability of the family.

2. What effect will this Rule have on the authority and rights of persons regarding the education and supervision of their children? The proposed Rule should have no effect on the authority and rights of persons regarding the education and supervision of their children.

3. What effect will this Rule have on the functioning of the family? The proposed Rule should have no effect on the functioning of the family.

4. What effect will this Rule have on family earnings and family budget? The proposed Rule should have no effect on family earnings and family budget.

5. What effect will this Rule have on the behavior and personal responsibility of children? The proposed Rule should have no effect on the behavior and personal responsibility of children.

6. Is the family or local government able to perform the function as contained in this proposed Rule? No, family or local government may not perform any of the functions outlined in the proposed Rule.

Poverty Impact Statement

In compliance with Act 854 of the 2012 Regular Session of the Louisiana Legislature, it is anticipated that this proposed Rule will have no impact on child, individual, or family poverty in relation to individual or community asset development as described in R.S. 49:973

Provider Impact Statement

The proposed Rule should not have any known or foreseeable impact on providers as defined by HCR 170 of 2014 Regular Legislative Session. In particular, there should be no known foreseeable effect on:

1. Is there an effect on the staffing level requirements or qualifications required to provide the same level of service? There will be no effect on the staffing level requirements or qualifications required to provide the same level of service.

2. Is there a total direct and indirect effect on the cost to the providers to provide the same level of service? There is not a direct or indirect effect on the cost to the providers to provide the same level of service.

3. What is the overall effect on the ability of the provider to provide the same level of service? There is no effect on the ability of the provide to provide the same level of service.

Public Comments

Interested persons may submit written comments on the proposed Rule to Karen C. Lyon, 17373 Perkins Road, Baton Rouge, LA 70810, or by facsimile to (225) 755-7585. All comments must be submitted by 5 p.m. on or before July 10, 2014.

Public Hearings

A public hearing has been scheduled for July 29, 2014 at 10 a.m. at 17373 Perkins Road, Baton Rouge, LA 70810. At that time, all interested persons will be afforded an opportunity to submit data, views and/or arguments either orally or in writing.

Karen C. Lyon
Executive Director

**FISCAL AND ECONOMIC IMPACT STATEMENT
FOR ADMINISTRATIVE RULES**

RULE TITLE: Fees for Registration and Licensure

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

Other than publication costs associated with the rule changes, which are estimated to be \$250.00 in FY14, the proposed rule is not anticipated to result in any implementation costs or savings to state or local governmental units. The proposed rule increases specified fees for registration and licensure. Existing staff will be used to update the Louisiana State Board of Nursing's (LSBN) websites and templates referencing the new fee increases. LSBN will utilize increased revenues to supplement operating funds which will further the mission of the LSBN.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

The proposed rule changes will require 57,600 registered nurses (RN) and 4,350 advanced practice registered nurses (APRN) in the State of Louisiana to pay an additional \$20-\$50 fee for licensure renewal and related late fees, for an estimated \$1.4 million in additional revenue annually. The proposed rule would also require 4,059 clinical students to pay an additional \$30 for enrollment application, for an estimated \$121,000 in additional revenue annually. Finally, the proposed rule would require 1,200 RNs and APRNs to pay an additional fee of \$25-\$50 for change and permit fees, for an additional \$44,000 in revenue annually.

The proposed fee increases are within the range of fees that the Board has legislative authority to impose. The proposed rule change would increase the following fees from \$80 to \$100: RN Renewal Fee, APRN Renewal Fee, and Retired License Fee (one-time fee); the following fees from \$50 to \$100: RN/APRN Endorsement Temporary Permit Fee and Reinstatement of Prescriptive Authority Privileges; and the following fees from \$25 to \$50: RN Late Fee (plus Renewal Fee), APRN Late Fee (plus Renewal Fee), and APRN Prescriptive Authority Site Change Fee. Returned items, including credit cards and money orders, will incur a \$25 fee to address Non-Sufficient Funds (NSF) checks and the charge back from credit cards. The licensure enrollment application fee (student clinical fee) increases from \$20 to \$50.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

The proposed rule change would increase the economic costs of attaining and retaining licensure as a RN or APRN as well as clinical nursing students. The following fees increase from \$80 to \$100: RN Renewal Fee, APRN Renewal Fee, and

Retired License Fee (one-time fee); the following fees from \$50 to \$100: RN/APRN Endorsement Temporary Permit Fee and Reinstatement of Prescriptive Authority Privileges; and the following fees from \$25 to \$50: RN Late Fee (plus Renewal Fee), APRN Late Fee (plus Renewal Fee), and APRN Prescriptive Authority Site Change Fee. Returned items, including credit cards and money orders, will incur a \$25 fee to address Non-Sufficient Funds (NSF) checks and the charge back from credit cards. The licensure enrollment application fee (student clinical fee) increases from \$20 to \$50.

The LSBN board of directors approved a new 3-year strategic plan to "provide leadership to protect the public and advance nursing in Louisiana". Top funding priorities will address key operational issues and process improvements including: disaster preparedness, paperless systems, workforce planning and research through the Louisiana Center for Nursing, personnel costs and related benefits, caseload complexity in investigative and legal services, monitoring and recovery services through Recovery Nurse Program (RNP), and the LSBN's adoption and implementation of the National Council of State Boards of Nursing (NCSBN) evidence-based Regulatory Management System. The most recent fee increase for nurses occurred in 2006 when the LSBN served approximately 49,294 RNs and 2,886 APRNs, along with an estimated 4.5 million Louisiana citizens. Since that time, the number of RNs and APRNs have increased by 17% and 50% respectively.

With a current overall growth rate of 3% annually in the number of nurses served, along with an increase in the number of criminally and drug related complaints, it is projected that LSBN's annual operational expenses will exceed the revenues currently generated. The fundamental purpose of the LSBN is to protect the public. The increased revenue generated from the modest increase in fees will impact the LSBN's ability to better serve the public and provide potential economic benefits to the nursing profession and to the public.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

The proposed rule will increase the cost of licensure, renewal and related fees for RNs, APRNs and clinical nursing students. The increased fees raise the cost of entry and continuing practice for these specified professions by a moderate amount with specific fees rising between 25% and 100% at initial licensure and annual renewal in the future. Additionally, the fee associated with the enrollment application (clinical student fees) will increase by 150%.

Karen C. Lyon
Executive Director
1406#020

Evan Brasseaux
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

**Department of Health and Hospitals
Board of Pharmacy**

Prescriptions (LAC 46:LIII.2511)

In accordance with the provisions of the Administrative Procedure Act (R.S. 49:950 et seq.) and the Pharmacy Practice Act (R.S. 37:1161 et seq.), the Louisiana Board of Pharmacy hereby gives notice of its intent to amend §2511, Prescriptions of its rules. The proposed Rule is intended to update the requirements for prescription forms and to codify contemporary practice standards for the minimum data set for prescriptions.

**Title 46
PROFESSIONAL AND OCCUPATIONAL
STANDARDS**

Part LIII. Pharmacists

Chapter 25. Prescriptions, Drugs, and Devices

Subchapter B. Prescriptions

§2511. Prescriptions

A. ...

B. Requirements. A prescription shall contain the following data elements:

1. prescriber's name, licensure designation, address, telephone number, and if for a controlled substance, the Drug Enforcement Administration (DEA) registration number;
2. patient's name, and if for a controlled substance, address;
3. date prescription issued by the prescriber;
4. name of drug or device, and if applicable, strength, and quantity to be dispensed;
5. directions for use;
6. signature of prescriber; and
7. refill instructions, if any. In the absence of refill instructions on the original prescription, the prescription shall not be refilled.

C. Written Prescriptions. A written prescription shall conform to the following format.

1. The prescription form shall be of a size not less than 4 inches by 5 inches, and shall bear a single printed signature line.
2. The prescription form shall clearly indicate the authorized prescriber's name, licensure designation, address, telephone number, and, if for a controlled substance, the Drug Enforcement Administration (DEA) registration number. In the event that multiple practitioners are identified on the prescription form, the authorizing prescriber's specific identity shall be clear and unambiguous. This identification may be indicated by any means, including but not limited to, a marked check box next to, or circling the authorizing prescriber's printed name.
3. No prescription form shall contain more than four prescription drug orders. Each prescription drug order recorded on the form shall provide the following:
 - a. check box labeled "Dispense as Written", or "DAW", or both; and
 - b. the number of refills, if any.
4. The prescription shall be written with ink or indelible pencil, typewriter, or printed on a computer printer and shall be manually signed by the practitioner on the date issued and in the same manner as he would sign a check or legal document (e.g., J. H. Smith or John H. Smith). Examples of invalid signatures include rubber stamps, signatures of anyone other than the prescriber, and computer generated signatures.
5. Facsimile Prescription
 - a. The receiving facsimile machine of a prescription transmitted by facsimile shall be located within the pharmacy department.
 - b. The prescription transmitted by facsimile shall be on a non-fading legible medium.

c. All requirements applicable to written prescriptions in this Subsection shall apply to facsimile prescriptions, except Subparagraph B.7.c.

6. Forms used by pharmacists to record telephoned or transferred prescriptions are exempt from the format requirements listed above.

7. Equivalent Drug Product Interchange

a. The pharmacist shall not select an equivalent drug product when the prescriber handwrites a mark in the check box labeled "Dispense as Written", or "DAW", or both, and personally handwrites his signature on a printed single signature line. Otherwise, the pharmacist may select an equivalent drug product provided the patient has been informed of, and has consented to, the proposed cost saving interchange.

b. In the event an authorized prescriber has indicated that an equivalent drug product interchange is prohibited by handwriting a mark in the check box labeled "Dispense as Written" or "DAW" or both, then a non-licensed, non-certified, or non-registered agent of the pharmacy shall not inquire as to a patient's desire for an equivalent drug product interchange.

c. For prescriptions reimbursable by Medicaid, the authorized prescriber may only prohibit equivalent drug product interchange by handwriting the words "brand necessary" or "brand medically necessary" on the face of the prescription order or on a sheet attached to the prescription order.

D. Oral Prescriptions

1. Upon receipt of an oral prescription from an authorized prescriber, the pharmacist or pharmacy intern or pharmacy technician shall reduce the order to a written form prior to dispensing the medication. As an alternative to recording such prescriptions on paper forms, a pharmacist may enter the prescription information directly into the pharmacy's dispensing information system. In the event a pharmacy intern or pharmacy technicians transcribes such a prescription, the supervising pharmacist shall initial or countersign the prescription form prior to processing the prescription.

2. The pharmacist shall not select an equivalent drug product when the authorized prescriber or his agent has verbally indicated a specific brand name drug or product is ordered.

3. The pharmacist may select an equivalent drug product if the authorized prescriber or his agent has given his approval to the equivalent drug product interchange. The patient shall be informed of, and consent to, the proposed cost saving interchange.

E. Electronic Prescriptions

1. The prescription shall clearly indicate the authorized prescriber's name, licensure designation, address, telephone number, and if for a controlled substance, DEA registration number.

2. The pharmacist shall not select an equivalent drug product when the prescriber indicates in the check box labeled "Dispense as Written" or "DAW" or both, and electronically transmits his signature on the formatted single signature line. Otherwise, the pharmacist may select an equivalent drug product, provided the patient has been informed of, and consents to, the proposed cost saving interchange.

F. Exclusion. The provisions of this Section shall not apply to medical orders written for patients in facilities licensed by the Department of Health and Hospitals or its successor.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1182.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Pharmacy, LR 14:708 (October 1988), effective January 1, 1989, amended LR 29:2102 (October 2003), effective January 1, 2004, LR 40:

Family Impact Statement

In accordance with Section 953 of Title 49 of the Louisiana Revised Statutes, there is hereby submitted a Family Impact Statement on the Rule proposed for adoption, repeal, or amendment. The following statements will be published in the *Louisiana Register* with the proposed agency Rule.

1. The effect on the stability of the family. We anticipate no effect on the stability of the family.

2. The effect on the authority and rights of parents regarding the education and supervision of their children. We anticipate no effect on the authority and rights of parents regarding the education and supervision of their children.

3. The effect on the functioning of the family. We anticipate no effect on the functioning of the family.

4. The effect on family earnings and family budget. We anticipate no effect on family earnings and the family budget.

5. The effect on the behavior and personal responsibility of children. We anticipate no effect on the behavior and personal responsibility of children.

6. The ability of the family or a local government to perform the function as contained in the proposed rule. We anticipate no effect on the ability of the family or a local government to perform the activity as contained in the proposed rule.

Poverty Impact Statement

In accordance with Section 973 of Title 49 of the Louisiana Revised Statutes, there is hereby submitted a Poverty Impact Statement on the Rule proposed for adoption, repeal, or amendment.

1. The effect on household income, assets, and financial security. We anticipate no impact on household income, assets, and financial security.

2. The effect on early childhood development and preschool through postsecondary education development. We anticipate no impact early childhood development or preschool through postsecondary education development.

3. The effect on employment and workforce development. We anticipate no positive impact on employment and workforce development.

4. The effect on taxes and tax credits. We anticipate no impact on taxes or tax credits.

5. The effect on child and dependent care, housing, health care, nutrition, transportation, and utilities assistance. We anticipate no impact on child and dependent care, housing, health care, nutrition, transportation, or utilities assistance.

Provider Impact Statement

In accordance with House Concurrent Resolution No. 170 of the Regular Session of the 2014 Legislature, there is hereby submitted a Provider Impact Statement on the Rule proposed for adoption, repeal, or amendment. This will

certify the agency has considered, without limitation, the following effects on the providers of services to individuals with developmental disabilities.

1. The effect on the staffing level requirements or qualifications required to provide the same level of service. We anticipate no effect on the staffing level requirements or the qualifications for that staff to provide the same level of service.

2. The total direct and indirect effect on the cost to the provider to provide the same level of service. To the extent a pharmacy provides services to individuals with developmental disabilities, and in the event the pharmacy receives a prescription that is incomplete according to the minimum data set identified in the proposed amendment, then one of the pharmacy's credentialed staff members may need to contact the prescriber of the prescription to obtain the missing information. That could require additional time which would have an indirect cost.

3. The overall effect on the ability of the provider to provide the same level of service. We anticipate no effect on the ability of the provider to provide the same level of service.

Small Business Statement

In accordance with Section 965 of Title 49 of the Louisiana Revised Statutes, there is hereby submitted a regulatory flexibility analysis on the Rule proposed for adoption, repeal, or amendment. This will certify the agency has considered, without limitation, each of the following methods of reducing the impact of the proposed Rule on small businesses.

1. The establishment of less stringent compliance or reporting requirements for small businesses. There are no reporting requirements in the proposed Rule, but there is an allowance for the pharmacist to bypass the recording of verbal prescriptions on paper forms before entering the data into the pharmacy's information system.

2. The establishment of less stringent schedules or deadlines for compliance or reporting requirements for small businesses. There are no schedules or deadlines or reporting requirements in the proposed Rule.

3. The consolidation or simplification of compliance or reporting requirements for small businesses. There are no reporting requirements in the proposed Rule.

4. The establishment of performance standards for small businesses to replace design or operational standards required in the proposed Rule. There are no design standards in the proposed Rule. As noted above, there is an allowance for pharmacists to bypass the written recording of verbal prescription information prior to the data entry of that prescription information.

5. The exemption of small businesses from all or any part of the requirements contained in the proposed Rule. There are exemptions for those pharmacies located within hospitals or other facilities licensed by the Dept. of Health and Hospitals.

Public Comments

Interested persons may submit written comments to Malcolm J. Broussard, Executive Director, Louisiana Board of Pharmacy, 3388 Brentwood Drive, Baton Rouge, LA 70809-1700. He is responsible for responding to inquiries regarding this proposed Rule.

Public Hearing

A public hearing on this proposed Rule is scheduled for Monday, July 28, 2014 at 9 a.m. in the board office. At that time, all interested persons will be afforded an opportunity to submit data, views, or arguments, either orally or in writing. The deadline for the receipt of all comments is 12 noon that same day.

Malcolm J. Broussard
Executive Director

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES RULE TITLE: Prescriptions

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

The proposed rule changes will result in a cost of approximately \$1,500 for printing costs of the proposed and final rules in FY 15. The proposed rule changes amend and clarify requirements for pharmacists regarding prescriptions transmitted in writing, orally or by electronic means.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

There will be no impact on revenue collections of state or local governmental units from the proposed rule changes.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

The proposed rule changes directly affect pharmacists and pharmacies in how they receive, evaluate and process prescriptions. There are no significant estimated costs or economic benefits to pharmacists or pharmacies, though the proposed rule changes may provide a potential for some level of efficiency for the processing of verbal prescriptions. Additionally, the rule may indirectly affect certain prescribers in the information they include on their forms or how they sign their written prescription forms.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

The proposed rule changes will not have any effect on competition or employment.

Malcolm J. Broussard
Executive Director
1406#024

Evan Brasseaux
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

Department of Health and Hospitals Bureau of Health Services Financing and Office of Behavioral Health

Behavioral Health Services
Physician Reimbursement Methodology
(LAC 50:XXXIII.1701)

The Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health propose to amend LAC 50:XXXIII.1701 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This proposed Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

The Department of Health and Hospitals, Bureau of Health Services Financing adopted provisions to implement a coordinated behavioral health services system under the Medicaid Program, called the Louisiana Behavioral Health Partnership (LBHP), to provide adequate coordination and delivery of behavioral health services through the utilization of a statewide management organization (*Louisiana Register*, Volume 38, Number 2).

The Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health promulgated an Emergency Rule which amended the provisions governing the reimbursement of physician services rendered in the LBHP in order to establish a distinct payment methodology that is independent of the payment methodology established for physicians in the Professional Services Program (*Louisiana Register*, Volume 39, Number 4). The department promulgated an Emergency Rule which amended the provisions governing the reimbursement methodology for certain physician services provided under the LBHP to exclude these services from the January 2013 Medicare rate changes (*Louisiana Register*, Volume 39, Number 9). This proposed Rule is being promulgated to continue the provisions of the September 1, 2013 Emergency Rule.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE

Part XXXIII. Behavioral Health Services

Subpart 2. General Provisions

Chapter 17. Behavioral Health Services

Reimbursements

§1701. Physician Payment Methodology

A. - B. Reserved.

C. Effective for dates of service on or after September 1, 2013, the reimbursement for procedure codes 90791, 90792, 90832, 90834 and 90837 shall be excluded from the January 2013 Medicare rate changes and shall remain at the Medicaid fee schedule on file as of December 31, 2012.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 40:

Family Impact Statement

In compliance with Act 1183 of the 1999 Regular Session of the Louisiana Legislature, the impact of this proposed Rule on the family has been considered. It is anticipated that this proposed Rule will have a positive impact on family functioning, stability and autonomy as described in R.S. 49:972 by ensuring continued provider participation in the Medicaid Program.

Poverty Impact Statement

In compliance with Act 854 of the 2012 Regular Session of the Louisiana Legislature, the poverty impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have a positive impact on child, individual, or family poverty in relation to individual or community asset development as described in R.S. 49:973 by ensuring continued provider participation in the Medicaid Program which is expected to reduce health care costs to families.

Provider Impact Statement

In compliance with House Concurrent Resolution (HCR) 170 of the 2014 Regular Session of the Louisiana Legislature, the provider impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have no impact on the staffing level requirements or qualifications required to provide the same level of service, no direct or indirect cost to the provider to provide the same level of service, and will have no impact on the provider's ability to provide the same level of service as described in HCR 170.

Public Comments

Interested persons may submit written comments to J. Ruth Kennedy, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030 or by email to MedicaidPolicy@la.gov. Ms. Kennedy is responsible for responding to inquiries regarding this proposed Rule. The deadline for receipt of all written comments is 4:30 p.m. on the next business day following the public hearing.

Public Hearing

A public hearing on this proposed Rule is scheduled for Wednesday, July 30, 2014 at 9:30 a.m. in Room 118, Bienville Building, 628 North Fourth Street, Baton Rouge, LA. At that time all interested persons will be afforded an opportunity to submit data, views or arguments either orally or in writing.

Kathy H. Kliebert
Secretary

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES

RULE TITLE: Behavioral Health Services Physician Reimbursement Methodology

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

It is anticipated that implementation of this proposed rule will have no programmatic fiscal impact to the state other than the cost of promulgation for FY 13-14. It is anticipated that \$328 (\$164 SGF and \$164 FED) will be expended in FY 13-14 for the state's administrative expense for promulgation of this proposed rule and the final rule.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

It is anticipated that the implementation of this proposed rule will not affect revenue collections other than the federal share of the promulgation costs for FY 13-14. It is anticipated that \$164 will be collected in FY 13-14 for the federal share of the expense for promulgation of this proposed rule and the final rule.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

This proposed Rule continues the provisions of the September 1, 2013 Emergency Rule which amended the provisions governing the reimbursement methodology for certain physician services provided under the Louisiana Behavioral Health Partnership (LBHP) to exclude these services from the January 2013 Medicare rate changes because the changes would have reduced the rates paid to physicians for these services. It is anticipated that implementation of this

proposed rule will not have economic costs, but will be beneficial to physicians in the LBHP for FY 13-14, FY 14-15 and FY 15-16.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

This rule has no known effect on competition and employment.

J. Ruth Kennedy
Medicaid Director
1406#072

Evan Brasseaux
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

**Department of Health and Hospitals
Bureau of Health Services Financing**

Inpatient Hospital Services
Major Teaching Hospitals
Qualifying Criteria
(LAC 50:V.Chapter 13)

The Department of Health and Hospitals, Bureau of Health Services Financing proposes to amend LAC 50:V.1301-1309 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This proposed Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

Act 347 of the 2009 Regular Session of the Louisiana Legislature revised the qualifying criteria for major teaching hospitals. In compliance with Act 347, the department amended the provisions governing the qualifying criteria for major teaching hospitals and repromulgated the provisions of the March 20, 2000 Rule governing teaching hospitals in a codified format for inclusion in the *Louisiana Administrative Code (Louisiana Register, Volume 39, Number 2)*. The department promulgated an Emergency Rule which amended the provisions of the February 20, 2013 Rule governing the qualifying criteria for teaching hospitals in order to correlate with Medicare guidelines, and to clarify deadlines for submissions of qualifying documentation and provisions for conversion to private ownership (*Louisiana Register, Volume 39, Number 6*). This proposed Rule is being promulgated to continue the provisions of the July 1, 2013 Emergency Rule.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE

Part V. Hospital Services

Subpart 1. Inpatient Hospital Services

Chapter 13. Teaching Hospitals

Subchapter A. General Provisions

§1301. Major Teaching Hospitals

A. The Louisiana Medical Assistance Program's recognition of a major teaching hospital is limited to facilities having a documented affiliation agreement with a Louisiana medical school accredited by the Liaison Committee on Medical Education (LCME). A major teaching hospital shall meet one of the following criteria:

1. be a major participant in at least four approved medical residency programs and maintain at least 15 intern and resident un-weighted full time equivalent positions. For purposes of this rule full time equivalent positions will be calculated as defined in 42 CFR 413.78. At least two of the

programs must be in medicine, surgery, obstetrics/gynecology, pediatrics, family practice, emergency medicine or psychiatry; or

2. maintain at least 20 intern and resident un-weighted full time equivalent positions, with an approved medical residency program in family practice located more than 150 miles from the medical school accredited by the LCME. For purposes of this rule full time equivalent positions will be calculated as defined in 42 CFR 413.78.

B. For the purposes of recognition as a major teaching hospital, a facility shall be considered a "major participant" in a graduate medical education program if it meets the following criteria. The facility must participate in residency programs that:

1. require residents to rotate for a required experience;
a. - c. Repealed.

2. require explicit approval by the appropriate Residency Review Committee (RRC) of the medical school with which the facility is affiliated prior to utilization of the facility; or

a. - c. Repealed.

3. provide residency rotations of more than one sixth of the program length or more than a total of six months at the facility and are listed as part of an accredited program in the graduate medical education directory of the Accreditation Council for Graduate Medical Education (ACGME).

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 39:324 (February 2013), amended LR 40:

§1303. Minor Teaching Hospitals

A. The Louisiana Medical Assistance Program's recognition of a minor teaching hospital is limited to facilities having a documented affiliation agreement with a Louisiana medical school accredited by the LCME. A minor teaching hospital shall meet the following criteria:

1. ...

2. maintain at least six intern and resident un-weighted full time equivalent positions. For purposes of this rule full time equivalent positions will be calculated as defined in 42 CFR 413.78.

B. For the purposes of recognition as a minor teaching hospital, a facility is considered to "participate significantly" in a graduate medical education program if it meets the following criteria. The facility must participate in residency programs that:

1. require residents to rotate for a required experience;
a. - c. Repealed.

2. require explicit approval by the appropriate Residency Review Committee of the medical school with which the facility is affiliated prior to utilization of the facility; or

a. - c.i. Repealed.

3. provide residency rotations of more than one sixth of the program length or more than a total of six months at the facility and are listed as part of an accredited program in the graduate medical education directory of the Accreditation Council for Graduate Medical Education.

a. If not listed, the sponsoring institution must have notified the ACGME, in writing, that the residents rotate through the facility and spend more than one sixth of the

program length or more than a total of six months at the facility.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 39:324 (February 2013), amended LR 40:

§1305. Approved Medical Residency Program

A. An approved medical residency program is one that meets one of the following criteria:

1. is approved by one of the national organizations listed in 42 CFR 415.152;

2. may count towards certification of the participant in a specialty or subspecialty listed in the current edition of either of the following publications:

a. The directory of graduate medical education programs published by the American Medical Association, and available from American Medical Association, Department of Directories and Publications; or

b. The annual report and reference handbook published by the American Board of Medical Specialties, and available from American Board of Medical Specialties;

3. is approved by the Accreditation Council for Graduate Medical Education (ACGME) as a fellowship program in geriatric medicine; or

4. is a program that would be accredited except for the accrediting agency's reliance upon an accreditation standard that requires an entity to perform an induced abortion or require, provide, or refer for training in the performance of induced abortions, or make arrangements for such training, regardless of whether the standard provides exceptions or exemptions.

B. - B.2. Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 39:324 (February 2013), amended LR 40:

§1307. Graduate Medical Education

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 39:325 (February 2013), repealed LR 40:

§1309. Requirements for Reimbursement

A. Qualification for teaching hospital status shall be re-established at the beginning of each fiscal year.

B. To be reimbursed as a teaching hospital, a facility shall submit a signed "certification for teaching hospital recognition" form to the Bureau of Health Services, Rate Setting and Audit Section at least 30 days prior to the beginning of each state fiscal year or at least 30 days prior to the effective date of the conversion of a state owned and operated teaching hospital to private ownership in accordance with a public/private partnership cooperative endeavor agreement that was instituted to preserve graduate medical education training and access to healthcare services for indigent patients.

1. - 3. Repealed.

C. Each hospital which is reimbursed as a teaching hospital shall submit the following documentation with their Medicaid cost report filing:

1. - 2. ...

D. Copies of all affiliation agreements, contracts, payroll records and time allocations related to graduate medical education must be maintained by the hospital and available for review by the state and federal agencies or their agents upon request.

E. If it is subsequently discovered that a hospital has been reimbursed as a major or minor teaching hospital and did not qualify for that peer group for any reimbursement period, retroactive adjustment shall be made to reflect the correct peer group to which the facility should have been assigned. The resulting overpayment will be recovered through either immediate repayment by the hospital or recoupment from any funds due to the hospital from the department.

F. - G. Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 39:325 (February 2013), amended LR 40:

Family Impact Statement

In compliance with Act 1183 of the 1999 Regular Session of the Louisiana Legislature, the impact of this proposed Rule on the family has been considered. It is anticipated that this proposed Rule will have no impact on family functioning, stability or autonomy as described in R.S. 49:972.

Poverty Impact Statement

In compliance with Act 854 of the 2012 Regular Session of the Louisiana Legislature, the poverty impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have no impact on child, individual, or family poverty in relation to individual or community asset development as described in R.S. 49:973.

Provider Impact Statement

In compliance with House Concurrent Resolution (HCR) 170 of the 2014 Regular Session of the Louisiana Legislature, the provider impact of this proposed Rule has been considered. It is anticipated that this proposed Rule may have a negative impact on the staffing level requirements or qualifications required to provide the same level of service and may increase direct or indirect cost to the provider to provide the same level of service if their current operations are not in compliance with the new qualifying criteria. The proposed Rule may also have a negative impact on the provider's ability to provide the same level of service as described in HCR 170 if they do not meet the new qualifying criteria.

Public Comments

Interested persons may submit written comments to J. Ruth Kennedy, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030 or by email to MedicaidPolicy@la.gov. Ms. Kennedy is responsible for responding to inquiries regarding this proposed Rule. The deadline for receipt of all written comments is 4:30 p.m. on the next business day following the public hearing.

Public Hearing

A public hearing on this proposed Rule is scheduled for Wednesday, July 30, 2014 at 9:30 a.m. in Room 118, Bienville Building, 628 North Fourth Street, Baton Rouge, LA. At that time all interested persons will be afforded an

opportunity to submit data, views or arguments either orally or in writing.

Kathy H. Kliebert
Secretary

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES

RULE TITLE: **Inpatient Hospital Services Major Teaching Hospitals—Qualifying Criteria**

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

It is anticipated that implementation of this proposed rule will have no programmatic fiscal impact to the state other than the cost of promulgation for FY 13-14. It is anticipated that \$820(\$410 SGF and \$410 FED) will be expended in FY 13-14 for the state's administrative expense for promulgation of this proposed rule and the final rule.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

It is anticipated that the implementation of this proposed rule will not affect revenue collections other than the federal share of the promulgation costs for FY 13-14. It is anticipated that \$410 will be collected in FY 13-14 for the federal share of the expense for promulgation of this proposed rule and the final rule.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

This proposed Rule continues the provisions of the July 1, 2013 Emergency Rule which amended the provisions governing the qualifying criteria for teaching hospitals in order to correlate with Medicare guidelines, and to clarify deadlines for submissions of qualifying documentation and provisions for conversion to private ownership. It is anticipated that implementation of this proposed rule will not have economic costs or benefits for FY 13-14, FY 14-15 and FY 15-16.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

This rule has no known effect on competition and employment.

J. Ruth Kennedy
Medicaid Director
1406#073

Evan Brasseaux
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

Department of Health and Hospitals Bureau of Health Services Financing

Outpatient Hospital Services
Non-Rural, Non-State Public Hospitals
Supplemental Payments
(LAC 50:V.5315, 5515, 5717, 5915 and 6117)

The Department of Health and Hospitals, Bureau of Health Services Financing proposes to amend LAC 50:V.5315, §5515, §5717, §5915 and §6117 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This proposed Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

The Department of Health and Hospitals, Bureau of Health Services Financing amended the provisions governing the reimbursement methodology for outpatient hospital services to provide supplemental Medicaid payments to qualifying non-rural, non-state public hospitals for state fiscal year 2013 (*Louisiana Register*, Volume 39, Number 6).

The department promulgated an Emergency Rule which amended the provisions governing the reimbursement methodology for outpatient hospital services in order to revise the qualifying criteria and reimbursement methodology for non-rural, non-state public hospitals (*Louisiana Register*, Volume 39, Number 7). The department promulgated an Emergency Rule which amended the provisions of the July 1, 2013 Emergency Rule in order to further revise the qualifying criteria and reimbursement methodology for non-rural, non-state public hospitals and to correct the Code of Federal Regulation citation (*Louisiana Register*, Volume 39, Number 9). This proposed Rule is being promulgated to continue the provisions of the September 20, 2013 Emergency Rule.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE

Part V. Hospital Services

Subpart 5. Outpatient Hospitals

Chapter 53. Outpatient Surgery

Subchapter B. Reimbursement Methodology

§5315. Non-Rural, Non-State Public Hospitals

A. Effective for dates of service on or after July 1, 2013, quarterly supplemental payments may be issued to qualifying non-rural, non-state public hospitals for outpatient surgical services rendered during the quarter. Payment amounts may be reimbursed up to the Medicare outpatient upper payment limits as determined in accordance with 42 CFR §447.321.

1. Qualifying Criteria. In order to qualify for the quarterly supplemental payment, the non-rural, non-state public acute care hospital must be designated as a non-teaching hospital by the department and must:

a. be located in a Medicare metropolitan statistical area (MSA) per 42 CFR 413.231(b)(1);

b. provide inpatient obstetrical and neonatal intensive care unit services; and

c. per the cost report period ending in SFY 2012, have a Medicaid inpatient day utilization percentage in excess of 21 percent and a Medicaid newborn day utilization percentage in excess of 65 percent as documented on the as filed cost report.

2. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:2867 (December 2010), amended LR 39:1473 (June 2013), LR 40:

Chapter 55. Clinic Services

Subchapter B. Reimbursement Methodology

§5515. Non-Rural, Non-State Public Hospitals

A. Effective for dates of service on or after July 1, 2013, quarterly supplemental payments may be issued to qualifying non-rural, non-state public hospitals for clinic

services rendered during the quarter. Payment amounts may be reimbursed up to the Medicare outpatient upper payment limits as determined in accordance with 42 CFR §447.321.

1. Qualifying Criteria. In order to qualify for the quarterly supplemental payment, the non-rural, non-state public acute care hospital must be designated as a non-teaching hospital by the department and must:

- a. be located in a MSA per 42 CFR 413.231(b)(1);
- b. provide inpatient obstetrical and neonatal intensive care unit services; and
- c. per the cost report period ending in SFY 2012, have a Medicaid inpatient day utilization percentage in excess of 21 percent and a Medicaid newborn day utilization percentage in excess of 65 percent as documented on the as filed cost report.

2. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:2867 (December 2010), amended LR 39:1473 (June 2013), LR 40:

Chapter 57. Laboratory Services

Subchapter B. Reimbursement Methodology

§5717. Non-Rural, Non-State Public Hospitals

A. Effective for dates of service on or after July 1, 2013, quarterly supplemental payments may be issued to qualifying non-rural, non-state public hospitals for laboratory services rendered during the quarter. Payment amounts may be reimbursed up to the Medicare outpatient upper payment limits as determined in accordance with 42 CFR §447.321.

1. Qualifying Criteria. In order to qualify for the quarterly supplemental payment, the non-rural, non-state public acute care hospital must be designated as a non-teaching hospital by the department and must:

- a. be located in a MSA per 42 CFR 413.231(b)(1);
- b. provide inpatient obstetrical and neonatal intensive care unit services; and
- c. per the cost report period ending in SFY 2012, have a Medicaid inpatient day utilization percentage in excess of 21 percent and a Medicaid newborn day utilization percentage in excess of 65 percent as documented on the as filed cost report.

2. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:2868 (December 2010), amended LR 39:1473 (June 2013), LR 40:

Chapter 59. Rehabilitation Services

Subchapter B. Reimbursement Methodology

§5915. Non-Rural, Non-State Public Hospitals

A. Effective for dates of service on or after July 1, 2013, quarterly supplemental payments may be issued to qualifying non-rural, non-state public hospitals for rehabilitation services rendered during the quarter. Payment amounts may be reimbursed up to the Medicare outpatient upper payment limits as determined in accordance with 42 CFR §447.321.

1. Qualifying Criteria. In order to qualify for the quarterly supplemental payment, the non-rural, non-state

public acute care hospital must be designated as a non-teaching hospital by the department and must:

- a. be located in a MSA per 42 CFR 413.231(b)(1);
- b. provide inpatient obstetrical and neonatal intensive care unit services; and
- c. per the cost report period ending in SFY 2012, have a Medicaid inpatient day utilization percentage in excess of 21 percent and a Medicaid newborn day utilization percentage in excess of 65 percent as documented on the as filed cost report.

2. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:2867 (December 2010), amended LR 39:1473 (June 2013), LR 40:

Chapter 61. Other Outpatient Hospital Services

Subchapter B. Reimbursement Methodology

§6117. Non-Rural, Non-State Public Hospitals

A. Effective for dates of service on or after July 1, 2013, quarterly supplemental payments may be issued to qualifying non-rural, non-state public hospitals for outpatient services other than clinic services, diagnostic laboratory services, outpatient surgeries and rehabilitation services rendered during the quarter. Payment amounts may be reimbursed up to the Medicare outpatient upper payment limits as determined in accordance with 42 CFR §447.321.

1. Qualifying Criteria. In order to qualify for the quarterly supplemental payment, the non-rural, non-state public acute care hospital must be designated as a non-teaching hospital by the department and must:

- a. be located in a MSA per 42 CFR 413.231(b)(1);
- b. provide inpatient obstetrical and neonatal intensive care unit services; and
- c. per the cost report period ending in SFY 2012, have a Medicaid inpatient day utilization percentage in excess of 21 percent and a Medicaid newborn day utilization percentage in excess of 65 percent as documented on the as filed cost report.

2. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:2867 (December 2010), amended LR 39:1473 (June 2013), LR 40:

Family Impact Statement

In compliance with Act 1183 of the 1999 Regular Session of the Louisiana Legislature, the impact of this proposed Rule on the family has been considered. It is anticipated that this proposed Rule will have a positive impact on family functioning, stability or autonomy as described in R.S. 49:972 as it will enhance recipient access to outpatient hospital services by ensuring sufficient provider participation in the Hospital Program.

Poverty Impact Statement

In compliance with Act 854 of the 2012 Regular Session of the Louisiana Legislature, the poverty impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have a positive impact on child, individual, or family poverty in relation to individual or community asset development as described in R.S. 49:973 as

it is expected to enhance recipient access to outpatient hospital services which is expected to reduce health care costs to families.

Provider Impact Statement

In compliance with House Concurrent Resolution (HCR) 170 of the 2014 Regular Session of the Louisiana Legislature, the provider impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have no impact on the staffing level requirements or qualifications required to provide the same level of service, may reduce the total direct and indirect cost to the provider to provide the same level of service, and may enhance the provider's ability to provide the same level of service as described in HCR 170 since this proposed Rule increases payments to providers for the same services they already render.

Public Comments

Interested persons may submit written comments to J. Ruth Kennedy, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030 or by email to MedicaidPolicy@la.gov. Ms. Kennedy is responsible for responding to inquiries regarding this proposed Rule. The deadline for receipt of all written comments is 4:30 p.m. on the next business day following the public hearing.

Public Hearing

A public hearing on this proposed Rule is scheduled for Wednesday, July 30, 2014 at 9:30 a.m. in Room 118, Bienville Building, 628 North Fourth Street, Baton Rouge, LA. At that time all interested persons will be afforded an opportunity to submit data, views or arguments either orally or in writing.

Kathy H. Kliebert
Secretary

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES

RULE TITLE: Outpatient Hospital Services Non-Rural, Non-State Public Hospitals Supplemental Payments

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

It is anticipated that the implementation of this proposed rule will result in estimated state general fund programmatic costs of \$4,593,706 for FY 13-14, \$4,846,138 for FY 14-15 and \$4,959,947 for FY 15-16. It is anticipated that \$656 (\$328 SGF and \$328 FED) will be expended in in FY 13-14 for the state's administrative expense for promulgation of this proposed rule and the final rule. The numbers reflected above are based on a blended Federal Medical Assistance Percentage (FMAP) rate of 61.48 percent in FY 14-15. The enhanced rate of 62.11 percent for the last nine months of FY 14 is the federal rate for disaster-recovery FMAP adjustment states.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

It is anticipated that the implementation of this proposed rule will increase federal revenue collections by approximately \$7,808,078 for FY 13-14, \$7,927,024 for FY 14-15 and \$8,196,410 for FY 15-16. It is anticipated that \$328 will be expended in FY 12-13 for the federal administrative expenses for promulgation of this proposed rule and the final rule. The

numbers reflected above are based on a blended Federal Medical Assistance Percentage (FMAP) rate of 61.48 percent in FY 14-15. The enhanced rate of 62.11 percent for the last nine months of FY 14 is the federal rate for disaster-recovery FMAP adjustment states.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

This proposed rule continues the provisions of the September 20, 2013 Emergency Rule which amended the provisions governing the reimbursement methodology for outpatient hospital services in order to revise the qualifying criteria and reimbursement methodology for a specific non-rural, non-state public hospital. It is anticipated that implementation of this proposed rule will increase programmatic expenditures in the Medicaid Program by approximately \$12,401,128 for FY 13-14, \$12,773,162 for FY 14-15 and \$13,156,357 for FY 15-16.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

It is anticipated that the implementation of this proposed rule will not have an effect on competition and employment.

J. Ruth Kennedy
Medicaid Director
1406#074

Evan Brasseaux
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

Department of Health and Hospitals Bureau of Health Services Financing

Targeted Case Management
HIV Coverage Termination
(LAC 50:XV.10505, 10701 and Chapter 119)

The Department of Health and Hospitals, Bureau of Health Services Financing proposes to amend LAC 50:XV.10505, §10701 and repeal Chapter 119 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This proposed Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R. S. 49:950 et seq.

The Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Public Health (OPH) amended the provisions governing the reimbursement of targeted case management (TCM) services rendered by the Office of Public Health in the Nurse Family Partnership Program in order to establish Medicaid payment of uncompensated care costs for services rendered by OPH to Medicaid eligible recipients (*Louisiana Register*, Volume 39, Number 1).

Due to a budgetary shortfall in state fiscal year 2013, the Department of Health and Hospitals, Bureau of Health Services Financing promulgated an Emergency Rule which amended the provisions governing targeted case management in order to terminate the coverage and Medicaid reimbursement of TCM services rendered to HIV disabled individuals (*Louisiana Register*, Volume 39, Number 1). This proposed Rule is being promulgated to continue the provisions of the February 1, 2013 Emergency Rule.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE

Part XV. Services for Special Populations

Subpart 7. Targeted Case Management

Chapter 105. Provider Participation

§10505. Staff Education and Experience

A - D.2. ...

E. Case Manager Trainee

1. The case management agency must obtain prior approval from the bureau before a case management trainee can be hired. The maximum allowable caseload for a case manager trainee is 20 recipients. The case management trainee position may be utilized to provide services to the following target populations:

- a. ...
- b. new opportunities waiver;
- c. elderly and disabled adult waiver;
- d. targeted EPSDT; and
- e. children's choice waiver.
- f. Repealed.

2. - 2.e....

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 12:834 (December 1986) amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 23:732 (June 1997) repealed and promulgated LR 25:1251 (July 1999), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services, LR 29:38 (January 2003), repromulgated for inclusion in LAC, LR 30:1038 (May 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 32:1608 (September 2006), amended LR 34:663 (April 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:

Chapter 107. Reimbursement

§10701. Reimbursement

A. - H.3.a. ...

I. Effective for dates of service on or after February 1, 2013, reimbursement shall not be made for case management services rendered to HIV disabled individuals.

J. Reserved.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:1040 (May 2004), amended LR 31:2032 (August 2005), amended LR 35:73 (January 2009), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:1903 (September 2009), amended LR 36:1783 (August 2010), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Public Health, LR 39:97 January 2013, amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 39:3302 (December 2013), LR 40:

Chapter 119. HIV Disabled

§11901. Introduction

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health

Services Financing, LR 30:1043 (May 2004), repealed by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:

§11903. Recipient Requirements

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:1043 (May 2004), repealed by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:

§11905. Provider Requirements

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:1043 (May 2004), repealed by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:

Family Impact Statement

In compliance with Act 1183 of the 1999 Regular Session of the Louisiana Legislature, the impact of this proposed Rule on the family has been considered. It is anticipated that this proposed Rule may have an adverse impact on family functioning, stability and autonomy as described in R.S. 49:972 due to the loss of HIV targeted case management services.

Poverty Impact Statement

In compliance with Act 854 of the 2012 Regular Session of the Louisiana Legislature, the poverty impact of this proposed Rule has been considered. It is anticipated that this proposed Rule may have an adverse impact on child, individual, or family poverty in relation to individual or community asset development as described in R.S. 49:973 in the event that health care assistance is reduced as the result of loss of HIV targeted case management services.

Provider Impact Statement

In compliance with House Concurrent Resolution (HCR) 170 of the 2014 Regular Session of the Louisiana Legislature, the provider impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have no impact on the staffing level requirements or qualifications required to provide the same level of service, but may increase direct or indirect cost to the provider to provide the same level of service due to the termination of Medicaid payments for the service. The proposed Rule may also have a negative impact on the provider's ability to provide the same level of service as described in HCR 170 if the reduction in payments adversely impacts the provider's financial standing.

Public Comments

Interested persons may submit written comments to J. Ruth Kennedy, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030 or by email to MedicaidPolicy@la.gov. Ms. Kennedy is responsible for responding to inquiries regarding this proposed Rule. The deadline for receipt of all written comments is 4:30 p.m. on the next business day following the public hearing.

Public Hearing

A public hearing on this proposed Rule is scheduled for Wednesday, July 30, 2014 at 9:30 a.m. in Room 118,

Bienville Building, 628 North Fourth Street, Baton Rouge, LA. At that time all interested persons will be afforded an opportunity to submit data, views or arguments either orally or in writing.

Kathy H. Kliebert
Secretary

**FISCAL AND ECONOMIC IMPACT STATEMENT
FOR ADMINISTRATIVE RULES
RULE TITLE: Targeted Case Management
HIV Coverage Termination**

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

It is anticipated that the implementation of this proposed rule will result in estimated state general fund programmatic savings of \$99,349 for FY 13-14, \$105,075 for FY 14-15 and \$107,543 for FY 15-16. It is anticipated that \$492 (\$246 SGF and \$246 FED) will be expended in FY 13-14 for the state's administrative expense for promulgation of this proposed rule and the final rule. The numbers reflected above are based on a blended Federal Medical Assistance Percentage (FMAP) rate of 61.48 percent in FY 14-15. The enhanced rate of 62.11 percent for the last nine months of FY 14 is the federal rate for disaster-recovery FMAP adjustment states.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

It is anticipated that the implementation of this proposed rule will reduce federal revenue collections by approximately \$169,043 for FY 13-14, \$171,875 for FY 14-15 and \$177,716 for FY 15-16. It is anticipated that \$246 will be expended in FY 13-14 for the federal administrative expenses for promulgation of this proposed rule and the final rule. The numbers reflected above are based on a blended Federal Medical Assistance Percentage (FMAP) rate of 61.48 percent in FY 14-15. The enhanced rate of 62.11 percent for the last nine months of FY 14 is the federal rate for disaster-recovery FMAP adjustment states.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

This proposed rule continues the provisions of the February 1, 2013 Emergency Rule which amended the provisions governing targeted case management services rendered to HIV disabled individuals in order to terminate coverage of these services. It is anticipated that implementation of this proposed rule will reduce expenditures in the Medicaid Program by approximately \$268,884 for FY 13-14, \$276,950 for FY 14-15 and \$285,259 for FY 15-16.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

It is anticipated that the implementation of this proposed rule will have no effect on competition. However, it is anticipated that the implementation of this proposed rule may have a negative effect on employment as it will reduce the payments made for TCM services provided to HIV disabled individuals. The reduction in payments may adversely impact the financial standing of providers and could possibly cause a reduction in employment opportunities.

J. Ruth Kennedy
Medicaid Director
1406#075

Evan Brasseaux
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

**Department of Health and Hospitals
Bureau of Health Services Financing**

Targeted Case Management
Nurse Family Partnership
Program Termination
(LAC 50:XV.10505, 10701 and Chapter 111)

The Department of Health and Hospitals, Bureau of Health Services Financing proposes to amend LAC 50:XV.10505, §10701 and repeal Chapter 111 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This proposed Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R. S. 49:950 et seq.

The Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Public Health (OPH) amended the provisions governing the reimbursement of targeted case management (TCM) services rendered by the Office of Public Health in the Nurse Family Partnership Program in order to establish Medicaid payment of uncompensated care costs for services rendered by OPH to Medicaid eligible recipients (*Louisiana Register*, Volume 39, Number 1).

Due to a budgetary shortfall in state fiscal year 2013, the Department of Health and Hospitals, Bureau of Health Services Financing promulgated an Emergency Rule which amended the provisions governing targeted case management in order to terminate Medicaid reimbursement of TCM services provided to first-time mothers in the Nurse Family Partnership Program (*Louisiana Register*, Volume 39, Number 1). This proposed Rule is being promulgated to continue the provisions of the February 1, 2013 Emergency Rule.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE

Part XV. Services for Special Populations

Subpart 7. Targeted Case Management

Chapter 105. Provider Participation

§10505. Staff Education and Experience

A. ...

B. Case Managers. All case managers must meet one of the following minimum education and experience qualifications:

1. - 3.a. ...

b. Repealed.

4. ...

C. Case Management Supervisors. All case management supervisors must meet one of the following education and experience requirements:

C.1. - E.2.e. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services, LR 30:1038 (May 2004), amended by the Department of Health and Hospitals, Office of the

Secretary, Office for Citizens with Developmental Disabilities, LR 32:1608 (September 2006), amended LR 34:663 (April 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:

Chapter 107. Reimbursement

§10701. Reimbursement

A. - I. ...

J. Effective for dates of service on or after February 1, 2013, the department shall terminate Medicaid reimbursement of targeted case management services provided to first-time mothers in the Nurse Family Partnership Program.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:1040 (May 2004), amended LR 31:2032 (August 2005), amended LR 35:73 (January 2009), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, amended LR 35:1903 (September 2009), amended LR 36:1783 (August 2010), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Public Health, LR 39:97 (January 2013), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 39:3302 (December 2013), LR 40:

Chapter 111. Nurse Family Partnership Program

§11101. Introduction

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services, LR 30:1041 (May 2004), amended LR 31:2028 (August 2005), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:1036 (June 2008), amended LR 36:1783 (August 2010), repealed by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:

§11103. Recipient Qualifications

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services, LR 30:1041 (May 2004), amended LR 31:2028 (August 2005), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:1037 (June 2008), LR 36:1783 (August 2010), repealed by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:

§11105. Staff Qualifications

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 26:2796 (December 2000), repromulgated for inclusion in LAC, LR 30:1042 (May 2004), amended LR 31:2028 (August 2005), repealed by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:

Family Impact Statement

In compliance with Act 1183 of the 1999 Regular Session of the Louisiana Legislature, the impact of this proposed Rule on the family has been considered. It is anticipated that this proposed Rule will have no impact on family functioning, stability or autonomy as described in R.S.

49:972 as TCM services are available to first time mothers via the Bayou Health Program or other funding sources.

Poverty Impact Statement

In compliance with Act 854 of the 2012 Regular Session of the Louisiana Legislature, the poverty impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have no impact on child, individual, or family poverty in relation to individual or community asset development as described in R.S. 49:973 as TCM services are available to first time mothers via the Bayou Health Program or other funding sources.

Provider Impact Statement

In compliance with House Concurrent Resolution (HCR) 170 of the 2014 Regular Session of the Louisiana Legislature, the provider impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have no impact on the staffing level requirements or qualifications required to provide the same level of service, but may increase direct or indirect cost to the provider to provide the same level of service due to the termination of Medicaid payments for the service. The proposed Rule may also have a negative impact on the provider's ability to provide the same level of service as described in HCR 170 if the reduction in payments adversely impacts the provider's financial standing.

Public Comments

Interested persons may submit written comments to J. Ruth Kennedy, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 708219030 or by email to MedicaidPolicy@la.gov. Ms. Kennedy is responsible for responding to inquiries regarding this proposed Rule. The deadline for receipt of all written comments is 4:30 p.m. on the next business day following the public hearing.

Public Hearing

A public hearing on this proposed Rule is scheduled for Wednesday, July 30, 2014 at 9:30 a.m. in Room 118, Bienville Building, 628 North Fourth Street, Baton Rouge, LA. At that time all interested persons will be afforded an opportunity to submit data, views or arguments either orally or in writing.

Kathy H. Kliebert
Secretary

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES

RULE TITLE: Targeted Case Management Nurse Family Partnership—Program Termination

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

It is anticipated that the implementation of this proposed rule will result in estimated state general fund programmatic savings of \$770,648 for FY 13-14, \$813,314 for FY 14-15 and \$832,414 for FY 15-16. It is anticipated that \$492 (\$246 SGF and \$246 FED) will be expended in FY 13-14 for the state's administrative expense for promulgation of this proposed rule and the final rule. The numbers reflected above are based on a blended Federal Medical Assistance Percentage (FMAP) rate of 61.48 percent in FY 14-15. The enhanced rate of 62.11 percent for the last nine months of FY 14 is the federal rate for disaster-recovery FMAP adjustment states.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

It is anticipated that the implementation of this proposed rule will reduce federal revenue collections by approximately \$1,310,107 for FY 13-14, \$1,330,370 for FY 14-15 and \$1,375,581 for FY 15-16. It is anticipated that \$246 will be expended in FY 13-14 for the federal administrative expenses for promulgation of this proposed rule and the final rule. The numbers reflected above are based on a blended Federal Medical Assistance Percentage (FMAP) rate of 61.48 percent in FY 14-15. The enhanced rate of 62.11 percent for the last nine months of FY 14 is the federal rate for disaster-recovery FMAP adjustment states.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

This proposed rule continues the provisions of the February 1, 2013 Emergency Rule which amended the provisions governing targeted case management in order to terminate the Nurse Family Partnership Program and Medicaid reimbursement of TCM services to first-time mothers. It is anticipated that implementation of this proposed rule will reduce expenditures in the Medicaid Program by approximately \$2,081,247 for FY 13-14, \$2,143,684 for FY 14-15 and \$2,207,995 for FY 15-16.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

It is anticipated that the implementation of this proposed rule will have no effect on competition. However, it is anticipated that the implementation of this proposed rule may have a negative effect on employment as it will reduce the payments made for TCM services provided to first-time mothers. The reduction in payments may adversely impact the financial standing of providers and could possibly cause a reduction in employment opportunities.

J. Ruth Kennedy
Medicaid Director
1406#076

Evan Brasseaux
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

**Department of Health and Hospitals
Emergency Response Network**

**Requirements for Stroke Center Recognition and
STEMI Receiving/Referral Centers Recognition
(LAC 48:I.Chapters 187 and 189)**

Notice is hereby given that the Louisiana Emergency Response Network Board has exercised the provisions of R.S. 49:950 et seq., the Administrative Procedure Act, and intends to promulgate LAC 48:I.Chapters 187, Requirements for Stroke Center Recognition; §§18701 to 18709; and Chapter 189, Requirements for Louisiana STEMI Receiving/Referral Centers Recognition, §§18901 to 18907.

The Louisiana Emergency Response Network (LERN) is created by R.S. 40:2841-2846. R.S. 40:2846(A) authorizes the LERN board to adopt rules and regulations necessary to carry out the provisions of the Chapter. R.S. 40:2845(A)(7) authorizes the board to work with the Department of Health and Hospitals to develop stroke and ST segment elevation myocardial infarction (STEMI) systems that are designed to promote rapid identification of and access to appropriate stroke and STEMI resources statewide. This Rule is adopted in accordance therewith.

Title 48

PUBLIC HEALTH—GENERAL

Part I. General Administration

**Subpart 15. Louisiana Emergency Response Network
Board**

**Chapter 187. Requirements for Louisiana Stroke
Center Recognition**

§18701. Stroke Center Recognition

A. The Louisiana Emergency Response Network Board (LERN) and the Louisiana Department of Health and Hospitals recognize the following four levels of stroke facilities:

1. level 1: comprehensive stroke center;
2. level 2: primary stroke center;
3. level 3: acute stroke ready hospital; and
4. level 4: non-stroke hospital.

B. Participation in Louisiana stroke center recognition is voluntary and no hospital shall be required to participate.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2846(A) and 48:2845(A)(7).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Emergency Response Network, LR 40:

§18703. Stroke Center Criteria

A. Each facility participating in stroke center recognition shall meet the following criteria.

1. Level 1: A comprehensive stroke center (CSC) will meet the requirements specified by the joint commission or other board approved accrediting/certification body approved by LERN for comprehensive stroke center certification. Attestation as a CSC is only allowed after verification by the joint commission or other LERN approved accrediting/certification body that the facility meets all requirements set forth in the CSC standards.

2. Level 2: A primary stroke center (PSC) shall meet the requirements specified by the joint commission, healthcare facilities accreditation program (HFAP), or other LERN approved accrediting/certification body for Primary Stroke Center verification. Attestation as a PSC is only allowed after verification by the joint commission, HFAP, or other LERN approved accrediting/certification body that the facility meets all requirements set forth in the PSC standards.

3. Level 3: An acute stroke ready hospital (ACRH) will provide timely access to stroke care but may not meet all criteria for a Level 1 or a Level 2 facility. An ACRH will provide acute stroke care in urban and rural areas where transportation and access are limited. An ACRH is intended to recognize models of care delivery that have shown utility, including “drip-and-ship” and telemedicine. An ACRH must meet requirements adopted by LERN. LERN approved requirements are based on national best practice guidelines.

4. Level 4: A non-stroke hospital (NSH) should not receive patients exhibiting signs or symptoms of stroke except for instances when the clinical situation requires stopping at the closest emergency department. A non stroke hospital must have:

- a. physician staffed ER 24/7;
- b. CT scan available within 12 hours; and
- c. transfer protocol in place for transfer to higher levels of care with a written and agreed upon relationship with a level I, II, or III stroke center.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2846(A) and 48:2845(A)(7).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Emergency Response Network, LR 40:

§18705. Attestation for Stroke Center Recognition

A. A hospital seeking level 1, level 2, level 3 or level 4 stroke center recognition will submit an affidavit of the hospital CEO to LERN detailing compliance with the requirements designated herein.

1. A center or hospital seeking level 1 CSC recognition which submits a copy of that level of certification by a LERN-recognized organization, such as the joint commission or other LERN approved accrediting/certification body, shall be assumed to meet the requirements for recognition.

2. A center or hospital seeking level 2 PSC stroke center recognition which submits a copy of that level of certification by a LERN-recognized organization, such as the joint commission, HFAP, or other LERN approved accrediting/certification body, shall be assumed to meet the requirements for recognition.

3. Although a center or hospital seeking level 3 stroke center recognition is not required to obtain certification by an external certifying body, a level 3 center which submits a copy of that level of certification by a LERN-recognized organization, such as HFAP or other LERN approved accrediting/certification body, shall be assumed to meet the requirements for recognition.

4. Each center or hospital shall submit proof of continued compliance every two years by submission of an affidavit by its CEO.

B. A hospital or center which fails to meet the criteria for a stroke facility level or which no longer choose to maintain state Stroke Facility level recognition, shall immediately notify LERN and local EMS.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2846(A) and 48:2845(A)(7).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Emergency Response Network, LR 40:

§18707. Stroke Center Listing

A. LERN will publish a list on its website of hospitals or centers attesting to or meeting stroke center criteria and their stroke center recognition. This list shall be made available to LERN regional commissions for facilitation of EMS transportation plans.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2846(A) and 48:2845(A)(7).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Emergency Response Network, LR 40:

§18709. Hospital Destination/Stroke System Transport

A. These rules are not intended to prevent any hospital or medical facility from providing medical care to any patient but rather to serve as a guideline to facilitate the timely and appropriate delivery of stroke patients to the most appropriate care site for the definitive treatment of stroke.

B. Knowledge of statewide stroke capabilities and the use of a stroke pre-hospital destination protocol will enable providers to make timely decisions, promote appropriate utilization of the stroke care delivery system, and ultimately save lives.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2846(A), 48:2845(A)(7) and La. R.S. 9:2798.5.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Emergency Response Network, LR 40:

Chapter 189. Requirements for Louisiana STEMI Receiving/Referral Centers

§18901. STEMI Center Recognition

A. The Louisiana Emergency Response Network Board (LERN), and the Louisiana Department of Health and Hospitals recognize the following types of facilities for the treatment of ST elevated myocardial infarction (STEMI):

1. STEMI receiving center; and
2. STEMI referral center.

B. Participation in the Louisiana STEMI center recognition is voluntary and no hospital shall be required to participate.

C. A facility seeking STEMI receiving center recognition shall meet the STEMI receiving center requirements adopted by LERN. LERN approved requirements are based on national best practice guidelines.

D. A hospital with an emergency room not meeting criteria for a STEMI receiving center will automatically default to a STEMI referral center.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2846(A) and 48:2845(A)(7).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Emergency Response Network, LR 40:

§18903. Attestation for STEMI Center Recognition

A. A hospital seeking STEMI Center recognition will submit an affidavit of the hospital CEO to LERN detailing compliance with the requirements designated herein.

1. A center or hospital seeking STEMI Center recognition which submits a copy of that level of certification by LERN-recognized organization, such as The Joint Commission or other LERN approved accrediting/certification body, shall be assumed to meet the requirements for recognition.

2. Each center or hospital shall submit proof of continued compliance every two years by submission of an affidavit of its CEO.

B. A hospital or center which fails to meet the criteria for a STEMI receiving center or which no longer choose to maintain state STEMI receiving center recognition, shall immediately notify LERN and local EMS.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2846(A) and 48:2845(A)(7).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Emergency Response Network, LR 40:

§18905. STEMI Center Listing

A. LERN will publish a list on its website of hospitals or centers attesting to STEMI center criteria for recognition as either a STEMI receiving center or STEMI referral center. This list shall be made available to the LERN regional commissions for facilitation of EMS transportation plans.

AUTHORITY NOTE: Promulgated in accordance with La. R.S. 40:2846(A) and 48:2845(A)(7).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Emergency Response Network, LR 40:

§18907. Hospital Destination/STEMI System Transport:

A. These rules are not intended to prevent any hospital or medical facility from providing medical care to any patient but rather to serve as a guideline to facilitate the timely and appropriate delivery of STEMI patients to the most appropriate care site for the definitive treatment of STEMI.

B. Knowledge of STEMI capabilities and the use of a STEMI pre-hospital destination protocol will enable providers to make timely decisions, promote appropriate

utilization of the STEMI care delivery system, and ultimately save lives.

AUTHORITY NOTE: Promulgated in accordance with La. R.S. 40:2846(A), 48:2845(A)(7) and R.S. 9:2798.5.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Emergency Response Network, LR 40:

Family Impact Statement

1. What effect will this Rule have on the stability of the family? The proposed Rule will not affect the stability of the family.

2. What effect will this have on the authority and rights of persons regarding the education and supervision of their children? The proposed Rule will not affect the authority and rights of persons regarding the education and supervision of their children.

3. What effect will this have on the functioning of the family? This Rule will not affect the functioning of the family.

4. What effect will this have on family earnings and family budget? This Rule will not affect the family earnings or family budget. This Rule should result in an increase of child support collections since it allows for another tool in collecting child support obligations.

5. What effect will this have on the behavior and personal responsibility of children? This Rule will not affect the behavior or personal responsibility of children.

6. Is the family or local government able to perform the function as contained in this proposed Rule? No, the action proposed is strictly a state enforcement function.

Poverty Impact Statement

The proposed rulemaking will have no impact on poverty as described in R.S. 49:973.

Small Business Statement

The impact of the proposed amendments to various sections of the Rule on small business has been considered and it is estimated that the proposed action is not expected to have a significant adverse impact on small business as defined in the Regulatory Flexibility Act. The agency, consistent with health, safety, environmental and economic welfare factors has considered and, where possible, utilized regulatory methods in the drafting of the proposed Rule that will accomplish the objectives of applicable statutes while minimizing the adverse impact of the proposed Rule on small business.

Provider Impact Statement

The proposed Rule should not have any known or foreseeable impact on providers as defined by HCR 170 of 2014 Regular Legislative Session. In particular, there should be no known or foreseeable effect on:

1. the effect on the staffing level requirements or qualifications required to provide the same level of service;

2. the total direct and indirect effect on the cost to the providers to provide the same level of service; or

3. the overall effect on the ability of the provider to provide the same level of service.

Public Comments

Interested persons may submit written comments relative to the proposed Rule until 4:30 p.m., Thursday, June 26, 2014

to Paige Hargrove, Louisiana Emergency Response Network, 14141 Airline Hwy., Suite B, Building 1, Baton Rouge, LA 70817, or via email to paige.hargrove@la.gov.

Paige Hargrove
Executive Director

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES RULE TITLE: Requirements for Stroke Center Recognition and STEMI Receiving/Referral Centers Recognition

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

The proposed rule provides for LERN to develop stroke and ST segment elevation myocardial infarction (STEMI, commonly known as a heart attack) systems statewide. Specifically, the proposed rule addresses requirements for stroke and STEMI center attestation and recognition, stroke and STEMI center criteria as well as hospital destination/transport guidelines for stroke and STEMI patients.

Besides the cost of publishing the rule in the Louisiana Register, which is estimated at \$600, there is no cost to implement this proposed rule. Once the stroke and STEMI systems are fully implemented, the proposed rule is anticipated to result in a cost savings to the Medicaid program within DHH due to following: (1) decrease in the number of secondary transfers by EMS for patients needing a higher level of care; (2) better clinical outcomes and a decrease in residual physical deficits that often results in prolonged hospitalization, rehabilitation or nursing home placement; (3) increase in the use of tPA (the only FDA approved drug for ischemic stroke), which is associated with a \$600 net cost savings for each tPA-treated patient.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

There will be no effect on revenue collections for state or local governmental units.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

There are no estimated costs to directly affected persons or non-governmental groups.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

There will be no effect on employment. With the establishment of stroke and STEMI systems and with the associated requirements for hospital levels designated by LERN, there may be an increase in the number of hospitals seeking certification in order to compete. Since the LERN Board approved the Stroke Levels there have been two Comprehensive Stroke Centers certified and three primary stroke centers certified in the state. Several others are working towards these designations. This is primarily due to each hospital's desire to provide quality care but there may also be a competitive component in the market. This is a voluntary process.

Paige Hargrove
Executive Director
1406#091

Evan Brasseaux
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

Department of Insurance Office of the Commissioner

Rule Number 8—Annuity Mortality Table for Use in Determining Reserve Liabilities for Annuities (LAC 37:XI.Chapter 21)

Under the authority of the Louisiana Insurance Code, R.S. 22:1 et seq., and in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., R.S. 22:11, and R.S. 22:753, notice is hereby given that the Department of Insurance proposes to amend Rule Number 8. The purpose of the amendment is to update the current provisions of Rule Number 8 to maintain consistency with the National Association of Insurance Commissioners' (NAIC) model rule regarding the mortality tables for use in determining the minimum standard of valuation for annuity and pure endowment contracts: the 1983 table "a," the 1983 group annuity mortality (1983 GAM) table, the annuity 2000 mortality table, the 2012 individual annuity reserving (2012 IAR) table, and the 1994 group annuity reserving (1994 GAR) table.

Title 37 INSURANCE Part XI. Rules

Chapter 21. Rule Number 8—A New Annuity Mortality Table for Use in Determining Reserve Liabilities for Annuities

§2100. Authority

A. This Rule is promulgated by the commissioner of insurance pursuant to R.S. 22:753 of the *Insurance Code*.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:753.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 24:2281 (December 1998), amended by the Department of Insurance, Office of the Commissioner, LR 40:

§2101. Purpose

A. The purpose of this Rule is to recognize the following mortality tables for use in determining the minimum standard of valuation for annuity and pure endowment contracts: the 1983 table "a," the 1983 group annuity mortality (1983 GAM) table, the annuity 2000 mortality table, the 2012 individual annuity reserving (2012 IAR) table, and the 1994 group annuity reserving (1994 GAR) table.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:753.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 11:1089 (November 1985), amended LR 24:2281 (December 1998), amended by the Department of Insurance, Office of the Commissioner, LR 40:

§2103. Definitions

1983 GAM Table—that mortality table developed by the Society of Actuaries Committee on Annuities and adopted as a recognized mortality table for annuities in December 1983 by the National Association of Insurance Commissioners.

1983 Table "a"—that mortality table developed by the Society of Actuaries Committee to Recommend a New Mortality Basis for Individual Annuity Valuation and adopted as a recognized mortality table for annuities in June

1982 by the National Association of Insurance Commissioners.

1994 GAR Table—that mortality table developed by the Society of Actuaries Group Annuity Valuation Table Task Force. The 1994 GAR table is included in the report on pages 866-867 of Volume XLVII of the *Transactions of the Society of Actuaries* (1995).

2012 IAR Table—that generational mortality table developed by the Society of Actuaries Committee on Life Insurance Research and containing rates, qx 2012+n, derived from a combination of the 2012 IAM period table and projection scale G2, using the methodology stated in §2106.

2012 Individual Annuity Mortality Period Life (2012 IAM Period) Table—the period table containing loaded mortality rates for calendar year 2012. This table contains rates, qx 2012, developed by the Society of Actuaries Committee on Life Insurance Research and is shown in §2113.A and B.

Annuity 2000 Mortality Table—that mortality table developed by the Society of Actuaries Committee on Life Insurance Research. The annuity 2000 Table is included in the report on page 240 of Volume XLVII of the *Transactions of the Society of Actuaries* (1995).

Generational Mortality Table—a mortality table containing a set of mortality rates that decrease for a given age from one year to the next based on a combination of a Period table and a projection scale containing rates of mortality improvement.

Period Table—a table of mortality rates applicable to a given calendar year (the period).

Projection Scale G2 (Scale G2)—is a table of annual rates, G2x, of mortality improvement by age for projecting future mortality rates beyond calendar year 2012. This table was developed by the Society of Actuaries Committee on Life Insurance Research and is shown in §2113.C and D.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:753.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 11:1089 (November 1985), amended LR 24:2281 (December 1998), amended by the Department of Insurance, Office of the Commissioner, LR 40:

§2105. Individual Annuity for Pure Endowment

Contracts

A. Except as provided in Subsections B and C of this Section, the 1983 table "a" is recognized and approved as an individual annuity mortality table for valuation and, at the option of the company, may be used for purposes of determining the minimum standard of valuation for any individual annuity or pure endowment contract issued on or after September 7, 1979.

B. Except as provided in Subsection C of this Section, either the 1983 table "a" or the annuity 2000 mortality table shall be used for determining the minimum standard of valuation for any individual annuity or pure endowment contract issued on or after January 1, 1987.

C. Except as provided in Subsection D of this Section, the annuity 2000 mortality table shall be used for determining the minimum standard of valuation for any individual annuity or pure endowment contract issued on or after January 1, 1999.

D. Except as provided in Subsection E of this Section, the 2012 IAR mortality table shall be used for determining the minimum standard of valuation for any individual

annuity or pure endowment contract issued on or after January 1, 2015.

E. The 1983 table "a" without projection is to be used for determining the minimum standards of valuation for an individual annuity or pure endowment contract issued on or after January 1, 1999, solely when the contract is based on life contingencies and is issued to fund periodic benefits arising from:

1. settlements of various forms of claims pertaining to court settlements or out of court settlements from tort actions;
2. settlements involving similar actions such as worker's compensation claims; or
3. settlements of long term disability claims where a temporary or life annuity has been used in lieu of continuing disability payments.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:753.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 11:1089 (November 1985), amended LR 24:2281 (December 1998), amended by the Department of Insurance, Office of the Commissioner, LR 40:

§2106. Application of the 2012 IAR Mortality Table

A. In using the 2012 IAR mortality table, the mortality rate for a person age x in year (2012 + n) is calculated as follows:

$$q_x^{2012+n} = q_x^{2012}(1 - G_{2x})^n$$

The resulting q_x^{2012+n} shall be rounded to three decimal places per 1,000, e.g., 0.741 deaths per 1,000. Also, the rounding shall occur according to the formula above, starting at the 2012 period table rate. For example, for a male age 30, $q_x^{2012} = 0.741$. $q_x^{2013} = 0.741 * (1 - 0.010) ^ 1 = 0.73359$, which is rounded to 0.734. $q_x^{2014} = 0.741 * (1 - 0.010) ^ 2 = 0.7262541$, which is rounded to 0.726. A method leading to incorrect rounding would be to calculate q_x^{2014} as $q_x^{2013} * (1 - 0.010)$, or $0.734 * 0.99 = 0.727$. It is incorrect to use the already rounded q_x^{2013} to calculate q_x^{2014} .

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:753.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 40:

§2107. Group Annuity or Pure Endowment Contracts

A. Except as provided in Subsections B and C of this Section, the 1983 GAM table, the 1983 table "a" and the 1994 GAR table are recognized and approved as group annuity mortality tables for valuation and, at the option of the company, any one of these tables may be used for purposes of valuation for an annuity or pure endowment purchased on or after September 7, 1979 under a group annuity or pure endowment contract.

§2113. Tables

A. 2012 IAM Period Table, Female, Age nearest Birthday

Age	1000 q_x^{2012}						
0	1.621	30	0.300	60	3.460	90	88.377
1	0.405	31	0.321	61	3.916	91	97.491
2	0.259	32	0.338	62	4.409	92	107.269
3	0.179	33	0.351	63	4.933	93	118.201
4	0.137	34	0.365	64	5.507	94	130.969
5	0.125	35	0.381	65	6.146	95	146.449
6	0.117	36	0.402	66	6.551	96	163.908
7	0.110	37	0.429	67	7.039	97	179.695
8	0.095	38	0.463	68	7.628	98	196.151
9	0.088	39	0.504	69	8.311	99	213.150

B. Except as provided in Subsection C of this Section, either the 1983 GAM table or the 1994 GAR table shall be used for determining the minimum standard of valuation for any annuity or pure endowment purchased on or after January 1, 1987 under a group annuity or pure endowment contract.

C. The 1994 GAR table shall be used for determining the minimum standard of valuation for any annuity or pure endowment purchased on or after January 1, 1999 under a group annuity or pure endowment contract.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:753.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 11:1089 (November 1985), amended LR 24:2281 (December 1998), amended by the Department of Insurance, Office of the Commissioner, LR 40:

§2108. Application of the 1994 GAR Table

A. In using the 1994 GAR table, the mortality rate for a person age x in year (1994 + n) is calculated as follows:

$$q_x^{1994+n} = q_x^{1994} (1 - AA_x)^n$$

where the q_x^{1994} s and AA_x s are as specified in the 1994 GAR Table.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:753.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 24:2281 (December 1998), amended by the Department of Insurance, Office of the Commissioner, LR 40:

§2109. Separability

A. If any provision of this rule or its application to any person or circumstances is for any reason held to be invalid, the remainder of the regulation and the application of its provisions to other persons or circumstances shall not be affected.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:753.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 11:1089 (November 1985), amended LR 24:2281 (December 1998), amended by the Department of Insurance, Office of the Commissioner, LR 40:

§2111. Effective Date

A. The effective date of this Rule is January 1, 2015.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:753.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 11:1089 (November 1985), amended LR 24:2281 (December 1998), amended by the Department of Insurance, Office of the Commissioner, LR 40:

Age	1000 q _x ²⁰¹²						
10	0.085	40	0.552	70	9.074	100	230.722
11	0.086	41	0.600	71	9.910	101	251.505
12	0.094	42	0.650	72	10.827	102	273.007
13	0.108	43	0.697	73	11.839	103	295.086
14	0.131	44	0.740	74	12.974	104	317.591
15	0.156	45	0.780	75	14.282	105	340.362
16	0.179	46	0.825	76	15.799	106	362.371
17	0.198	47	0.885	77	17.550	107	384.113
18	0.211	48	0.964	78	19.582	108	400.000
19	0.221	49	1.051	79	21.970	109	400.000
20	0.228	50	1.161	80	24.821	110	400.000
21	0.234	51	1.308	81	28.351	111	400.000
22	0.240	52	1.460	82	32.509	112	400.000
23	0.245	53	1.613	83	37.329	113	400.000
24	0.247	54	1.774	84	42.830	114	400.000
25	0.250	55	1.950	85	48.997	115	400.000
26	0.256	56	2.154	86	55.774	116	400.000
27	0.261	57	2.399	87	63.140	117	400.000
28	0.270	58	2.700	88	71.066	118	400.000
29	0.281	59	3.054	89	79.502	119	400.000
						120	1000.000

B. 2012 IAM Period Table, Male, Age nearest Birthday

Age	1000 q _x ²⁰¹²						
0	1.605	30	0.741	60	5.096	90	109.993
1	0.401	31	0.751	61	5.614	91	123.119
2	0.275	32	0.754	62	6.169	92	137.168
3	0.229	33	0.756	63	6.759	93	152.171
4	0.174	34	0.756	64	7.398	94	168.194
5	0.168	35	0.756	65	8.106	95	185.260
6	0.165	36	0.756	66	8.548	96	197.322
7	0.159	37	0.756	67	9.076	97	214.751
8	0.143	38	0.756	68	9.708	98	232.507
9	0.129	39	0.800	69	10.463	99	250.397
10	0.113	40	0.859	70	11.357	100	268.607
11	0.111	41	0.926	71	12.418	101	290.016
12	0.132	42	0.999	72	13.675	102	311.849
13	0.169	43	1.069	73	15.150	103	333.962
14	0.213	44	1.142	74	16.860	104	356.207
15	0.254	45	1.219	75	18.815	105	380.000
16	0.293	46	1.318	76	21.031	106	400.000
17	0.328	47	1.454	77	23.540	107	400.000
18	0.359	48	1.627	78	26.375	108	400.000
19	0.387	49	1.829	79	29.572	109	400.000
20	0.414	50	2.057	80	33.234	110	400.000
21	0.443	51	2.302	81	37.533	111	400.000
22	0.473	52	2.545	82	42.261	112	400.000
23	0.513	53	2.779	83	47.441	113	400.000
24	0.554	54	3.011	84	53.233	114	400.000
25	0.602	55	3.254	85	59.855	115	400.000
26	0.655	56	3.529	86	67.514	116	400.000
27	0.688	57	3.845	87	76.340	117	400.000
28	0.710	58	4.213	88	86.388	118	400.000
29	0.727	59	4.631	89	97.634	119	400.000
						120	1000.000

C. Projection Scale G2, Female, Age nearest Birthday

Age	G2 _x						
0	0.010	30	0.010	60	0.013	90	0.006
1	0.010	31	0.010	61	0.013	91	0.006
2	0.010	32	0.010	62	0.013	92	0.005
3	0.010	33	0.010	63	0.013	93	0.005
4	0.010	34	0.010	64	0.013	94	0.004
5	0.010	35	0.010	65	0.013	95	0.004
6	0.010	36	0.010	66	0.013	96	0.004
7	0.010	37	0.010	67	0.013	97	0.003
8	0.010	38	0.010	68	0.013	98	0.003

Age	G2 _x						
9	0.010	39	0.010	69	0.013	99	0.002
10	0.010	40	0.010	70	0.013	100	0.002
11	0.010	41	0.010	71	0.013	101	0.002
12	0.010	42	0.010	72	0.013	102	0.001
13	0.010	43	0.010	73	0.013	103	0.001
14	0.010	44	0.010	74	0.013	104	0.000
15	0.010	45	0.010	75	0.013	105	0.000
16	0.010	46	0.010	76	0.013	106	0.000
17	0.010	47	0.010	77	0.013	107	0.000
18	0.010	48	0.010	78	0.013	108	0.000
19	0.010	49	0.010	79	0.013	109	0.000
20	0.010	50	0.010	80	0.013	110	0.000
21	0.010	51	0.010	81	0.012	111	0.000
22	0.010	52	0.011	82	0.012	112	0.000
23	0.010	53	0.011	83	0.011	113	0.000
24	0.010	54	0.011	84	0.010	114	0.000
25	0.010	55	0.012	85	0.010	115	0.000
26	0.010	56	0.012	86	0.009	116	0.000
27	0.010	57	0.012	87	0.008	117	0.000
28	0.010	58	0.012	88	0.007	118	0.000
29	0.010	59	0.013	89	0.007	119	0.000
						120	0.000

D. Projection Scale G2, Male, Age nearest Birthday

Age	G2 _x						
0	0.010	30	0.010	60	0.015	90	0.007
1	0.010	31	0.010	61	0.015	91	0.007
2	0.010	32	0.010	62	0.015	92	0.006
3	0.010	33	0.010	63	0.015	93	0.005
4	0.010	34	0.010	64	0.015	94	0.005
5	0.010	35	0.010	65	0.015	95	0.004
6	0.010	36	0.010	66	0.015	96	0.004
7	0.010	37	0.010	67	0.015	97	0.003
8	0.010	38	0.010	68	0.015	98	0.003
9	0.010	39	0.010	69	0.015	99	0.002
10	0.010	40	0.010	70	0.015	100	0.002
11	0.010	41	0.010	71	0.015	101	0.002
12	0.010	42	0.010	72	0.015	102	0.001
13	0.010	43	0.010	73	0.015	103	0.001
14	0.010	44	0.010	74	0.015	104	0.000
15	0.010	45	0.010	75	0.015	105	0.000
16	0.010	46	0.010	76	0.015	106	0.000
17	0.010	47	0.010	77	0.015	107	0.000
18	0.010	48	0.010	78	0.015	108	0.000
19	0.010	49	0.010	79	0.015	109	0.000
20	0.010	50	0.010	80	0.015	110	0.000
21	0.010	51	0.011	81	0.014	111	0.000
22	0.010	52	0.011	82	0.013	112	0.000
23	0.010	53	0.012	83	0.013	113	0.000
24	0.010	54	0.012	84	0.012	114	0.000
25	0.010	55	0.013	85	0.011	115	0.000
26	0.010	56	0.013	86	0.010	116	0.000
27	0.010	57	0.014	87	0.009	117	0.000
28	0.010	58	0.014	88	0.009	118	0.000
29	0.010	59	0.015	89	0.008	119	0.000
						120	0.000

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:753.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 40:

Family Impact Statement

1. Describe the Effect of the Proposed Rule on the Stability of the Family. The proposed Rule should have no measurable impact upon the stability of the family.

2. Describe the Effect of the proposed Rule on the Authority and Rights of Parents Regarding the Education

and Supervision of their Children. The proposed Rule should have no impact upon the rights and authority of children regarding the education and supervision of their children.

3. Describe the Effect of the Proposed Rule on the Functioning of the Family. The proposed Rule should have no direct impact upon the functioning of the family.

4. Describe the Effect of the Proposed Rule on Family Earnings and Budget. The proposed Rule should have no direct impact upon family earnings and budget.

5. Describe the Effect of the Proposed Rule on the Behavior and Personal Responsibility of Children. The proposed Rule should have no impact upon the behavior and personal responsibility of children.

6. Describe the Effect of the Proposed Rule on the Ability of the Family or a Local Government to Perform the Function as Contained in the Rule. The proposed Rule should have no impact upon the ability of the family or a local governmental unit to perform the function as contained in the Rule.

Poverty Impact Statement

1. Describe the Effect on Household Income, Assets, and Financial Security. The proposed Rule change should have no effect on household income assets and financial security.

2. Describe the Effect on Early Childhood Development and Preschool through Postsecondary Education Development. The proposed Rule change should have no effect on early childhood development and preschool through postsecondary education development.

3. Describe the Effect on Employment and Workforce Development. The proposed Rule change should have no effect on employment and workforce development.

4. Describe the Effect on Taxes and Tax Credits. The proposed Rule change should have no effect on taxes and tax credits.

5. Describe the Effect on Child and Dependent Care, Housing, Health Care, Nutrition, Transportation and Utilities Assistance. The proposed Rule change should have no effect on child and dependent care, housing, health care, nutrition, transportation and utilities assistance.

Small Business Statement

The impact of the amendments to Rule Number 8 on small businesses as defined in the Regulatory Flexibility Act has been considered. It is estimated that the proposed action is not expected to have a significant adverse impact on small businesses. The agency, consistent with health, safety, environmental and economic welfare factors has considered and, where possible, utilized regulatory methods in the drafting of the proposed Rule that will accomplish the objectives of applicable statutes while minimizing the adverse impact of the proposed rule on small businesses.

1. Identification and Estimate of the Number of the Small Businesses Subject to the Proposed Rule. The proposed Rule should have no measurable impact upon small businesses.

2. The Projected Reporting, Record Keeping, and Other Administrative Costs Required for Compliance with the Proposed Rule, Including the Type of Professional Skills Necessary for Preparation of the Report or Record. The proposed Rule should have no measurable impact upon small businesses.

3. A Statement of the Probable Effect on Impacted Small Businesses. The proposed Rule should have no measurable impact upon small businesses.

4. Describe Any Less Intrusive or Less Costly Alternative Methods of Achieving the Purpose of the Proposed Rule. The proposed Rule should have no measurable impact on small businesses; therefore, will have no less intrusive or less cost alternative methods.

Provider Impact Statement

1. Describe the Effect on the Staffing Level Requirements or Qualifications Required to Provide the Same Level of Service. The proposed Rule change will have no effect.

2. The Total Direct and Indirect Effect on the Cost to the Provider to Provide the Same Level of Service. The proposed Rule change will have no effect.

3. The Overall Effect on the Ability of the Provider to Provide the Same Level of Service. The proposed Rule change will have no effect

Public Comments

Interested persons may submit written comments on the proposed amendments to Rule Number 8 until 5 p.m., Tuesday July 29, 2014, to Walter Corey, Division of Legal Services, Office of the Commissioner, P.O. Box 94214, Baton Rouge, LA 70804.

Public Hearing

A public hearing on the proposed amendments to Rule Number 8 will be held Tuesday July 29, 2014, at 10 a.m., in the Poydras Hearing Room at the Louisiana Department of Insurance, 1702 North Third Street, Baton Rouge, LA. At that time all interested persons will be afforded an opportunity to submit data, views or arguments either orally or in writing.

James J. Donelon
Commissioner

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES

RULE TITLE: Rule Number 8—Annuity Mortality Table for Use in Determining Reserve Liabilities for Annuities

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

The proposed rule change will not result in implementation costs or savings to state or local governmental units. The proposed rule change updates the *Louisiana Administrative Code* to maintain consistency with the National Association of Insurance Commissioners' (NAIC) valuation for annuity and pure endowment contracts.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

The proposed rule change will have no impact on state or local governmental revenues.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

The proposed rule change will have no impact on economic costs or benefits to directly affected persons or non-governmental groups.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

The proposed rule change will have no impact upon competition and employment in the state.

Denise Brignac
Deputy Commissioner
1406#021

John D. Carpenter
Legislative Fiscal Officer
Legislative Fiscal Office

NOTICE OF INTENT

Department of Transportation and Development Office of Operations

Louisiana Transportation Authority (LAC 70:XI.101)

Notice is hereby given in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., and through the authority granted in R.S. 47:820.5.6, that the Louisiana Transportation Authority proposes to amend Chapter 1 to allow the LTA to adjust the amount charged for a toll tag to reflect the cost incurred by LTA to purchase a toll tag.

Title 70

TRANSPORTATION

Part XI. Louisiana Transportation Authority

Chapter 1. Toll Exemption—LA 1

§101. Exempt Entities

A.-A.1.e. ...

f. A reasonable fee shall be charged to offset the cost of the toll tags.

1.g. - 2.d. ...

e. A reasonable fee shall be charged to offset the cost of the toll tags.

2.f. - 3.b. ...

c. A reasonable fee shall be charged to offset the cost of the toll tags.

3.d. - 4.a.ii. ...

iii. A reasonable fee shall be charged to offset the cost of the toll tags.

a.iv. - b.ii. ...

iii. A reasonable fee shall be charged to offset the cost of the toll tags.

4.b.iv. - 5.c. ...

d. A reasonable fee shall be charged to offset the cost of the toll tags.

5.e. - 7.c. ...

d. A reasonable fee shall be charged to offset the cost of the toll tags.

7.e. - 8.c. ...

d. A reasonable fee shall be charged to offset the cost of the toll tags.

8.e. - 9.a. ...

b. A reasonable fee shall be charged to offset the cost of the toll tags.

c. - d. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 47:820.5.4 and 820.5.5.

HISTORICAL NOTE: Promulgated by the Department of Transportation and Development, Transportation Authority, LR 38:2380 (September 2012), amended by the Department of Transportation and Development, Office of Operations, LR 40:

Family Impact Statement

Implementation of this proposed rule change should not have any known or foreseeable impact on any family as defined by R.S. 49:972(D) or on family formation, stability and autonomy. Specifically:

1. The implementation of this proposed rule change will have no known or foreseeable effect on the stability of the family.

2. The implementation of this proposed rule change will have no known or foreseeable effect on the authority and rights of parents regarding the education and supervision of their children.

3. The implementation of this proposed rule change will have no known or foreseeable effect on the functioning of the family.

4. The implementation of this proposed rule change will have no known or foreseeable effect on the family earnings and family budget.

5. The implementation of this proposed rule change will have no known or foreseeable effect on the behavior and personal responsibility of children.

6. The implementation of this proposed rule change will have no known or foreseeable effect on the ability of the family or local government to perform this function.

Poverty Impact Statement

The implementation of this proposed rule change should not have any known or foreseeable impact on child, individual, or family poverty in relation to individual or community asset development as defined by R.S. 49:973. Specifically:

1. The implementation of this proposed rule change will have no known or foreseeable effect on household income, assets, and financial security.

2. The implementation of this proposed rule change will have no known or foreseeable effect on early childhood development and preschool through postsecondary education development.

3. The implementation of this proposed rule change will have no known or foreseeable effect on employment and workforce development.

4. The implementation of this proposed rule change will have no known or foreseeable effect on taxes and tax credits.

5. The implementation of this proposed rule change will have no known or foreseeable effect on child and dependent care, housing, health care, nutrition, transportation, and utilities assistance.

Provider Impact Statement

The implementation of this proposed rule change does not have any known or foreseeable impact on a provider as defined by House Concurrent Resolution No. 170 of the 2014 Regular Session of the Louisiana State Legislature. Specifically:

1. The implementation of this proposed rule change does not have any known or foreseeable impact on the staffing level requirements or qualifications required to provide the same level of service.

2. The implementation of this proposed rule change does not have any known or foreseeable impact on the total direct and indirect effect on the cost to a provider to provide the same levels of service.

3. The implementation of this proposed rule change does not have any known or foreseeable impact on the overall effect on the ability of a provider to provide the same level of service.

Small Business Statement

The implementation of this proposed rule change on small businesses, as defined in the Regulatory Flexibility Act, has

been considered. The proposed rule change is not expected to have a significant adverse impact on small businesses. The department, consistent with health, safety, environmental and economic welfare factors, has considered and, where possible, utilized regulatory methods in the drafting of the proposed rule that will accomplish the objectives of the proposed statutes while minimizing the adverse impact of the rule on small businesses.

Public Comments

All interested persons so desiring shall submit oral or written data, views, comments or arguments no later than 30 days from the date of publication of this Notice Of Intent to Stephen Glascock, ITS Director, Office of Operations, Department of Transportation and Development, P.O. Box 94245, Baton Rouge, LA 70804-9245, or by telephone (225) 379-2516.

Sherri H. LeBas
Secretary

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES

RULE TITLE: Louisiana Transportation Authority

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

There are no estimated implementation costs or savings to state or local governmental units associated with the proposed rule change. The proposed rule change will decrease the purchase price of a toll-exempt tag from \$12.50 to an amount equivalent to the actual cost of a toll tag, which is expected to drop to \$2 per tag in the upcoming fiscal year. The reduction in cost is a result of technological advances that have eliminated the use of hardware needed to track toll expenditures. The specific dollar amount will be removed from the rule and replaced with language that will give DOTD the flexibility to modify toll tag charges, as needed, to reflect the actual costs incurred by DOTD to purchase toll tags.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

DOTD will realize a revenue reduction of approximately \$10.50 per toll-exempt tag issued with the promulgation of the proposed rule change. The toll tag acquisition cost is projected to decrease to \$2 per tag in the upcoming fiscal year, from \$12.50 currently. The revenues collected for toll tag acquisition are equal to the department's cost of purchasing each tag.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

The proposed rule change will result in a savings of \$10.50 per toll tag issued to exempt toll patrons.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

There is no anticipated effect on competition and employment as a result of the proposed rule change.

Eric Kalivoda, Ph.D., P.E.
Deputy Secretary
1406#030

Evan Brasseaux
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

Department of Transportation and Development Office of Operations

Special Permits for Transporting Hay (LAC 73:I.303)

Notice is hereby given in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., and through the authority granted in R.S. 32:387(C)(2), that the Department of Transportation and Development, Office of Operations, proposes to amend Part I, Chapter 3, §303 to add Paragraph L authorizing the department to issue special permits for oversized loads of hay during a Presidential declaration of emergency or disaster.

Title 73

WEIGHTS, MEASURES AND STANDARDS

Part I. Weights and Standards

Chapter 3. Oversize and Overweight Permit

§303. Types of Permits

A. - K. ...

L. Special Permits for Transporting Hay

1. If there is a declaration of emergency or disaster in this state or another, for causes such as but not limited to severe and extended drought conditions, special permits may be issued by the secretary for those vehicles transporting hay. The permit fee shall be \$10 and shall be valid for only as long as the emergency exists, not to exceed one year. In addition, the following restrictions shall apply.

a. The total length of the vehicle and trailer shall not exceed 65 feet on non-interstate routes and the load and trailer shall not exceed 59 feet 6 inches on Interstate routes. The total weight of the vehicle and trailer shall not exceed 80,000 pounds for a 5 axle rig and 83,400 pounds for a 6 axle rig which also must include a tridum. Vehicles transporting hay bales loaded side by side across trailers shall not exceed 12 feet in width and 14 feet in height.

b. Travel is limited to daylight hours beginning at sunrise and ending at sunset and is limited by all no movement requirements on certain holidays.

c. Vehicles must travel with the required signs and flags properly placed and indicating that they carry oversized loads.

d. Vehicles must be equipped with mirrors that allow drivers to have a clear view of the highway to least 200 feet to the rear of the vehicle.

e. Loads must be securely bound to the transporting vehicles.

f. Carriers, owners and drivers of any vehicle being operated are responsible for verifying in advance that the actual dimensions and weights of the vehicles and loads are acceptable for all routes being traveled.

g. It is the responsibility of the carriers, owners and drivers to track the status of the declared emergencies. In the event the emergency expires prior to the one year period, the owner, carrier and driver shall be responsible for terminating use of the permit. Information regarding the status of

declared emergencies may be obtained by calling the department Permit Office toll free at (800) 654-1433 or (225) 343-2345 for the Baton Rouge area.

h. No vehicle shall exceed weight limits posted for bridges and similar structures, or relieve any vehicle or carrier, owner or driver of any vehicle from compliance with any restrictions other than those specified, or from any statute, rule, order or other legal requirement.

AUTHORITY NOTE: Promulgated in accordance with R.S. 32:2 et seq.

HISTORICAL NOTE: Promulgated by the Department of Transportation and Development, Office of Highways, LR 5:36 (February 1979), amended by the Department of Transportation and Development, Office of Operations and the Department of Public Safety and Corrections, Office of State Police, LR 39:98 (January 2013), amended by the Department of Transportation and Development, Office of Operations, LR 40:

Family Impact Statement

Implementation of this proposed rule change should not have any known or foreseeable impact on any family as defined by R.S. 49:972(D) or on family formation, stability and autonomy. Specifically:

1. The implementation of this proposed rule change will have no known or foreseeable effect on the stability of the family.

2. The implementation of this proposed rule change will have no known or foreseeable effect on the authority and rights of parents regarding the education and supervision of their children.

3. The implementation of this proposed rule change will have no known or foreseeable effect on the functioning of the family.

4. The implementation of this proposed rule change will have no known or foreseeable effect on the family earnings and family budget.

5. The implementation of this proposed rule change will have no known or foreseeable effect on the behavior and personal responsibility of children.

6. The implementation of this proposed rule change will have no known or foreseeable effect on the ability of the family or local government to perform this function.

Poverty Impact Statement

The implementation of this proposed rule change should not have any known or foreseeable impact on child, individual, or family poverty in relation to individual or community asset development as defined by R.S. 49:973. Specifically:

1. The implementation of this proposed rule change will have no known or foreseeable effect on household income, assets, and financial security.

2. The implementation of this proposed rule change will have no known or foreseeable effect on early childhood development and preschool through postsecondary education development.

3. The implementation of this proposed rule change will have no known or foreseeable effect on employment and workforce development.

4. The implementation of this proposed rule change will have no known or foreseeable effect on taxes and tax credits.

5. The implementation of this proposed rule change will have no known or foreseeable effect on child and dependent care, housing, health care, nutrition, transportation, and utilities assistance.

Provider Impact Statement

The implementation of this proposed rule change does not have any known or foreseeable impact on a provider as defined by House Concurrent Resolution No. 170 of the 2014 Regular Session of the Louisiana State Legislature. Specifically:

1. The implementation of this proposed rule change does not have any known or foreseeable impact on the staffing level requirements or qualifications required to provide the same level of service.

2. The implementation of this proposed rule change does not have any known or foreseeable impact on the total direct and indirect effect on the cost to a provider to provide the same levels of service.

3. The implementation of this proposed rule change does not have any known or foreseeable impact on the overall effect on the ability of a provider to provide the same level of service.

Small Business Statement

The implementation of this proposed rule change on small businesses, as defined in the Regulatory Flexibility Act, has been considered. The proposed rule change is not expected to have a significant adverse impact on small businesses. The department, consistent with health, safety, environmental and economic welfare factors, has considered and, where possible, utilized regulatory methods in the drafting of the proposed rule that will accomplish the objectives of the proposed statutes while minimizing the adverse impact of the rule on small businesses.

Public Comments

All interested persons so desiring shall submit oral or written data, views, comments or arguments no later than 30 days from the date of publication of this notice of intent to David Miller, Bridge Maintenance Administrator, Office of Operations, Department of Transportation and Development, P.O. Box 94245, Baton Rouge, LA 70804-9245, or by telephone (225) 379-1552.

Sherri H. LeBas
Secretary

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES RULE TITLE: Special Permits for Transporting Hay

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

The proposed rule change may result in an insignificant increase in costs of approximately \$10 per special permit issued. The proposed rule change will enable the Department of Transportation and Development to issue special permits for oversized vehicles hauling hay when there has been a declaration of emergency or disaster and the secretary determines that, as a result of the emergency or disaster, it is in the best interest of the state to expedite the transportation of hay on state roadways. It is anticipated that this permit will be

used when emergency conditions result in a shortage of hay in the affected area. The special permits will be valid only for the duration of the emergency or disaster, not to exceed one year.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

The proposed rule change may result in an insignificant increase in revenues. The department will charge an annual administrative fee of \$10 per vehicle to cover the costs of issuing the permit. This fee is consistent with other similar special permit fees. It is a new permit and therefore the department is unable to estimate the number of special permits that will be issued.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

The permit holder will be charged a fee of \$10 per year for each vehicle used to transport hay during an emergency or disaster. The permit shall be valid only for the duration of the emergency or disaster, not to exceed one year. Other directly affected persons, such as farmers and ranchers, will benefit by the timely delivery of hay needed to feed livestock.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

There are no estimated effects on competition and employment as a result of the proposed rule change.

Eric Kalivoda, Ph.D., P.E.
Deputy Secretary
1406#031

Evan Brasseaux
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

Department of Wildlife and Fisheries Wildlife and Fisheries Commission

Port Eads Possession Limit (LAC 76:VII.381)

The Department of Wildlife and Fisheries and the Wildlife and Fisheries Commission do hereby advertise their intent increase the possession limit on the water for recreational saltwater finfish landed by individuals lodging at the Port Eads Marina facility.

The secretary of the Department of Wildlife and Fisheries is authorized to take any and all necessary steps on behalf of the commission to promulgate and effectuate this Notice of Intent and final Rule, including but not limited to, the filing of the fiscal and economic impact statement, the filing of the Notice of Intent and final Rule and the preparation of reports and correspondence to other agencies of government.

Title 76

WILDLIFE AND FISHERIES

Part VII. Fish and Other Aquatic life

Chapter 3. Saltwater Sport and Commercial Fishery

§381. Possession Limits for Saltwater Recreational Finfish Landed at Port Eads Marina

A. Purpose. The Wildlife and Fisheries Commission recognizes that the Port Eads Marina in Plaquemines Parish is a remote fishing destination, only accessible by water, and that recreational fishermen may fish out of that facility for several consecutive days. In order to transport fish from the remote Port Eads Marina facility back to a location accessible by land, a recreational fisherman may have a need

to possess a limit on the water greater than what is allowed by general statewide possession limits for saltwater recreational finfish.

B. Possession Limit. Notwithstanding possession limits established elsewhere in this Chapter, for the purpose of transporting fish to a land-based facility the possession limit for saltwater finfish caught recreationally in Louisiana territorial waters or in the adjacent federal exclusive economic zone and landed at Port Eads Marina shall be equal to the daily take limit for the number of consecutive days, up to three times the daily creel limit, that a fisherman has been lodging at the Port Eads Marina facility, provided the fisherman is in compliance with the following requirements.

1. The fisherman holds and is in possession of all current recreational fishing licenses required.

2. The fisherman is in possession of and can provide a receipt issued by the Port Eads Marina facility that demonstrates, to the satisfaction of the department, the number of consecutive days that the fisherman has been lodging at the Port Eads Marina Facility.

3. Upon landing his or her daily catch at the Port Eads Marina, the fisherman shall notify the Wildlife and Fisheries employee, agent, or designated person on duty at the facility, and provide his or her catch for inspection and certification that the species, size and daily creel are within legal limits.

4. The fish are kept in separate bags for each daily take limit. The bags are marked with the date fish were taken, the species and number of fish contained in the bag, and the name and recreational fishing license number of the person taking the fish. The contents of the bags have been certified by the Wildlife and Fisheries employee, agent, or designated person on duty at the facility.

5. The fisherman is only in possession of his or her fish and shall not transport fish taken by another person back to the boat landing.

6. No person aboard the vessel may be engaged in or actively fishing.

AUTHORITY NOTE: Promulgated in accordance R.S. 56:6(25)(a), R.S. 56:325.1, and R.S. 56:326.3.

HISTORICAL NOTE: Promulgated by the Department of Wildlife and Fisheries, Wildlife and Fisheries Commission, LR 40:

Family Impact Statement

In accordance with Act No. 1183 of 1999, the Department of Wildlife and Fisheries/Wildlife and Fisheries Commission hereby issue its Family Impact Statement in connection with the preceding Notice of Intent.

Poverty Impact Statement

The proposed rulemaking will have no impact on poverty as described in R.S. 49:973.

Provider Impact Statement

This Rule has no known impact on providers as described in HCR 170 of 2014.

Public Comments

Interested persons may submit written comments relative to the proposed Rule to Jason Adriance, Marine Fisheries, P.O. Box 98000, Baton Rouge, LA 70898-9000, or jadriance@wlf.la.gov prior to August 1, 2014.

Billy Broussard
Chairman

**FISCAL AND ECONOMIC IMPACT STATEMENT
FOR ADMINISTRATIVE RULES**

RULE TITLE: Port Eads Possession Limit

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

The proposed Rule change is expected to have no effect on implementation costs to state or local governmental units.

The proposed Rule would allow anglers to possess up to three times the daily creel limit of saltwater fish in their vessels when transporting the fish to a location accessible by land from the remote Port Eads Marina in Plaquemines Parish.

The term "possession limit" refers to the number of fish of a particular species that a recreational angler may have in his or her possession at a particular time on or off the water. When onboard a vessel on the water, anglers may have in their possession a number of fish of a particular species equal to the species' daily creel limit. Currently the possession limit for recreational fish species off the water in Louisiana is twice the daily creel limit for a particular species.

Anglers who take prolonged fishing trips from remote locations like the Port Eads Marina are concerned that the current possession limits presents them with a difficult choice. To remain compliant with the possession limits during a multiple-day fishing trip, they must either cease fishing for a specific species after harvesting a single day's creel limit or take a boat trip from their remote camp to a distant land point to unload the equivalent of a single day's creel limit.

The proposed Rules change adjusts the general possession limit for anglers fishing in the vicinity of Port Eads near the mouth of the Mississippi River for more than one day at a time. Anglers who land a daily creel limit of fish at the Port Eads marina and receive certification from LDWF staff would be

permitted to possess up to three times the daily creel limit of saltwater fish when transporting the fish from the Port Eads marina to landing sites that are accessible by land. The fish must be kept in separate marked bags for each day's creel limit.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

The proposed Rule change is expected to have no effect on revenue collections of state or local governmental units.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

The proposed Rule change may result in a minor increase in activity among Louisiana anglers who fish for saltwater fish in the vicinity of Port Eads. The proposed Rule change may also benefit this group of anglers by reducing expenditures related to additional boats trips taken to and from distant land sites to unload fish to avoid noncompliance with current possession limits and general possession limits for saltwater fish.

The proposed Rules change would also be expected to benefit the Port Eads Fishing Refuge, the non-profit group that operates the Port Eads marina, because it would provide anglers additional incentives to use that facility. The Port Eads Fishing Refuge dedicates proceeds from the operation of the marina to a specified education fund for elementary, secondary, and vocational technical education in Plaquemines Parish.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

The proposed Rule change is expected to have no effect on competition or employment.

Bryan McClinton
Undersecretary
1406#042

Evan Brasseaux
Staff Director
Legislative Fiscal Office

Concurrent Resolutions

CONCURRENT RESOLUTION

House Concurrent Resolution No. 3

By Representative Stokes

A Concurrent Resolution

To amend and reenact the Office of Financial Institutions rules, LAC 10:XV.1303(E)(3) and 1315(A)(4), which provide that a repossession agency is prohibited from sponsoring more than one apprentice for every two licensed repossession agents at any one time, which provide that an apprentice is prohibited from repossessing collateral without on-site supervision of a repossession agent, and to direct the Office of the State Register to print the amendments in the Louisiana Administrative Code.

WHEREAS, R.S. 6:966 requires any individual who physically obtains possession of collateral pursuant to Chapter 10-A of Title 6 of the Louisiana Revised Statutes of 1950 to first obtain a repossession agent license from the Office of Financial Institutions; and

WHEREAS, R.S. 6:966.1 authorizes the commissioner of financial institutions to promulgate rules and regulations in accordance with the Administrative Procedure Act with respect to the repossession of collateral; and

WHEREAS, LAC 10:XV.1301 defines a repossession agency as "any person who through a designated repossession agent engages in business or accepts employment to locate or recover collateral registered under the provisions of the Louisiana Vehicle Certificate of Title Law, R.S. 32:701 et seq., which has been sold under a security agreement or used as security in a loan transaction, including any secured party which utilizes its employees to repossess collateral"; and

WHEREAS, LAC 10:XV.1303(D)(1)(d) requires that two years of experience within the previous three years be completed prior to application of any person seeking a license as a repossession agent; and

WHEREAS, LAC 10:XV.1303(F)(1) provides that one year of qualifying experience consists of not less than one thousand hours of actual compensated work performed by the applicant with a repossession agency prior to application for license as a repossession agent; and

WHEREAS, LAC 10:XV.1303(D)(1)(d) and LAC 10:XV.1303(F)(1) in combination require the completion of two thousand hours of actual compensated work within the previous three years as qualifying experience prior to application for license as a repossession agent; and

WHEREAS, LAC 10:XV.1301 defines an apprentice as a trainee who works under the direct supervision of a repossession agent; and

WHEREAS, LAC 10:XV.1303(E)(1) provides that a repossession agency may sponsor and apply for the licensing

of a previously unlicensed individual as an apprentice by providing to the commissioner a letter of intent to sponsor and accept responsibility for the apprentice applicant; and

WHEREAS, an apprentice shall complete two thousand hours of qualifying experience and satisfy other requirements within the three previous years prior to application for license as a repossession agent; and

WHEREAS, a repossession agency is limited to sponsoring only one apprentice for every two licensed repossession agents at any one time; and

WHEREAS, LAC 10:XV.1315(A)(4) provides that an apprentice is prohibited from repossessing collateral without on-site supervision of a repossession agent; and

WHEREAS, the direct supervision of an apprentice attempting to accrue two thousand hours of qualifying experience may create an undue hardship for the sponsoring repossession agency in terms of manpower; and

WHEREAS, the undue burden experienced by the sponsoring repossession agency may be relieved if the apprentice is permitted to physically obtain possession of collateral for a secured party, without the direct supervision and presence of a licensed repossession agent, if the apprentice has completed a minimum number of qualifying experience hours under the direction and supervision of the sponsor and the apprentice has received a designation as a certified recovery specialist from a recognized national certification program pursuant to LAC 10:XV.1303(D)(1)(e); and

WHEREAS, R.S. 49:969 provides that the legislature, by concurrent resolution, may suspend, amend, or repeal any rule adopted by a state department, agency, board, or commission.

THEREFORE, BE IT RESOLVED by the Legislature of Louisiana that LAC 10:XV.1303(E)(3) and 1315(A)(4) are hereby amended and reenacted to read as follows:

§1303. Licensing Requirements and Qualifications

* * *

E. Apprentice

* * *

3. No repossession agency shall sponsor more than one apprentice for every two licensed repossession agents at any one time. At the discretion of the sponsor, the apprentice may physically obtain possession of collateral for a secured party, without the direct supervision and presence of a licensed repossession agent, if the apprentice has completed a minimum of 250 hours of qualifying experience under the direction and supervision of the sponsor and satisfies the qualification requirements of §1303.(D)(1)(a), (b), (c), and (e).

* * *

§1315. Prohibitions

A. A repossession agent shall not:

* * *

4. allow an apprentice to repossess collateral without on-site supervision of a repossession agent, except as provided in LAC 10:XV.1303(E)(3);

* * *

BE IT FURTHER RESOLVED that a copy of this Resolution be transmitted to the Office of the State Register and the Office of Financial Institutions.

BE IT FURTHER RESOLVED that the Office of the State Register is hereby directed to have the amendments to LAC 10:XV.1303(E)(3) and 1315(A)(4) printed and incorporated into the Louisiana Administrative Code.

Charles E. "Chuck" Kleckley
Speaker of the House of Representatives

John A. Alario, Jr.
President of the Senate

1406#010

CONCURRENT RESOLUTION

House Concurrent Resolution No. 170

By Representative Tim Burns

A Concurrent Resolution

To direct state agencies to consider certain provider impact issues and to issue certain provider impact statements prior to the adoption, amendment, or repeal of rules.

WHEREAS, the legislature has historically encouraged transparency in the policy development process; and

WHEREAS, the members of the legislature need to be aware of the fiscal impact of any proposed policy changes as they impact the state budget and the fiscal impact on their constituents, including providers of services; and

WHEREAS, the legislature needs information regarding the potential fiscal impact on the state budget, the general public, and providers of services funded by the state to make fully informed policy decisions regarding proposed policy changes, including those effectuated by the adoption, amendment, or repeal of rules, including emergency rules.

THEREFORE, BE IT RESOLVED by the Legislature of Louisiana that prior to the adoption, amendment, or repeal of any rule, including an emergency rule, each state agency shall consider and state in writing the impact of the proposed rule on a provider prior to the adoption and implementation of the rule.

BE IT FURTHER RESOLVED that this written consideration of impact shall be known as the "provider impact statement" and shall contain the following considerations regarding the proposed rule:

(1) The effect on the staffing level requirements or qualifications required to provide the same level of service.

(2) The total direct and indirect effect on the cost to the provider to provide the same level of service.

(3) The overall effect on the ability of the provider to provide the same level of service.

BE IT FURTHER RESOLVED that the state agency shall include the provider impact statement in the notice required by R.S. 49:953(A)(1).

BE IT FURTHER RESOLVED that the state agency shall submit the provider impact statement on an emergency rule to the speaker of the House of Representatives and the president of the Senate at the same time in the same manner as the agency statement required by R.S. 49:953(A)(1)(a)(x).

BE IT FURTHER RESOLVED that if the state agency is reissuing an emergency rule previously published without revision, the state agency shall clearly indicate that the new publication is a reissue of a previously published rule and the date of the previous publication.

BE IT FURTHER RESOLVED that if the state agency is not materially or substantively revising an emergency rule previously published, the provider impact statement issued on the previously published rule shall suffice; however, if the emergency rule contains any material or substantive revisions from the previously published emergency rule, the agency shall revise the impact statement to reflect the revisions.

BE IT FURTHER RESOLVED that all provider impact statements shall be in writing and kept on file with the agency that adopted, amended, or repealed the rule and shall be available for inspection, copying, and reproduction in accordance with the Public Records Law.

BE IT FURTHER RESOLVED that for the purposes of this Resolution, "provider" means an organization that provides services for individuals with developmental disabilities, and "state agency" means each state board, commission, department, agency, officer, or other entity which makes rules, regulations, or policy, or formulates, or issues decisions or orders pursuant to, or as directed by, or in implementation of the constitution or laws of the United States or the constitution and statutes of Louisiana, except the legislature or any branch, committee, or officer thereof; any political subdivision, as defined in Article VI, Section 44 of Constitution of Louisiana and any board, commission, department, agency, officer, or other entity thereof; and the courts.

BE IT FURTHER RESOLVED that a copy of this Resolution be sent to the Office of the State Register in the division of administration.

BE IT FURTHER RESOLVED that the Office of State Register shall notify each state agency of the requirements of this Resolution.

Charles E. "Chuck" Kleckley
Speaker of the House of Representatives

John A. Alario, Jr.
President of the Senate

1406#092

Committee Reports

COMMITTEE REPORT

House Committee on Commerce

Post License Education (LAC 46:LXVII.5527)

Editor's Note: This Notice of Intent was published in the February 20, 2014 *Louisiana Register* on page 403.

At a meeting held on May 15, 2014, the House Committee on Commerce determined that a Rule proposed by the Louisiana Real Estate Commission was unacceptable.

Pursuant to R.S. 49:968(F), we have enclosed a report containing a summary of the determination made by the committee as required by R.S. 49:968(F)(1)(b) and a copy of the proposed Rule determined to be unacceptable as required by R.S. 49:968(F)(1)(a).

Erich Ponti
Chairman
House Committee on Commerce

1406#009

Potpourri

POTPOURRI

**Department of Environmental Quality
Office of the Secretary
Legal Division**

State Implementation Plan (SIP) for
Regional Haze Program

Under the authority of the Louisiana Environmental Quality Act, R.S. 30:2001 et seq., the secretary gives notice that the Office of Environmental Services, Air Permits Division, will submit to the U.S. Environmental Protection Agency (EPA) a proposed revision to the SIP for the Regional Haze Program as required under the Clean Air Act, Part C, Section 169, and 40 CFR Part 51.308. Regional haze is visibility impairment caused by the cumulative air pollutant emissions from numerous sources over a wide geographic area. (1406Pot1)

On July 3, 2012, the EPA made final a partial limited approval and partial disapproval of the original SIP submitted on June 13, 2008. This revision answers the requirements for the four nonelectrical generating units (nonEGUs) facilities that were addressed under the Best Available Retrofit Technology (BART) section in the original SIP and that are the subject of the EPA partial disapproval. This submittal will only pertain to Mosaic, Uncle Sam Facility.

A public hearing will be held at 1:30 pm on July 29, 2014, in the Galvez Building, Oliver Pollock Room C-111, 602 N. Fifth Street, Baton Rouge, LA. Individuals with a disability and need accommodation in order to participate, please contact Vivian H. Aucoin at (225) 219-3389, or at the address listed below. Interested persons are invited to attend and submit oral comments on the proposal.

All interested persons are invited to submit written comments concerning the SIP revision no later than 4:30 p.m., July 29, 2014 to Vivian H. Aucoin, Office of Environmental Services, Box 4313, Baton Rouge, LA 70821-4314, fax (225) 219-3156, or e-mail at vivian.aucoin@la.gov.

A copy of the SIP revision for the Regional Haze Program may be viewed from 8 a.m. to 4:30 p.m. in the LDEQ Public Records Center, Room 127, 602 N. Fifth Street, Baton Rouge, LA. The document is available at www/deq.louisiana.gov/portal/Default.aspx?tabid=2381.

Herman Robinson, CPM
Executive Counsel

1406#018

POTPOURRI

**Department of Health and Hospitals
Behavior Analyst Board**

Public Hearing—Substantive Changes to Proposed
Rule, Application Procedures and Board Fees
(LAC 46:VIII.Chapter 3)

The board published a Notice of Intent to promulgate LAC 46.VIII.Chapter 3, Application Procedures and Board Fees, in the April 20, 2014 edition of the *Louisiana Register* (LR 40:853-854). The notice solicited comments. As a result of its analysis of the comments, the board proposes to amend the rule by adding the word “American” as follows: “Submit verification of successful passage of a national exam administered by a nonprofit organization accredited by the National Commission for Certifying Agencies and the American National Standards Institute to credential professional practitioners of behavior analysis related to the principles and practice of the profession of behavior analysis that is approved by the board.”

No fiscal or economic impact will result from the amendments proposed in this notice.

Title 46

PROFESSIONAL AND OCCUPATIONAL STANDARDS

Part VIII. Behavior Analysts

Chapter 3. Application Procedures and Board Fees

§301. Application Procedures for Licensure/State Certification/ Registration

A. Application and/or Registration

1. An application for a license as a behavior analyst, state certified assistant behavior analyst or registration as a line technician may be submitted after the requirements in R.S. 37:3706-37:3708 are met.

2. Upon submission of application or registration on the forms provided by the board, accompanied by such fee determined by the board, the applicant must attest and acknowledge that the:

a. information provided to the board is true, correct and complete to the best of his knowledge and belief; and

b. the board reserves the right to deny an application in accordance with RS 37:3706-R.S. 37:3708, if the application or any application materials submitted for consideration contain misrepresentations or falsifications.

3. An applicant, who is denied licensure based on the information submitted to the board, may reapply to the board after one year, and having completed additional training, if necessary and having met the requirements of law as defined in the rules and regulations adopted by the board.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3706-R.S. 37:3708.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Behavior Analyst Board, LR 40:

§302. Licensure of Behavior Analysts

A. The applicant for licensure as a behavior analyst shall:

1. submit notarized application along with appropriate fee pursuant to §305;
2. provide proof of a master’s degree by requesting official transcripts from accredited university;
3. submit verification of successful passage of a national exam administered by a nonprofit organization accredited by the National Commission for Certifying Agencies and the American National Standards Institute to credential professional practitioners of behavior analysis related to the principles and practice of the profession of behavior analysis that is approved by the board;
4. take and successfully pass the Louisiana jurisprudence exam issued by the board;
5. complete a criminal background check as approved by the board; and
6. provide proof of good moral character as approved by the board

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3706.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Behavior Analyst Board, LR 40:

§303. Certification of State Certified Assistant Behavior Analysts.

A. The applicant for certification as a state certified assistant behavior analyst should:

1. submit notarized application along with appropriate fee pursuant to §305;
2. provide proof of a bachelors degree by requesting official transcripts from accredited university;
3. submit verification of successful passage of a national exam administered by a nonprofit organization accredited by the National Commission for Certifying Agencies and the American National Standards Institute to credential professional practitioners of behavior analysis related to the principles and practice of the profession of behavior analysis that is approved by the board;
4. take and successfully pass the Louisiana jurisprudence exam issued by the board;
5. complete a criminal background check approved by the board;
6. provide proof of good moral character as approved by the board; and
7. provide proof of supervision by a Louisiana licensed behavior analyst on the form required by the board. If there is more than one supervisor, a form must be submitted for each supervisor.

B. If the supervision relationship between a Louisiana licensed behavior analyst and state certified assistant behavior analyst ends, both parties are responsible for notifying the board in writing, within 10 calendar days of the termination of the arrangement.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3707.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Behavior Analyst Board, LR 40:

§304. Registration of Line Technicians

A. A Louisiana licensed behavior analyst must register with the board all line technicians functioning under their authority and direction. It is the responsibility of both the licensed behavior analyst and line technician to submit registration paperwork for each supervisory relationship. The registration must be completed on the form provided by the board along with payment of the appropriate fee pursuant to §305.

B. A line technician must complete a criminal background check approved by the board.

C. If the supervision relationship between a Louisiana licensed behavior analyst and line technician ends, both parties are responsible for notifying the board in writing, within 10 calendar days of the termination of the arrangement.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3708.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Behavior Analyst Board, LR 40:

§305. Licensing and Administrative Fees

A. Licensing Fees

Application for Licensed Behavior Analyst	\$400
Application for State Certified Assistant Behavior Analyst	\$250
Registration for Line Technicians	\$ 50
Temporary Licensure	\$125
Annual Renewal – Behavior Analyst	\$400
Annual Renewal - Assistant Behavior Analyst	\$250
Annual Renewal - Line Technicians	\$ 50
Jurisprudence Examination	\$ 75
Criminal Background Check	\$ 50

B. Administrative Fees

Late fees	\$50
Duplicate copy of license	\$15
Official Name Change on License	\$25
License Verification	\$15
Insufficient Check Fee	\$15
Copies of documents	\$2/page

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3714.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Behavior Analyst Board, LR 40:

Public Comments

Interested persons may submit written comments to Kelly Parker, Executive Director, 8706 Jefferson Highway, Ste. B, Baton Rouge, LA 70809. She is responsible for responding to inquiries regarding these substantive amendments to the proposed Rule. The deadline for receipt of all written comments is 10 a.m. on Wednesday, July 16, 2014.

Public Hearing

In accordance with the provisions of the Administrative Procedure Act, specifically at R.S. 49:968(H)(2), the board gives notice of a public hearing to receive additional comments on these substantive amendments to the proposed Rule. The hearing will be held at 10 a.m. on Wednesday,

July 16, 2014 at the office of the Louisiana Behavior Analyst Board. At that time, all interested persons will be afforded an opportunity to submit comments, either orally or in writing.

Kelly Parker
Executive Director

1406#043

POTPOURRI

**Department of Health and Hospitals
Bureau of Health Services Financing**

Outpatient Hospital Services
Triage Fees for Non-Emergent Care

The Department of Health and Hospitals, Bureau of Health Services Financing provides Medicaid coverage and reimbursement of outpatient hospital services rendered by emergency departments of acute care hospitals. The department promulgated a Notice of Intent which proposed to adopt provisions in the Hospital Program to establish a triage fee for outpatient services rendered by hospital emergency departments when it is determined that the services provided were for treatment of a non-emergent condition (*Louisiana Register* Volume 40, Number 3).

Upon further consideration, the department has now determined that it is necessary to abandon the March 20, 2014 Notice of Intent and will not proceed with the proposed provisions governing outpatient hospital services. No further rulemaking activity will be taken on this proposed Notice of Intent.

Kathy H. Kliebert
Secretary

1406#082

POTPOURRI

**Department of Health and Hospitals
Office of Public Health
Bureau of Family Health**

Maternal and Child Health Block Grant

The Department of Health and Hospitals (DHH) intends to apply for Maternal and Child (MCH) Block Grant Federal Funding for FY 2014-2015 in accordance with Public Law 97-35 and the Omnibus Budget Reconciliation Act of 1981. The Office of Public Health, Bureau of Family Health is responsible for program administration of the grant.

The block grant application describes in detail the goals and planned activities of the Bureau of Family Health for the next year. Program priorities are based on the results of a statewide needs assessment conducted in 2010, which is updated annually based on relevant data collection.

Interested persons may request copies of the application from:

State of Louisiana
DHH - Office of Public Health
Maternal and Child Health Program
1450 Poydras Street Room 2032
New Orleans. LA 70112

Or view a summary of the application at:
<http://www.dhh.louisiana.gov/index.cfm/page/935>

Additional information may be gathered by contacting Tracy Hubbard at (504) 568-3504.

J.T. Lane
Assistant Secretary

1406#036

POTPOURRI

**Department of Insurance
Office of Health Insurance**

Annual HIPAA Assessment Rate

Pursuant to Louisiana Revised Statute 22:1071(D)(2), the annual HIPAA assessment rate has been determined by the Department of Insurance to be .00028 percent.

James J. Donelon
Commissioner

1406#092

POTPOURRI

**Department of Natural Resources
Office of Conservation**

Orphaned Oilfield Sites

Office of Conservation records indicate that the Oilfield Sites listed in the table below have met the requirements as set forth by Section 91 of Act 404, R.S. 30:80 et seq., and as such are being declared Orphaned Oilfield Sites.

Operator	Field	District	Well Name	Well Number	Serial Number
Sinclair Oil & Gas Co.	Napoleonville	L	Armeline Planting Co B	001	59748
John W. Ballard	Caddo Pine Island	S	Gamm A	003	51517

James H. Welsh
Commissioner

1406#019

POTPOURRI
Department of Natural Resources
Office of the Secretary
Fishermen's Gear Compensation Fund

Underwater Obstruction—Latitude/Longitude Coordinates

In accordance with the provisions of R.S. 56:700.1 et seq., notice is given that 8 claims in the amount of \$34,195.34 were received for payment during the period May 1, 2014-May 31, 2014.

There were 7 paid and 1 denied.

Latitude/longitude coordinates, in degree decimal minutes, of reported underwater obstructions are:

29 08.275 90 05.130 Jefferson

29 12.316	89 31.348	Plaquemines
29 14.874	89 55.476	Jefferson
29 28.735	90 08.459	Lafourche
29 36.285	89 33.580	Plaquemines
29 38.545	89 35.590	Plaquemines
29 50.893	89 20.360	Saint Bernard

A list of claimants and amounts paid can be obtained from Gwendolyn Thomas, Administrator, Fishermen's Gear Compensation Fund, P.O. Box 44277, Baton Rouge, LA 70804 or you can call (225) 342-9388.

Stephen Chustz
Secretary

1406#035

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