

Emergency Rules

DECLARATION OF EMERGENCY

**Department of Agriculture and Forestry
Office of Agricultural and Environmental Sciences**

Pesticide Restrictions (LAC 7:XXIII.143)

In accordance with the Administrative Procedure Act R.S. 49:953(B) and R.S. 3:3203(A), the Commissioner of Agriculture and Forestry is exercising the emergency provisions of the Administrative Procedure Act in adopting the following rules for the implementation of regulations governing the application of certain pesticides in certain parishes.

The Department of Agriculture and Forestry, Advisory Commission is amending these rules and regulations for the purpose of adding Wards 1, 3, 4, and 10 of Point Coupee Parish through the emergency process due to the planting of cotton in these Wards. The application of certain pesticides by commercial applicators between March 15 and September 15 in Point Coupee Parish, as well as other parishes, should be prohibited. The application of certain pesticides poses a threat to Louisiana cotton growers in these Wards. Even though the pesticides will not be applied to the cotton itself, but to the surrounding areas, the cotton is in a very delicate stage and if there is any drift from the application of these pesticides it will irreparably damage the cotton that has already been planted causing Louisiana cotton growers to lose potential production from their crops and greatly effecting the Louisiana cotton industry.

The Department has, therefore, determined that these emergency rules are necessary in order to restrict the commercial application of certain pesticides so that certain pesticides do not do irreparable damage to this seasons cotton crop. This rule becomes effective upon signature and will remain in effect 120 days.

Title 7

Agriculture and Animals

Part XXIII. Advisory Commission on Pesticides

Chapter 1. Advisory Commission on Pesticides Subchapter I. Regulations Governing Application of Pesticides

§143. Restriction on Application of Certain Pesticides

A. - B.15. ...

C. The pesticides listed in §143.B shall not be applied by commercial applicators between March 15 and September 15 in the following parishes.

- | | |
|----------------------|---|
| 1. Avoyelles | 14. Madison |
| 2. Bossier | 15. Morehouse |
| 3. Caddo | 16. Natchitoches |
| 4. Caldwell | 17. Ouachita |
| 5. Catahoula | 18. Pointe Coupee, Ward 1, 2, 3, 4 and 10 |
| 6. Claiborne, Ward 4 | 19. Rapides |
| 7. Concordia | 20. Red River |
| 8. DeSoto, Ward 7 | 21. Richland |
| 9. East Carroll | 22. St. Landry, Wards 1, 4, 5 and 6 |

- | | |
|-------------------------------|------------------|
| 10. Evangeline, Wards 1, 3, 5 | 23. Tensas |
| 11. Franklin | 24. Union |
| 12. Grant | 25. West Carroll |
| 13. LaSalle | 26. Winn, Ward 7 |

D. - M.2. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:3203, R.S. 3:3242 and R.S. 3:3249.

HISTORICAL NOTE: Promulgated by the Department of Agriculture, Advisory Commission on Pesticides, LR 9:169 (April 1983), amended LR 10:193 (March 1984), LR 11:219 (March 1985), LR 11:942 (October 1985), amended by the Department of Agriculture and Forestry, Office of Agricultural and Environmental Sciences, LR 18:953 (September 1992), amended LR 19:791 (September 1993), LR 21:668 (July 1993), LR 21:668 (July 1995), LR 24:281 (February 1998), LR 24:2076 (November 1998) LR 26:

Interested persons should submit written comments on the proposed rules to Bobby Simoneaux through the close of business on June 27, 2000 at 5825 Florida Blvd., Baton Rouge, LA 70806. A public hearing will be held on these rules on June 27, 2000 at 9:30 a.m. at the address listed above. All interested persons will be afforded an opportunity to submit data, views or arguments, orally or in writing, at the hearing. No preamble regarding these rules is necessary.

Family Impact Statement

The proposed amendments to rules LAC 7:XXIII.143 regarding applications of certain pesticides in certain parishes 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 there should be no known or foreseeable effect on:

1. the stability of the family;
2. the authority and rights of parents regarding the education and supervision of their children;
3. the functioning of the family;
4. family earnings and family budget;
5. 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.

Bob Odom
Commissioner

0006#005

DECLARATION OF EMERGENCY

**Student Financial Assistance Commission
Office of Student Financial Assistance**

Tuition Opportunity Program for Students
(TOPS)CQualified Summer Session
(LAC 28:IV.301, 509, 701, 703, 705, 805, 1903 and 2103)

The Louisiana Student Financial Assistance Commission (LASFAC) is exercising the emergency provisions of the Administrative Procedure Act, R.S. 49:953(B), to amend rules of the Tuition Opportunity Program for Students (TOPS), R.S. 17:3042.1 and R.S. 17:3048.1.

The emergency rules are necessary to implement changes to the TOPS rules to allow the Louisiana Office of Student Financial Assistance and state educational institutions to effectively administer these programs. A delay in promulgating rules would have an adverse impact on the financial welfare of the eligible students and the financial condition of their families. The commission has, therefore, determined that these emergency rules are necessary in order to prevent imminent financial peril to the welfare of the affected students.

This declaration of emergency is effective May 4, 2000, and shall remain in effect for the maximum period allowed under the Administrative Procedure Act.

**Title 28
EDUCATION**

**Part IV. Student Financial AssistanceC Higher Education
Scholarship and Grant Programs**

Chapter 3. Definitions

§301. Definitions

*Academic Year (College)C*the two- and four-year college and university academic year begins with the fall term of the award year, includes the winter term, if applicable, and concludes with the completion of the spring term of the award year. The two- and four-year college and university academic year does not include summer sessions nor intersessions.

*ACT ScoreC*the highest composite score achieved by the student on the official American College Test (including National, International, Military or Special test types) or an equivalent score, as determined by the comparison tables used by LASFAC, on an equivalent Scholastic Aptitude Test (SAT). ACT or SAT test scores which are unofficial, including so-called "residual" test scores, are not acceptable for purposes of determining program eligibility.

*Program Year (Non-academic Program)C*the schedule of terms during a year leading to a vocational or technical education certificate or diploma or a non-academic undergraduate degree for such programs offered by Eligible Colleges and Universities, beginning with the fall term, including the winter and spring terms, and concluding with the summer term or the equivalent schedule at an institution which operates on units other than terms.

*Qualified Summer SessionC*those summer sessions for which the student's institution certifies that:

1. the summer session is required in the student's degree program for graduation and the student enrolled for at least the minimum number of hours required for the degree program for the session; or
2. the student can complete his program's graduation requirements in the summer session; or
3. the course(s) taken during the summer session is required for graduation in the program in which the student is enrolled and is only offered during the summer session.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:3021-3036, R.S. 17:3042.1 and R.S. 17:3048.1.

HISTORICAL NOTE: Promulgated by the Student Financial Assistance Commission, Office of Student Financial Assistance, LR 17:959 (October 1991), amended LR 22:338 (May 1996), LR 23:1645, 1648 (December 1997), repromulgated LR 24:632 (April 1998), amended LR 24:1898 (October 1998), LR 24:2237 (December 1998), LR 25:256 (February 1999), LR 25:654 (April 1999), LR 25:1458, 1460 (August 1999), LR 25:1794 (October 1999), LR 26:65 (January 2000), LR 26:688 (April 2000), LR 26:

Chapter 5. Application; Application Deadlines and Proof of Compliance

§509. American College Test (ACT) Testing Deadline

A. The student must take the official American College Test (including National, International, Military or Special test types) on or before the official April test date in the Academic Year (High School) in which the student graduates.

B. The student may substitute an equivalent score, as determined by the comparison tables used by LASFAC, on an equivalent Scholastic Aptitude Test (SAT) taken on or before the official April test date in the Academic Year (High School) in which the student graduates.

C. Final ACT Testing Deadline for Reduced Awards

1. Beginning with awards made for the 2000-2001 academic year and thereafter, an applicant's first qualifying score on the American College Test or on the Scholastic Aptitude Test for either the TOPS Opportunity Award or for the TOPS-TECH Award, or if the student has not previously qualified for either the TOPS Opportunity Award or for the TOPS-TECH Award, an applicant's first qualifying score on the American College Test or on the Scholastic Aptitude Test for the TOPS Performance Award or the TOPS Honors Award that is obtained on an authorized testing date after the date of the applicant's high school graduation but prior to July 1 of the year of such graduation will be accepted; however, when granting an award to an applicant whose qualifying test score is considered by the agency pursuant to the provisions of this Subparagraph, the applicant's period of eligibility for the award shall be reduced by one semester, two quarters, or an equivalent number of units at an eligible institution which operates on a schedule based on units other than semesters or quarters. An applicant will not be allowed to use a test score obtained after high school graduation to upgrade a TOPS Opportunity Award to a TOPS Performance or Honors Award.

2. Students who fail to achieve an ACT or SAT qualifying score by July 1 after high school graduation shall not be considered for an award.

D. For 1997 and 1998 high school graduates who have not previously taken an ACT test, the ACT Score shall include those scores obtained from a national ACT test taken not later than the October 1998 national test date.

E. Students who graduated during the 1998-1999 school year who are otherwise qualified for a TOPS award and who obtained a qualifying score on the American College Test or the Scholastic Aptitude Test on an authorized testing date after the date of the student's graduation but prior to July 1, 1999 shall be considered to have met the requirements of §509.A and §509.B.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:3021-3036, R.S. 17:3042.1 and R.S. 17:3048.1.

HISTORICAL NOTE: Promulgated by the Student Financial Assistance Commission, Office of Student Financial Assistance, LR 26:

Chapter 7. Tuition Opportunity Program for Students (TOPS) Opportunity; Performance and Honors Awards

§701. General Provisions

A. - D.3. ...

E. Award Amounts. The specific award amounts for each component of TOPS are as follows.

1. The TOPS Opportunity Award provides an amount equal to undergraduate tuition for full-time attendance at an eligible college or university for a period not to exceed eight semesters, including qualified summer sessions, twelve quarters, including qualified summer sessions, or an equivalent number of units in an eligible institution which operates on a schedule based on units other than semesters or quarters, except as provided by R.S. 17:3048.1.H, or §503.D or §509.C. Attending a qualified summer session for which tuition is paid will count toward the eight semester limit for TOPS.

2. The TOPS Performance Award provides a \$400 annual stipend, prorated by two semesters, three quarters, or equivalent units in each Academic Year (College) or by four terms or equivalent units in each program year (non-academic program), in addition to an amount equal to tuition for full-time attendance at an eligible college or university, for a period not to exceed eight semesters, including qualified summer sessions, twelve quarters, including qualified summer sessions, or an equivalent number of units in an eligible institution which operates on a schedule based on units other than semesters or quarters, except as provided by R.S. 17:3048.1.H, or §503.D or §509.C. The stipend will be paid for each qualified summer session, semester, quarter, term, or equivalent unit for which tuition is paid. Attending a qualified summer session for which tuition is paid will count toward the eight semester limit for TOPS.

3. The TOPS Honors Award provides an \$800 annual stipend, prorated by two semesters, three quarters, or equivalent units in each Academic Year (College) or by four terms or equivalent units in each Program Year (Non-academic Program), in addition to an amount equal to tuition for full-time attendance at an Eligible College or University, for a period not to exceed eight semesters, including qualified summer sessions, twelve quarters, including qualified summer sessions, or an equivalent number of units in an eligible institution which operates on a schedule based on units other than semesters or quarters, except as provided by R.S. 17:3048.1.H, or §503.D or §509.C. The stipend will be paid for each qualified summer session, semester, quarter, term, or equivalent unit for which tuition is paid. Attending a qualified summer session for which tuition is paid will count toward the eight semester limit for TOPS.

4. ...

5. Students attending a regionally accredited independent college or university which is a member of the Louisiana Association of Independent Colleges and Universities (LAICU):

a. in an academic program receive an amount equal to the weighted average award amount, as defined in §301, plus any applicable stipend, prorated by two semesters, three quarters, or equivalent units in each academic year (college). The stipend will be paid for each qualified summer session, semester, quarter, or equivalent unit for which tuition is paid.

Attending a qualified summer session for which tuition is paid will count toward the eight semester limit for TOPS;

b. in a program for a vocational or technical education certificate or diploma or a non-academic undergraduate degree receive an amount equal to the average award amount, as defined in §301, plus any applicable stipend, prorated by four terms or equivalent units in each program year (non-academic program). The stipend will be paid for each term or equivalent unit for which tuition is paid.

6. - 9. ...

F. Beginning with the 2000-2001 academic year (college) or program year (non-academic program) and continuing for the remainder of their program eligibility, students who meet each of the following requirements shall be awarded a stipend in the amount of \$200 per qualified summer session, semester, quarter, term, or equivalent unit for which tuition is paid which shall be in addition to the amount determined to equal the tuition charged by the public college or university attended or, if applicable, the amount provided for attendance at an eligible nonpublic college or university:

1. - 2. ...

G. Beginning with the 2000-2001 academic year (college) or program year (non-academic program) and continuing for the remainder of their program eligibility, students who meet each of the following requirements shall be awarded a stipend in the amount of \$400 per qualified summer session, semester, quarter, term, or equivalent unit for which tuition is paid which shall be in addition to the amount determined to equal the tuition charged by the public college or university attended or, if applicable, the amount provided for attendance at an eligible nonpublic college or university:

1. - 2. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:3021-3036, R.S. 17:3042.1 and R.S. 17:3048.1.

HISTORICAL NOTE: Adopted by the Student Financial Assistance Commission, Office of Student Financial Assistance, LR 17:959 (October 1991), amended LR 22:338 (May 1996), LR 23:1645, 1648 (December 1997), repromulgated LR 24:635 (April 1998), amended LR 24:1901 (October 1998), LR 25:256 (February 1999) LR 26:67 (January 2000), LR 26:

§703. Establishing Eligibility

A. - A.3. ...

4. initially apply and enroll as a First-Time Freshman as defined in §301, unless granted an exception for cause by LASFAC, in an eligible postsecondary institution defined in §1901, and:

a. - f. ...

g. all students must apply for an award by July 1 of the academic year (high school) in which they graduate to establish their initial qualification for an award, except as provided by §503.D. For a student entitled to defer acceptance of an award under §703.A.4.b. or d. that student must apply by July 1 of the academic year (high school) in which the student graduates, except as provided by section 503.D:

i. and, if enrolling in an academic program, must also apply by July 1 prior to the academic year (college) in which the student intends to first accept the award, and by July 1 of every year of eligibility thereafter, except as provided in §501.B; or

ii. and, if enrolling in a program for a vocational or technical education certificate or diploma or a non-academic undergraduate degree, must also apply by the July 1 immediately after the start of the program year (non-academic program) in which the student intends to first accept the award, and by July 1 of every year of eligibility thereafter, except as provided in §501.B.

A.5. - G.1. ...

2. A student who graduates from high school in less than four years or who enters an eligible college or university early admissions program prior to graduation from high school shall be considered a first-time freshman, as defined in §703, not earlier than the first semester following the academic year (high school) in which the student would have normally graduated had he or she not graduated early or entered an early admissions program. A student who graduates high school in less than four years or enters an early admissions program will remain eligible for a TOPS award until the semester or term, excluding summer semesters or sessions, immediately following the first anniversary of the date that the student normally would have graduated.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:3021-3036, R.S. 17:3042.1 and R.S. 17:3048.1.

HISTORICAL NOTE: Promulgated by the Student Financial Assistance Commission, Office of Student Financial Assistance, LR 17:959 (October 1991), amended LR 22:338 (May 1996), LR 23:1648 (December 1997), repromulgated LR 24:632 (April 1998), amended LR 24:1902 (October 1998), LR 25:2237 (December 1998), LR 25:257 (February 1999), LR 25:655 (April 1999), LR 25:1794 (October 1999), LR 26:67 (January 2000), LR 26:689 (April 2000), LR 26:

§705. Maintaining Eligibility

A. ...

1. have received less than four years or eight semesters of TOPS Award funds, provided that each two terms or equivalent units of enrollment in a program for a vocational or technical education certificate or diploma or a non-academic undergraduate degree shall be the equivalent of a semester; and

2. - 6. ...

7. Minimum Academic Progress:

a. in an academic program at an eligible college or university, by the end of each academic year (college), earn a total of at least 24 college credit hours as determined by totaling the earned hours reported by the institution for each semester or quarter in the academic year (college). These hours shall include remedial course work required by the institution, but shall not include hours earned during qualified summer sessions, summer sessions nor intersessions nor by advanced placement course credits. Unless granted an exception for cause by LASFAC, failure to earn the required number of hours will result in permanent cancellation of the recipient's eligibility; or

b. in a program for a vocational or technical education certificate or diploma or a non-academic undergraduate degree at an eligible college or university, maintain steady academic progress as defined in §301 and by the end of the spring term, earn a cumulative college grade point average of at least 2.50 on a 4.00 maximum scale. Unless granted an exception for cause by LASFAC, failure to maintain steady academic progress and to earn a

2.50 at the conclusion of the spring term will result in permanent cancellation of the recipient's eligibility; and

8. ...

9. maintain at an eligible college or university, by the end of the spring semester, quarter, or term, a cumulative college grade point average (GPA) on a 4.00 maximum scale of at least:

a. a 2.30 with the completion of less than 48 credit hours, a 2.50 after the completion of 48 credit hours, for continuing receipt of an opportunity award, if enrolled in an academic program; or

b. a 2.50, for continuing receipt of an opportunity award, if enrolled in a program for a vocational or technical education certificate or diploma or a non-academic undergraduate degree; and

c. a 3.00 for continuing receipt of either a performance or honors award; and

10. has not enrolled in a program for a vocational or technical education certificate or diploma or a non-academic undergraduate degree after having received a vocational or technical education certificate or diploma, or a non-academic undergraduate degree;

11. has not received a baccalaureate degree;

12. has not been enrolled in a program for a vocational or technical education certificate or diploma or a non-academic undergraduate degree for more than two years.

B. - D. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:3021-3036, R.S. 17:3042.1 and R.S. 17:3048.1.

HISTORICAL NOTE: Promulgated by the Student Financial Assistance Commission, Office of Student Financial Assistance, LR 17:959 (October 1991), amended LR 22:338 (May 1996), LR 23:1648 (December 1997), repromulgated LR 24:637 (April 1998), amended LR 24:1904 (October 1998), LR 25:257 (February 1999); LR 25:656 (April 1999), LR 25:1091 (June 1999), LR 26:67 (January 2000), LR 26:688 (April 2000), LR 26:

Chapter 8. TOPS-TECH Award

§805. Maintaining Eligibility

A. - A.6. ...

7. has not received a vocational or technical education certificate or diploma, or a non-academic undergraduate degree, or a baccalaureate degree; and

8. has maintained steady academic progress as defined in §301; and

9. maintain, by the end of the spring term, a cumulative college grade point average of at least 2.50 on a 4.00 maximum scale.

B. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:3021-3036, R.S. 17:3042.1 and R.S. 17:3048.1.

HISTORICAL NOTE: Promulgated by the Student Financial Assistance Commission, Office of Student Financial Assistance, LR 24:1905 (October 1998) LR 25:1091 (June 1999), LR 26:68 (January 2000), LR 26:689 (April 2000), LR 26:

Chapter 19. Eligibility and Responsibilities of Postsecondary Institutions

§1903. Responsibilities of Postsecondary Institutions

A. - F. ...

G Certification of Qualified Summer Session. The institution's submission of a payment request for tuition for a student's enrollment in a summer session will constitute certification of the student's eligibility for tuition payment for the summer session, the student's acknowledgment and

consent that each payment will consume one semester of eligibility, and the student's enrollment.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:3021-3036, R.S. 17:3042.1 and R.S. 17:3048.1.

HISTORICAL NOTE: Promulgated by the Student Financial Assistance Commission, Office of Student Financial Assistance, LR 17:959 (October 1991), amended LR 22:338 (May 1996), repromulgated LR 24:645 (April 1998), amended LR 24:1914 (October 1998), LR 25:1459 (August 1999), LR 26:

Chapter 21. Miscellaneous Provisions and Exceptions
§2103. Circumstances Warranting Exception to the Initial and Continuous Enrollment Requirements

A. Initial Enrollment Requirement. Initially apply and enroll as a first-time freshman as defined in §301, unless granted an exception for cause by LASFAC, in an eligible postsecondary institution defined in §1901. Initial enrollment requirements specific to the TOPS are defined at §703.A.4 and for TOPS-TECH at §803.A.4.

B. ...

C. Less Than Full-time Attendance. The LASFAC will authorize awards under the TOPS opportunity, performance, honors and teachers awards, the TOPS-TECH award, and the T.H. Harris Scholarship Program for less than full-time enrollment provided that the student meets all other eligibility criteria and at least one of the following:

C.1. - E.11.c. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:3021-3036, R.S. 17:3042.1 and R.S. 17:3048.1.

HISTORICAL NOTE: Promulgated by the Student Financial Assistance Commission, Office of Student Financial Assistance, LR 17:959 (October 1991), amended LR 22:338 (May 1996), LR 23:1648 (December 1997), repromulgated LR 24:649 (April 1998), amended LR 24:1916 (October 1998), LR 26:

Mark Riley
Assistant Executive Director

0006#006

DECLARATION OF EMERGENCY

Office of the Governor
Board of the Trustees of the State Employees
Group Benefits Program

EPO Plan of Benefits
(LAC 32:V.101-107, 301, 307-317,
325, 403, 501, 511-515, 601 and 701)

Pursuant to the authority granted by R.S. 42:871(C) and 874(B)(2), vesting the Board of Trustees with the responsibility for administration of the State Employees Group Benefits Program and granting the power to adopt and promulgate rules with respect thereto, the Board of Trustees hereby invokes the Emergency Rule provisions of R.S. 49:953(B).

The board finds that it is necessary to revise and amend the EPO Plan Document for the play year commencing July 1, 2000. Failure to adopt this rule on an emergency basis will adversely affect the availability of services necessary to maintain the health and welfare of the covered employees and their dependents, which is crucial to the delivery of vital services to the citizens of the state.

Accordingly, the following Emergency Rule, is effective July 1, 2000 and shall remain in effect for a maximum of 120 days or until promulgation of the final Rule, whichever occurs first, revising and amending the EPO Plan of Benefits in the following particulars.

Title 32

EMPLOYEE BENEFITS

Part V. Exclusive Provider (EPO) Plan of Benefits

Chapter 1. Eligibility

§101. Persons to be Covered

Eligibility requirements apply to all participants in the Program, whether in the PPO Plan, the EPO Plan or an HMO plan.

A. Employee Coverage

1. - 2. ...

3. Effective Dates of Coverage, New Employee, Transferring Employee. Coverage for each employee who completes the applicable enrollment form and agrees to make the required payroll contributions to his participant employer is to be effective as follows:

a. - b. ...

c. Employee coverage will not become effective unless the employee completes an enrollment form within 30 days following the date of employment. An employee who completes an enrollment form after 30 days following the date of employment will be considered an overdue applicant.

d. An employee that transfers employment to another participating employer must complete a Transfer Form within 30 days following the date of transfer in order to maintain coverage without interruption. An employee who completes a Transfer Form after 30 days following the date of transfer will be considered an overdue applicant.

A.4. - G. ...

H. Medicare Risk HMO Option for Retirees (Effective July 1, 1999)

H.1. - 2. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1804 (October 1999), LR 26:

§103. Continued Coverage

A. - B. ...

C. Surviving Dependents/Spouse. The provisions of this section are applicable to surviving dependents who elect to continue coverage following the death of an employee or retiree. On or after July 1, 1999, eligibility ceases for a covered person who becomes eligible for coverage in a group health plan other than Medicare. Coverage under the group health plan may be subject to HIPAA.

1. Benefits under the plan for covered dependents of a deceased covered employee or retiree will terminate on the last day of the month in which the employee's or retiree's death occurred unless the surviving covered dependents elect to continue coverage.

a. ...

b. The surviving unmarried (never married) children of an employee or retiree may continue coverage until they are eligible for coverage under a group health plan other than Medicare, or until attainment of the termination age for children, whichever occurs first;

C.1.c. - D. ...

E. Family and Medical Leave Act (F.M.L.A.) Leave of Absence. An employee on approved F.M.L.A. leave may retain coverage for the duration of such leave. The participant employer shall pay the employer's share of the premium during F.M.L.A. leave, whether paid leave or leave without pay. The participant employer shall pay the employees share of the premium during unpaid F.M.L.A. leave, subject to reimbursement by the employee.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1806 (October 1999), LR 26:

§107. Change of Classification

A. Adding or Deleting Dependents. The plan member must notify the program whenever a dependent is added to, or deleted from, the plan member's coverage that would result in a change in the class of coverage. Notice must be provided within 30 days of the addition or deletion.

B. - C. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1809 (October 1999), LR 26:

Chapter 3. Medical Benefits

§301. Medical Benefits Apply When Eligible Expenses are Incurred by a Covered Person

A. Eligible expenses are the charges incurred for the following items of service and supply. These charges are subject to the applicable deductibles, limits of the Fee Schedule, Schedule of Benefits, exclusions and other provisions of the Plan. A charge is incurred on the date that the service or supply is performed or furnished. Eligible expenses are:

1. - 8. ...

9. Services of licensed speech therapist when prescribed by a physician and pre-approved through outpatient procedure certification for the purpose of restoring partial or complete loss of speech resulting from stroke, surgery, cancer, radiation laryngitis, cerebral palsy, accidental injuries or other similar structural or neurological disease;

10. - 11c. ...

d. Accidental injury means a condition occurring as a direct result of a traumatic bodily injury sustained solely through accidental means from an external force. With respect to injuries to teeth, the act of chewing does not constitute an injury caused by external force.

12. Durable Medical Equipment, subject to the lifetime maximum payment limitation as listed in the Schedule of Benefits [The program will require written certification by the treating physician to substantiate the medical necessity for the equipment and the length of time that it will be used. The purchase of durable medical equipment will be considered an eligible expense only upon showing that the rental cost would exceed the purchase price. Under no circumstances may the eligible expense for an item of durable medical equipment exceed the purchase price of such item].

13. - 18. ...

19. Acupuncture when rendered by a medical doctor licensed in the state in which the services are rendered;

20. ...

21. Services of a Physical Therapist and Occupational Therapist licensed by the state in which the services are rendered when:

a. - e. ...

f. approved through case management when rendered in the home;

22. - 23. ...

24. Not subject to the annual deductible:

a. ...

b. mammographic examinations performed according to the following schedule:

i. One mammogram during the five-year period a person is 35-39 years of age;

24.b.ii. - 26. ...

27. Services rendered by the following, when billed by the supervising physician:

a. Perfusionists and Registered Nurse Assistants assisting in the operating room;

b. Physician's Assistants and Registered Nurse Practitioners.

28. - 32. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1810 (October 1999), LR 26:

§307. Utilization Review/Pre-Admission Certification, Continued Stay Review

A. - A.2. ...

B. For a routine vaginal delivery, PAC is not required for a stay of 2 days or less. If the mother's stay exceeds or is expected to exceed 2 days, PAC is required within 24 hours after the delivery or the date on which any complications arose, whichever is applicable. If the baby's stay exceeds that of the mother, PAC is required within 72 hours of the mother's discharge and a separate pre-certification number must be obtained for the baby. In the case of a Caesarian Section, PAC is required if the mother's stay exceeds or is expected to exceed 4 days;

C. No benefits will be paid under the Plan:

1. ...

2. unless PAC is requested within two business days following admission in the case of an emergency;

C.3. - D. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1812 (October 1999), LR 26:

§309. Outpatient Procedure Certification

A. - A.2. ...

B. OPC is required on the following procedures:

1. - 6. ...

7. Speech Therapy;

C. No benefits will be paid for the facility fee in connection with outpatient procedures, or the facility and professional fee in connection with speech therapy:

C.1. - D. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1812 (October 1999), LR 26:

§311. Case Management

A. - E.8. ...

9. Physical and occupational therapy rendered in a home setting.

F. - H. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1812 (October 1999), LR 26:

§313. Dental Surgical Benefits

A. ...

B. Eligible expenses incurred in connection with the removal of impacted teeth, including pre-operative and post-operative care, anesthesia, radiology, and pathology services, and facility charges are subject to the deductible, co-insurance and the maximum benefit provisions of the Plan.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1813 (October 1999), LR 26:

§315. Medicare Reduction

A. ...

B. Retiree 100-Medicare COB. Upon enrollment and payment of the additional monthly premium, a plan member and dependents who are covered under Medicare, both parts A and B, may choose to have full coordination of benefits with Medicare. Enrollment must be made within 30 days of eligibility for Medicare or within 30 days of retirement if already eligible for Medicare and at the annual open enrollment.

§317. Exceptions and Exclusions for All Medical Benefits

A. No benefits are provided under this Plan for:

1. - 24. ...

25. repealed

26. - 40. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1813 (October 1999), LR 26:488 (March 2000), LR 26:

§325. Prescription Drug Benefits

A. This plan allows benefits for drugs and medicines approved by the Food and Drug Administration or its successor, requiring a prescription, and dispensed by a licensed pharmacist or pharmaceutical company, but which are not administered to a covered person as an inpatient Hospital patient or an outpatient hospital patient, including insulin, Retin-A dispensed for covered persons under the age of 26, Vitamin B12 injections, prescription Potassium Chloride, and over-the-counter diabetic supplies including, but not limited to, strips, lancets and swabs.

B. The following drugs, medicines, and related services are not covered:

1. - 10. ...

11. Drugs for Treatment of impotence.

C. ...

1. Upon presentation of the group benefits program health benefits identification card at a network pharmacy, the Plan Member will be responsible for copayment of \$6 per prescription when a generic drug is dispensed, \$20 per prescription when a preferred brand name drug is dispensed, and \$30 per prescription when a non-preferred brand name drug is dispensed. The copayment cannot exceed the actual charge by the pharmacy for the drug.

2. - 5.c. ...

6. Acute or Non-maintenance DrugCa covered drug other than a maintenance drug as define herein.

7. Brand DrugCthe trademark name of a drug approved by the U. S. Food and Drug Administration.

8. Generic DrugCa chemically equivalent copy of a brand name drug.

9. Maintenance DrugCcovered drug that is determined by the Program's contracted prescription benefits management firm, using standard industry reference materials, to be routinely taken over a long period of time for certain chronic medical conditions. The drug must be listed on the established maintenance drug list as an approved drug for the patient's condition

10. Non-Preferred Brand DrugCa brand drug for which there is an equally effective, less costly therapeutic alternative available, as determined by the Pharmacy and Therapeutic Committee.

11. Pharmacy and Therapeutic CommitteeCa committee created by the program's contracted prescription benefits management firm to advise its various plans on whether a drug has been accepted as safe and effective or investigations as well as whether a drug will be classified as a Preferred Brand Drug or a Non-Preferred Brand Drug. In making these determinations, the Pharmacy and Therapeutic Committee relies on the United States Food and Drug Administration as well as peer reviewed medical journals.

12. Preferred Brand DrugCa brand name drug that has received a classification of Preferred Brand from the Pharmacy and Therapeutic Committee based on the following criteria:

a. clinical uniqueness of the medication;

b. positive efficacy profile;

c. good side effect, safety, and drug interaction profile;

d. positive quality of the implications;

e. clinical experience with the medication; and

f. cost (only considered when clinical parameters are equal to other products in its class).

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1815 (October 1999), LR 26:

Chapter 4. Uniform Provisions

§403. Properly Submitted Claim Form

A. For plan reimbursements, all bills must show:

1. employee's name;

2. name of patient;

3. name, address, and telephone number of the provider of care;

4. diagnosis;

5. type of services rendered, with diagnosis and/or procedure codes;

6. date of service;
7. charges;
8. employee's member number;
9. provider Tax Identification number;
10. medicare explanation of benefits, if applicable.

B. The program can require additional documentation in order to determine the extent of coverage or the appropriate reimbursement. Failure to furnish the requested information within 90 days of the request will constitute reason for the denial of benefits.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1816 (October 1999), LR 26:

Chapter 5. Claims Review and Appeal

§501. Claims Review Procedures and Appeals

A. ...

B. The request for review must be directed to Attention: Appeals and Grievances within 90 days after the date of the notification of denial of benefits, denial of eligibility, or denial after review by the utilization review, pharmacy benefit or mental health contractors.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1818 (October 1999), LR 26:

§511. Subpoena of Witnesses; Production of Documents

A. - B. ...

C. No subpoena will be issued requiring the attendance and giving of testimony by witnesses unless a written request therefor is received in the office of the program, Attention: Appeals and Grievances no later than 15 calendar days before the date fixed for the hearing. The request for subpoenas must contain the names of the witnesses and a statement of what is intended to be proved by each witness. No subpoenas will be issued until the party requesting the subpoena deposits with the program a sum of money sufficient to pay all fees and expenses to which a witness in a civil case is entitled.

D. No subpoena for the production of books, papers and other documentary evidence will be issued unless written request therefor is received in the office of the program, Attention: Appeals and Grievances no later than 15 calendar days before the date fixed for the hearing. The request for subpoena for books, papers, and other documentary evidence must contain a description of the items to be produced in sufficient detail for identification and must contain the name and street address of the person who is to be required to produce the items and a brief statement of what is intended to be proved by each item.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1819 (October 1999), LR 26:

§513. Appeals Decisions

A. ...

B. Appeals Heard by Referee: At the conclusion of the hearing, the referee will take the matter under submission and, as soon as is reasonably possible thereafter, prepare a recommended decision in the case which will be based on

the evidence adduced at the hearing or otherwise included in the hearing records. The decision will contain findings of fact and statement of reasons. The recommended decision will be submitted to the committee for review.

C. The committee may adopt or reject the recommended decision. In the case of adoption, the referee's decision becomes the decision of the committee. In the case of rejection, the committee will render its decision, which will include a statement of reasons for disagreement with the referee's decision. The decision of the committee will be final. A copy will be mailed by certified mail to the covered person and any representative thereof.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1819 (October 1999), LR 26:

§515. Rehearing

A. - B. ...

C. The request for rehearing must be filed with the program, Attention: Appeals and Grievances on or before 30 calendar days after the mailing of the appeal decision of the committee. The request will be deemed filed on the date it is received in the office of the program.

D. ...

E. When the committee grants a rehearing, an order will be issued setting forth the grounds. A copy of the order will be sent, along with notice of the time and place fixed for the rehearing, to the appealing party and any representative by certified mail.

F. - G. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1819 (October 1999), LR 26:

Chapter 6. Definitions

§601. Definitions

*Acute or Non-maintenance Drug*Ca covered drug other than a maintenance drug as define herein.

*Brand Drug*the trademark name of a drug approved by the U. S. Food and Drug Administration.

*Children*C

1. any legitimate, duly acknowledged, or legally adopted Children of the Employee and/or the Employee's legal spouse dependent upon the Employee for support;

2. - 4. ...

*Generic Drug*Ca chemically equivalent copy of a brand name drug.

*Maintenance Drug*Ccovered drug that is determined by the program's contracted prescription benefits management firm, using standard industry reference materials, to be routinely taken over a long period of time for certain chronic medical conditions. The drug must be listed on the established maintenance drug list as an approved drug for the patient's condition.

Non-Preferred Brand Drug Ca brand drug for which there is an equally effective, less costly therapeutic alternative available, as determined by the Pharmacy and Therapeutic Committee.

Pharmacy and Therapeutic Committee Ca committee created by the Program's contracted prescription benefits management firm to advise its various plans on whether a drug has been accepted as safe and effective or investigations as well as whether a drug will be classified as a Preferred Brand Drug or a Non-Preferred Brand Drug. In making these determinations, the Pharmacy and Therapeutic Committee relies on the United States Food and Drug Administration as well as peer reviewed medical journals.

Preferred Brand Drug Ca brand name drug that has received a classification of Preferred Brand from the Pharmacy and Therapeutic Committee based on the following criteria:

1. clinical uniqueness of the medication;
2. positive efficacy profile;
3. good side effect, safety, and drug interaction profile;
4. positive quality of the implications;
5. clinical experience with the medication; and
6. cost (only considered when clinical parameters are equal to other products in its class).

Well-Baby Care Croutine care to a well newborn infant from the date of birth until age 1. This includes routine physical examinations, active immunizations, check-ups, and office visits to a physician and billed by that physician, except for the Treatment and/or diagnosis of a specific illness. All other health services coded with wellness procedures and diagnosis codes are excluded.

Well-Child Care Croutine physical examinations, active immunizations, check-ups and office visits to a physician, and billed by a health care provider that has entered into a contract with the State Employees Benefits Program, except for the Treatment and/or diagnosis of a specific illness, from age 1 to age 16. All other health services coded with wellness procedures and diagnosis codes are excluded.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1820 (October 1999), LR 26:

Chapter 7. Schedule of Benefits

§701 Comprehensive Medical Benefits

A. - A.3. ...

- | | |
|--|-----------------------------|
| 4. Prescription Drugs
(no deductible) | 50% non-Network in
state |
|--|-----------------------------|

\$6 copayment for generic drugs, \$20 copayment for preferred brand name drugs, and \$30 copayment for non-preferred brand name drugs purchased at a network pharmacy	80% non-Network out of state
--	------------------------------

B. - E. ...

F. Physical /Occupational Therapy ¹	See % payable after deductible	\$15 copay for outpatient services
--	-----------------------------------	--

Speech Therapy ²	See % payable after deductible	\$15 copay for outpatient services
-----------------------------	-----------------------------------	--

G ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1820 (October 1999), LR 26:488 (March 2000), LR 26:

1 ...

²Subject to Case Management Guideline if rendered in a home setting

³Subject to Outpatient Procedure Certification Guidelines

A. Kip Wall
Interim Chief Executive Officer

0006#115

DECLARATION OF EMERGENCY

**Office of the Governor
Board of the Trustees of the State Employees
Group Benefits Program**

EPO Plan of Benefits
Accidental Injury
(LAC 32:V.601)

Pursuant to the authority granted by R.S. 42:871(C) and 874(B)(2), vesting the Board of Trustees with the responsibility for administration of the State Employees Group Benefits Program and granting the power to adopt and promulgate rules with respect thereto, the Board of Trustees hereby invokes the Emergency Rule provisions of R.S. 49:953(B).

The Board finds that it is necessary to amend the EPO Plan Document to define the term *Accidental Injury* as used therein. Failure to adopt this rule on an emergency basis will adversely affect the availability of services necessary to maintain the health and welfare of the covered employees and their dependents, which is crucial to the delivery of vital services to the citizens of the state.

Accordingly, the following Emergency Rule, adding the definition of the term *Accidental Injury* in EPO Plan Document, is effective June 1, 2000, and shall remain in effect for 30 days, until July 1, 2000.

Title 32

EMPLOYEE BENEFITS

Part V. Exclusive Provider Organization

(EPO)—Plan of Benefits

Chapter 6. Definitions

§601. Definitions

Accidental Injury—means a condition occurring as a direct result of a traumatic bodily injury sustained solely through accidental means from and external force. With respect to injuries to teeth, the act of chewing does not constitute an injury caused by external force.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1820 (October 1999), LR 26:

A. Kip Wall
Chief Executive Officer

0006#111

DECLARATION OF EMERGENCY

**Office of the Governor
Board of the Trustees of the State Employees
Group Benefits Program**

EPO Plan of Benefits CF.M.L.A. Leave
(LAC 32:V.103)

Pursuant to the authority granted by R.S. 42:871(C) and 874(B)(2), vesting the Board of Trustees with the responsibility for administration of the State Employees Group Benefits Program and granting the power to adopt and promulgate rules with respect thereto, the Board of Trustees hereby invokes the Emergency Rule provisions of R.S. 49:953(B).

The Board finds that it is necessary to amend the EPO Plan of Benefits to provide for continuation of coverage for an employee on approved F.M.L.A. leave. This action is necessary to implement requirements of the federal Family and Medical Leave Act (F.M.L.A.), and the rules and regulations promulgated pursuant thereto, in order to avoid sanctions or penalties from the United States.

Accordingly, the following Emergency Rule, adding Subsection E to Section 103 of Louisiana Administrative Code, Title 32, Part V, the EPO Plan of Benefits, is effective May 31, 2000, and shall remain in effect for 31 days, until July 1, 2000.

**Title 32
EMPLOYEE BENEFITS
Part V. Exclusive Provider Organization
(EPO)—Plan of Benefits**

Chapter 1. Eligibility

§103. Continued Coverage

A. - D.3. ...

E. Family and Medical Leave Act (F.M.L.A.) Leave of Absence. An employee on approved F.M.L.A. leave may retain coverage for the duration of such leave. The participant employer shall pay the employer's share of the premium during F.M.L.A. leave, whether paid leave or leave without pay. The participant employer may pay the employee's share of the premium during unpaid F.M.L.A. leave, subject to reimbursement by the employer.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1806 (October 1999), LR 26:

A. Kip Wall
Chief Executive Officer

0006#114

DECLARATION OF EMERGENCY

**Office of the Governor
Board of the Trustees of the State Employees
Group Benefits Program**

PPO Plan of Benefits
(LAC 32:III.101-107, 301, 307-317,
325, 403, 501, 511-515, 601 and 701)

Pursuant to the authority granted by R.S. 42:871(C) and 874(B)(2), vesting the Board of Trustees with the responsibility for administration of the State Employees Group Benefits Program and granting the power to adopt and promulgate rules with respect thereto, the Board of Trustees hereby invokes the Emergency Rule provisions of R.S. 49:953(B).

The board finds that it is necessary to revise and amend the PPO Plan Document for the play year commencing July 1, 2000. Failure to adopt this rule on an emergency basis will adversely affect the availability of services necessary to maintain the health and welfare of the covered employees and their dependents, which is crucial to the delivery of vital services to the citizens of the state.

Accordingly, the following Emergency Rule, is effective July 1, 2000 and shall remain in effect for a maximum of 120 days or until promulgation of the final Rule, whichever occurs first, revising and amending the PPO Plan of Benefits in the following particulars.

**Title 32
EMPLOYEE BENEFITS**

**Part III. Exclusive Provider (PPO) Plan of Benefits
Chapter 1. Eligibility**

§101. Persons to be Covered

A. Eligibility requirements apply to all participants in the Program, whether in the PPO Plan, the EPO Plan or an HMO plan.

A. Employee Coverage

1. - 2. ...

3. Effective Dates of Coverage, New Employee, Transferring Employee. Coverage for each employee who completes the applicable enrollment form and agrees to make the required payroll contributions to his Participant Employer is to be effective as follows:

a. - b. ...

c. Employee coverage will not become effective unless the employee completes an enrollment form within 30 days following the date of employment. An employee who completes an enrollment form after 30 days following the date of employment will be considered an overdue applicant;

d. An employee that transfers employment to another participating employer must complete a Transfer Form within 30 days following the date of transfer in order to maintain coverage without interruption. An employee who completes a Transfer Form after 30 days following the date of transfer will be considered an overdue applicant.

A.4. - H.2. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1825 (October 1999), LR 26:

§103. Continued Coverage

A. - B. ...

C. Surviving Dependents/Spouse. The provisions of this section are applicable to surviving dependents who elect to continue coverage following the death of an employee or retiree. On or after July 1, 1999, eligibility ceases for a covered person who becomes eligible for coverage in a group health plan other than Medicare. Coverage under the group health plan may be subject to HIPAA.

1. Benefits under the plan for covered dependents of a deceased covered employee or retiree will terminate on the last day of the month in which the employee's or retiree's death occurred unless the surviving covered dependents elect to continue coverage.

a. ...

b. The surviving unmarried (never married) children of an employee or retiree may continue coverage until they are eligible for coverage under a group health plan other than Medicare, or until attainment of the termination age for children, whichever occurs first;

C.1.c - D.3. ...

E. Family and Medical Leave Act (F.M.L.A.) Leave of Absence. An employee on approved F.M.L.A. leave may retain coverage for the duration of such leave. The participant employer shall pay the employer's share of the premium during F.M.L.A. leave, whether paid leave or leave without pay. The participant employer shall pay the employee's share of the premium during unpaid F.M.L.A. leave, subject to reimbursement by the employee.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1827 (October 1999), LR 26:

§107. Change of Classification

A. Adding or Deleting Dependents. The plan member must notify the program whenever a dependent is added to, or deleted from, the plan member's coverage that would result in a change in the class of coverage. Notice must be provided within 30 days of the addition or deletion.

B. - C. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1829 (October 1999), LR 26:

Chapter 3. Medical Benefits

§301. Medical Benefits apply when eligible expenses are incurred by a Covered Person.

A. Eligible expenses are the charges incurred for the following items of service and supply. These charges are subject to the applicable deductibles, limits of the Fee Schedule, Schedule of Benefits, exclusions and other provisions of the plan. A charge is incurred on the date that the service or supply is performed or furnished. Eligible expenses are:

1. - 8.1....

9. Services of licensed speech therapist when prescribed by a physician and pre-approved through outpatient procedure certification for the purpose of restoring partial or complete loss of speech resulting from stroke, surgery, cancer, radiation laryngitis, cerebral palsy,

accidental injuries or other similar structural or neurological disease;

10. - 11.c ...

d. Accidental injury means a condition occurring as a direct result of a traumatic bodily injury sustained solely through accidental means from an external force. With respect to injuries to teeth, the act of chewing does not constitute an injury caused by external force.

12. Durable Medical Equipment, subject to the lifetime maximum payment limitation as listed in the Schedule of Benefits; [The program will require written certification by the treating physician to substantiate the medical necessity for the equipment and the length of time that it will be used. The purchase of durable medical equipment will be considered an eligible expense only upon showing that the rental cost would exceed the purchase price. Under no circumstances may the eligible expense for an item of durable medical equipment exceed the purchase price of such item.]

13. - 18. ...

19. Acupuncture when rendered by a medical doctor licensed in the state in which the services are rendered;

20. ...

21. Services of a Physical Therapist and Occupational Therapist licensed by the state in which the services are rendered when:

a. - e. ...

f. Approved through case management when rendered in the home;

22. - 23.c.iii. ...

24. Not subject to the annual deductible:

a. ...

b. mammographic examinations performed according to the following schedule:

i. one mammogram during the five-year period a person is 35-39 years of age;

ii. - iii. ...

c. ...

25. - 26. ...

27. Services rendered by the following, when billed by the supervising physician:

a. Perfusionists and Registered Nurse Assistants assisting in the operating room;

b. Physician's Assistants and Registered Nurse Practitioners;

28. - 32. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1830 (October 1999), LR 26:

§307. Utilization ReviewC pre-admission Certification, Continued Stay Review

A. - A.2. ...

B. For a routine vaginal delivery, PAC is not required for a stay of 2 days or less. If the mother's stay exceeds or is expected to exceed 2 days, PAC is required within 24 hours after the delivery or the date on which any complications arose, whichever is applicable. If the baby's stay exceeds that of the mother, PAC is required within 72 hours of the mother's discharge and a separate pre-certification number must be obtained for the baby. In the case of a Caesarean

Section, PAC is required if the mother's stay exceeds or is expected to exceed 4 days;

C. No benefits will be paid under the Plan:

1. ...
2. unless PAC is requested within two business days following admission in the case of an emergency;

C.3. - D. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1832 (October 1999), LR 26:

§309. Outpatient Procedure Certification

A. OPC certifies that certain outpatient procedures and therapies are Medically Necessary. OPC is required on the following procedures:

1. - 6. ...
7. Speech Therapy;

C. No benefits will be paid for the facility fee in connection with outpatient procedures, or the facility and professional fee in connection with speech therapy:

C.1. - D. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1832 (October 1999), LR 26:

§311. Case Management

A. - E.8. ...

9. Physical and occupational therapy rendered in a home setting.

F. - H. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1833 (October 1999), LR 26:

§313. Dental Surgical Benefits

A. ...

B. Eligible expenses incurred in connection with the removal of impacted teeth, including pre-operative and post-operative care, anesthesia, radiology, and pathology services, and facility charges are subject to the deductible, co-insurance and the maximum benefit provisions of the Plan.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1833 (October 1999), LR 26:

§315. Medicare Reduction

A. ...

B. Retiree 100-Medicare COB - Upon enrollment and payment of the additional monthly premium, a plan member and dependents who are covered under Medicare, both parts A and B, may choose to have full coordination of benefits with Medicare. Enrollment must be made within 30 days of eligibility for Medicare or within 30 days of retirement if already eligible for Medicare and at the annual open enrollment.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1833 (October 1999), LR 26:

§317. Exceptions and Exclusions for All Medical Benefits

A. No benefits are provided under this Plan for:

1. - 24. ...
25. repealed
26. - 40. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1834 (October 1999), LR 26:488 (March 2000), LR 26:

§323. Prescription Drug Benefits

A. This Plan allows benefits for drugs and medicines approved by the Food and Drug Administration or its successor, requiring a prescription, and dispensed by a licensed pharmacist or pharmaceutical company, but which are not administered to a covered person as an inpatient hospital patient or an outpatient hospital patient, including insulin, Retin-A dispensed for covered persons under the age of 26, Vitamin B12 injections, prescription Potassium Chloride, and over-the-counter diabetic supplies including, but not limited to, strips, lancets and swabs.

B. The following drugs, medicines, and related services are not covered:

1. - 10. ...
11. drugs for treatment of impotence;

C. ...

1. Upon presentation of the group benefits program health benefits identification card at a network pharmacy, the plan member will be responsible for copayment of \$6 per prescription when a generic drug is dispensed, \$20 per prescription when a preferred brand name drug is dispensed, and \$30 per prescription when a non-preferred brand name drug is dispensed. The copayment cannot exceed the actual charge by the pharmacy for the drug.

2. - 5.c. ...

6. Acute or Non-maintenance DrugCa covered drug other than a maintenance drug as define herein.

7. Brand DrugCthe trademark name of a drug approved by the U. S. Food and Drug Administration.

8. Generic DrugCa chemically equivalent copy of a brand name drug.

9. Maintenance DrugCcovered drug that is determined by the Program's contracted prescription benefits management firm, using standard industry reference materials, to be routinely taken over a long period of time for certain chronic medical conditions. The drug must be listed on the established maintenance drug list as an approved drug for the patient's condition.

10. Non-Preferred Brand DrugCa brand drug for which there is an equally effective, less costly therapeutic alternative available, as determined by the Pharmacy and Therapeutic Committee.

11. Pharmacy and Therapeutic CommitteeCa committee created by the Program's contracted prescription benefits management firm to advise its various plans on whether a drug has been accepted as safe and effective or investigations as well as whether a drug will be classified as a Preferred Brand Drug or a Non-Preferred Brand Drug. In making these determinations, the Pharmacy and Therapeutic Committee relies on the United States Food and Drug Administration as well as peer reviewed medical journals.

12. Preferred Brand DrugCa brand name drug that has received a classification of Preferred Brand from the Pharmacy and Therapeutic Committee based on the following criteria:

- a. clinical uniqueness of the medication;
- b. positive efficacy profile;
- c. good side effect, safety, and drug interaction profile;
- d. positive quality of the implications;
- e. clinical experience with the medication; and
- f. cost (only considered when clinical parameters are equal to other products in its class).

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1835 (October 1999), LR 26:

Chapter 4. Uniform Provisions

§403. Properly Submitted Claim Form

- A. For Plan reimbursements, all bills must show:
 1. employee's name;
 2. name of patient;
 3. name, address, and telephone number of the provider of care;
 4. diagnosis;
 5. type of services rendered, with diagnosis and/or procedure codes;
 6. date of service;
 7. charges;
 8. employee's member number;
 9. provider Tax Identification number;
 10. Medicare explanation of benefits, if applicable.

B. The Program can require additional documentation in order to determine the extent of coverage or the appropriate reimbursement. Failure to furnish the requested information within 90 days of the request will constitute reason for the denial of benefits.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1836 (October 1999), LR 26:

Chapter 5. Claims Review and Appeal

§501. Claims Review Procedures and Appeals

- A. ...
- B. The request for review must be directed to Attention: Appeals and Grievances within 90 days after the date of the notification of denial of benefits, denial of eligibility, or denial after review by the utilization review, pharmacy benefit or mental health contractors.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1838 (October 1999), LR 26:

§511. Subpoena of Witnesses; Production of Documents

- A. - B. ...
- C. No subpoena will be issued requiring the attendance and giving of testimony by witnesses unless a written request therefor is received in the office of the Program, Attention: Appeals and Grievances no later than 15 calendar days before the date fixed for the hearing. The request for subpoenas must contain the names of the witnesses and a

statement of what is intended to be proved by each witness. No subpoenas will be issued until the party requesting the subpoena deposits with the Program a sum of money sufficient to pay all fees and expenses to which a witness in a civil case is entitled.

D. No subpoena for the production of books, papers and other documentary evidence will be issued unless written request therefor is received in the office of the Program, Attention: Appeals and Grievances no later than 15 calendar days before the date fixed for the hearing. The request for subpoena for books, papers, and other documentary evidence must contain a description of the items to be produced in sufficient detail for identification and must contain the name and street address of the person who is to be required to produce the items and a brief statement of what is intended to be proved by each item.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1839 (October 1999), LR 26:

§513. Appeals Decisions

- A. ...
- B. Appeals Heard by Referee. At the conclusion of the hearing, the referee will take the matter under submission and, as soon as is reasonably possible thereafter, prepare a recommended decision in the case which will be based on the evidence adduced at the hearing or otherwise included in the hearing records. The decision will contain findings of fact and statement of reasons. The recommended decision will be submitted to the Committee for review.

C. The Committee may adopt or reject the recommended decision. In the case of adoption, the referee's decision becomes the decision of the committee. In the case of rejection, the committee will render its decision, which will include a statement of reasons for disagreement with the referee's decision. The decision of the committee will be final. A copy will be mailed by certified mail to the covered person and any representative thereof.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1839 (October 1999), LR 26:

§515. Rehearing

- A. - B. ...
- C. The request for rehearing must be filed with the program, Attention: Appeals and Grievances on or before 30 calendar days after the mailing of the appeal decision of the committee. The request will be deemed filed on the date it is received in the office of the program.

D. ...

E. When the committee grants a rehearing, an order will be issued setting forth the grounds. A copy of the order will be sent, along with notice of the time and place fixed for the rehearing, to the appealing party and any representative by certified mail.

F. - G. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1840 (October 1999), LR 26:

Chapter 6. Definitions

§601. Definitions

Acute or Non-maintenance Drug Ca covered drug other than a maintenance drug as define herein.

Brand Drug Cthe trademark name of a drug approved by the U. S. Food and Drug Administration.

Children C

1. any legitimate, duly acknowledged, or legally adopted Children of the Employee and/or the Employee's legal spouse dependent upon the Employee for support;

2. - 4. ...

Generic Drug Ca chemically equivalent copy of a "brand name" drug.

Maintenance Drug Ccovered drug that is determined by the Program's contracted prescription benefits management firm, using standard industry reference materials, to be routinely taken over a long period of time for certain chronic medical conditions. The drug must be listed on the established maintenance drug list as an approved drug for the patient's condition.

Non-Preferred Brand Drug Ca brand drug for which there is an equally effective, less costly therapeutic alternative available, as determined by the Pharmacy and Therapeutic Committee.

Pharmacy and Therapeutic Committee Ca committee created by the Program's contracted prescription benefits management firm to advise its various plans on whether a drug has been accepted as safe and effective or investigations as well as whether a drug will be classified as a Preferred Brand Drug or a Non-Preferred Brand Drug. In making these determinations, the Pharmacy and Therapeutic Committee relies on the United States Food and Drug Administration as well as peer reviewed medical journals.

Preferred Brand Drug Ca brand name drug that has received a classification of Preferred Brand from the Pharmacy and Therapeutic Committee based on the following criteria:

1. clinical uniqueness of the medication;
2. positive efficacy profile;
3. good side effect, safety, and drug interaction profile;
4. positive quality of the implications;
5. clinical experience with the medication; and
6. cost (only considered when clinical parameters are equal to other products in its class).

Well-Baby Care Croutine care to a well newborn infant from the date of birth until age 1. This includes routine physical examinations, active immunizations, check-ups, and office visits to a physician and billed by that physician, except for the treatment and/or diagnosis of a specific illness. All other health services coded with wellness procedures and diagnosis codes are excluded.

Well-Child Care Croutine physical examinations, active immunizations, check-ups and office visits to a Physician, and billed by a health care provider that has entered into a contract with the State Employees Benefits Program, except for the treatment and/or diagnosis of a specific illness, from age 1 to age 16. All other health services coded with wellness procedures and diagnosis codes are excluded.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1840 (October 1999), LR 26:

Chapter 7. Schedule of Benefits C PPO §701 Comprehensive Medical Benefits

A.1. - A.3. ...

4. Prescription Drugs

(No deductible)	50% non-Network in state
\$8 copayment for generic drugs,	80% non-Network for out of
\$25 copayment preferred brand state	
name drugs, and \$40 copayment for	
non-preferred brand name drugs	
purchased at a network pharmacy	

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1843 (October 1999), LR 26:488 (March 2000), LR 26:

A. Kip Wall
Interim Chief Executive Officer

0006#116

DECLARATION OF EMERGENCY

**Office of the Governor
Board of the Trustees of the State Employees
Group Benefits Program**

PPO Plan of Benefits C Accidental Injury
(LAC 32:III.601)

Pursuant to the authority granted by R.S. 42:871(C) and 874(B)(2), vesting the Board of Trustees with the responsibility for administration of the State Employees Group Benefits Program and granting the power to adopt and promulgate rules with respect thereto, the Board of Trustees hereby invokes the Emergency Rule provisions of R.S. 49:953(B).

The board finds that it is necessary to amend the PPO Plan of Benefits to define the term *Accidental Injury* as used therein. Failure to adopt this rule on an emergency basis will adversely affect the availability of services necessary to maintain the health and welfare of the covered employees and their dependents, which is crucial to the delivery of vital services to the citizens of the state.

Accordingly, the following Emergency Rule, adding the definition of the term *Accidental Injury* in PPO Plan of Benefits, is effective June 1, 2000, and shall remain in effect for 30 days, until July 1, 2000.

Title 32
EMPLOYEE BENEFITS
Part III. Preferred Provider Organization
(PPO)—Plan of Benefits

Chapter 6. Definitions
§601. Definitions

* * *

Accidental Injury Ca condition occurring as a direct result of a traumatic bodily injury sustained solely through accidental means from and external force. With respect to injuries to teeth, the act of chewing does not constitute an injury caused by external force.

* * *

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1840 (October 1999), LR 26:

A. Kip Wall
Chief Executive Officer

0006#112

DECLARATION OF EMERGENCY

Office of the Governor
Board of the Trustees of the State Employees
Group Benefits Program

PPO Plan of Benefits CF.M.L.A. Leave
(LAC 32:V.103)

Pursuant to the authority granted by R.S. 42:871(C) and 874(B)(2), vesting the Board of Trustees with the responsibility for administration of the State Employees Group Benefits Program and granting the power to adopt and promulgate rules with respect thereto, the Board of Trustees hereby invokes the Emergency Rule provisions of R.S. 49:953(B).

The board finds that it is necessary to amend the PPO Plan of Benefits to provide for continuation of coverage for an employee on approved F.M.L.A. leave. This action is necessary to implement requirements of the federal Family and Medical Leave Act (F.M.L.A.), and the rules and regulations promulgated pursuant thereto, in order to avoid sanctions or penalties from the United States.

Accordingly, the following Emergency Rule, adding Subsection E to Section 103 of Louisiana Administrative Code, Title 32, Part V, the PPO Plan of Benefits, is effective May 31, 2000, and shall remain in effect for 31 days, until July 1, 2000.

Title 32
EMPLOYEE BENEFITS
Part III. Preferred Provider Organization
(PPO)—Plan of Benefits

Chapter 1. Eligibility
§103. Continued Coverage

A. - D.3. ...

E. Family and Medical Leave Act (F.M.L.A.) Leave of Absence. An employee on approved F.M.L.A. leave may retain coverage for the duration of such leave. The participant employer shall pay the employer's share of the premium during F.M.L.A. leave, whether paid leave or leave

without pay. The participant employer may pay the employee's share of the premium during unpaid F.M.L.A. leave, subject to reimbursement by the employee.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1827 (October 1999), LR 26:

A. Kip Wall
Chief Executive Officer

0006#113

DECLARATION OF EMERGENCY

Office of the Governor
Commission on Law Enforcement and
Administration of Criminal Justice

Peace Officers CStandards and Training
(LAC 22:III.Chapter 47)

The following amendment is published in accordance with the emergency provision of R.S. 49:953(B), the Administrative Procedure Act, and R.S. 40:2401 et seq., the Peace Officer Standards and Training Act, which allows the Council on Peace Officer Standards and Training (POST) to promulgate rules necessary to carry out its business or the provision of Chapter 47.

This emergency rule is to be effective on June 1, 2000 and will remain in effect for 120 days or until a final rule takes effect through the normal rulemaking process, whichever occurs first.

Title 22
CORRECTIONS, CRIMINAL JUSTICE AND LAW
ENFORCEMENT

Part III. Commission on Law Enforcement and
Administration of Criminal Justice
Chapter 47. Standards and Training
§4703. Basic Certification

A. - C. ...

D. To maintain firearm certification, an officer shall be required to requalify yearly on the POST firearms qualification course, demonstrating at least 80 percent proficiency. Scores shall be computed and verified by a POST certified Firearms Instructor. If the period between qualifying exceeds 18 months for any reason, the officer will be required to successfully complete a Firearms Course prescribed by the POST Council conducted by a POST certified Firearms Instructor, unless the officer had been in the military for more than three years and was exercising his veteran reemployment rights.

E. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 15:1204 and R.S. 15:1207.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Commission on Law Enforcement and Administration of Criminal Justice, LR 13:434 (August 1987), amended LR 25:663 (April 1999), amended LR 26:

Michael A. Ranatza
Executive Director

0005#077

DECLARATION OF EMERGENCY

Department of Health and Hospitals Office of the Secretary Bureau of Health Services Financing

Chiropractic Services C Termination of Services

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing has adopted the following emergency rule under the Medical Assistance Program as authorized by R.S. 46:153 and 36:254 and pursuant to Title XIX of the Social Security Act and as directed by the 1999-2000 General Appropriation Act, which states: "The Secretary shall implement reductions in the Medicaid program as necessary to control expenditures to the level approved in this schedule. The Secretary is hereby directed to utilize various cost containment measures to accomplish these reductions, including but not limited to pre-certification, pre-admission screening, and utilization review, and other measures as allowed by federal law." This emergency rule is in accordance with the Administrative Procedure Act, R.S. 49:950, et seq. and shall be in effect for the maximum period allowed under the Administrative Procedure Act or until adoption of the rule, whichever occurs first.

The Department of Health and Hospitals, Bureau of Health Services Financing provides coverage for chiropractic services under the Medicaid Program. Section 440.225 of the Code of Federal Regulations (42 CFR) states that "any of the services defined in subpart A of this part that are not required under sections 440.210 and 440.220 may be furnished under the state plan at the state's option." Chiropractic services are considered optional under the Title XIX of the Social Security Act and a state may choose to either include or exclude these services under the Medicaid State Plan.

As a result of a budgetary shortfall, the Bureau has determined it is necessary to terminate coverage of chiropractic services for recipients aged 21 and older. However, the Medicaid Program will continue to provide coverage of medically necessary manual manipulation of the spine for Early and Periodic Screening, Diagnostic and Treatment Program (EPSDT) recipients under the age of 21 years when the service is rendered as the result of a referral from an EPSDT medical screening provider. Prior authorization shall continue to be required for chiropractic services rendered to recipients under four years of age and for the thirteenth chiropractic service rendered to recipients between the ages of 5 and 21. However, reimbursement shall no longer be made to chiropractors for radiology procedures.

This action is necessary to avoid a budget deficit in the medical assistance programs. This emergency rule is being adopted to continue the provisions of the February 1, 2000, rule.

Emergency Rule

Effective June 21, 2000, the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing terminates coverage and reimbursement for chiropractic services for recipients aged 21 and older.

However, the Medicaid Program will continue to provide coverage of medically necessary manual manipulation of the spine for Early and Periodic Screening, Diagnostic and Treatment Program (EPSDT) recipients under the age of 21 years when the service is rendered as the result of a referral from an EPSDT medical screening provider. Prior authorization shall continue to be required for chiropractic services rendered to recipients under four years of age and for the thirteenth chiropractic service rendered to recipients between the ages of 5 and 21. However, reimbursement shall no longer be made to chiropractors for radiology procedures.

Interested persons may submit written comments to the following address: Ben A. Bearden, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is the person 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.

David W. Hood
Secretary

0006#035

DECLARATION OF EMERGENCY

Department of Health and Hospitals Office of the Secretary Bureau of Health Services Financing

Durable Medical Equipment C Customized Wheelchairs Reimbursement

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing has adopted the following emergency rule in the Medical Assistance Program as authorized by R.S. 46:153 and 36:254 and pursuant to Title XIX of the Social Security Act and as directed by the 1999-2000 General Appropriation Act, which states: "The Secretary shall implement reductions in the Medicaid program as necessary to control expenditures to the level approved in this schedule. The Secretary is hereby directed to utilize various cost containment measures to accomplish these reductions, including but not limited to pre-certification, pre-admission screening and utilization review, and other measures as allowed by federal law." This emergency rule is adopted in accordance with the Administrative Procedure Act, R.S. 49:950, et seq. and shall be in effect for the maximum period allowed under the Administrative Procedure Act or until adoption of the rule, whichever occurs first.

The Department of Health and Hospitals, Bureau of Health Services Financing reimburses certain durable medical equipment items using a formula based on a percentage calculation of the Manufacturer's Suggested Retail Price (MSRP). As a result of a budgetary shortfall, the Bureau has determined it is necessary to reduce the reimbursement for manual type customized wheelchairs and their components from MSRP minus 15 percent to MSRP minus 20 percent and reduce the reimbursement for motorized type customized wheelchairs from MSRP minus 12 percent to MSRP minus 17 percent.

This action is necessary in order to avoid a budget deficit in the medical assistance programs. This emergency rule is being adopted to continue the provisions of the February 8, 2000, rule.

Emergency Rule

Effective for dates of service June 8, 2000 and after, the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing reduces reimbursement for manual type customized wheelchairs and their components from Manufacturer's Suggested Retail Price (MSRP) minus 15 percent to MSRP minus 20 percent and motorized type customized wheelchairs from MSRP minus 12 percent to MSRP minus 17 percent.

Interested persons may submit written comments to the following address: Ben A. Bearden, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is the person 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.

David W. Hood
Secretary

0006#058

DECLARATION OF EMERGENCY

**Department of Health and Hospitals
Office of the Secretary
Bureau of Health Services Financing**

Durable Medical Equipment CE and K Procedure Codes

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing has adopted the following emergency rule under the Medical Assistance Program as authorized by R.S. 46:153 and 36:254 et seq. and pursuant to Title XIX of the Social Security Act and as directed by the 1999-2000 General Appropriation Act, which states: "The Secretary shall implement reductions in the Medicaid program as necessary to control expenditures to the level approved in this schedule. The Secretary is hereby directed to utilize various cost containment measures to accomplish these reductions, including but not limited to pre-certification, pre-admission screening and utilization review, and other measures as allowed by federal law." This emergency rule is adopted in accordance with the Administrative Procedure Act, R.S. 49:950, et seq. and shall be in effect for the maximum period allowed under the Administrative Procedure Act or until adoption of the rule, whichever occurs first.

The Department of Health and Hospitals, Bureau of Health Services Financing reimburses certain durable medical equipment items at 80 percent of the Medicare Fee Schedule amount or billed charges whichever is the lesser amount for specific Health Care Financing Administration Common Procedure Codes (HCPC). As a result of a budgetary shortfall, the Bureau has determined it is necessary to reduce reimbursement for these specified HCPC procedure codes by 10 percent. Reimbursement will be reduced to 70 percent of the Medicare fee schedule

amount or billed charges, whichever is the lesser amount for the following HCPC procedure codes:

E1050-E1060	Wheelchairs with special features
E1070-E1110	
E1170-E1213	
E1221-E1224	
E1240-E1295	
K0002-K0014	
L7803-L8030	Breast Prosthesis
L8039	
L8400-L8435	Prosthetic Sheaths
L8470-L8485	Prosthetic Socks
L8100-L8230	Elastic Support Stockings
L8239	
A7003-A7017	Nebulizer Administrative Supplies
K0168-K0181	
K0529-K0530	
E0840-E0948	Traction Equipment
E0781, K0455	External Ambulatory Infusion Pumps
E0621	Patient Lift Slings
E0480	Percussors
E0550-E0560	Humidifiers
E0565	Compressors

This action is necessary in order to avoid a budget deficit in the medical assistance programs. This emergency rule is being adopted to continue the provisions of the February 8, 2000, rule.

Emergency Rule

Effective for dates of service June 8, 2000 and after, the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing reduces the reimbursement for certain durable medical equipment items identified by specific HCPC procedure codes by 10 percent. Reimbursement will be reduced to 70 percent of the Medicare Fee Schedule amount or billed charges whichever is the lesser amount for the following HCPC procedure codes:

E1050-E1060	Wheelchairs with special features
E1070-E1110	
E1170-E1213	
E1221-E1224	
E1240-E1295	
K0002-K0014	
L7803-L8030	Breast Prosthesis
L8039	
L8400-L8435	Prosthetic Sheaths
L8470-L8485	Prosthetic Socks
L8100-L8230	Elastic Support Stockings
L8239	
A7003-A7017	Nebulizer Administrative Supplies
K0168-K0181	
K0529-K0530	
E0840-E0948	Traction Equipment
E0781, K0455	External Ambulatory Infusion Pumps

E0621	Patient Lift Slings
E0480	Percussors
E0550-E0560	Humidifiers
E0565	Compressors

Interested persons may submit written comments to the following address: Ben A. Bearden, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is the person 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.

David W. Hood
Secretary

0006#057

DECLARATION OF EMERGENCY
Department of Health and Hospitals
Office of the Secretary
Bureau of Health Services Financing

Durable Medical Equipment Enteral
Formulas Reimbursement

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing has adopted the following emergency rule in the Medical Assistance Program as authorized by R.S. 46:153 and 36:254 and pursuant to Title XIX of the Social Security Act and as directed by the 1999-2000 General Appropriation Act, which states: "The Secretary shall implement reductions in the Medicaid program as necessary to control expenditures to the level approved in this schedule. The Secretary is hereby directed to utilize various cost containment measures to accomplish these reductions, including but not limited to pre-certification, pre-admission screening and utilization review, and other measures as allowed by federal law." This emergency rule is adopted in accordance with the Administrative Procedure Act, R.S. 49:950, et seq. and shall be in effect for the maximum period allowed under the Administrative Procedure Act or until adoption of the rule, whichever occurs first.

The Department of Health and Hospitals, Bureau of Health Services Financing reimburses for various groupings of enteral formulas either at 100 percent of the Medicare Fee Schedule or at an established flat fee amount for individual formulas or billed charges whichever is the lesser amount. As a result of a budgetary shortfall, the Bureau has determined it is necessary to reduce reimbursement for these enteral formulas by 20 percent. Reimbursement will be reduced to 80 percent of the Medicare Fee Schedule for various groupings of formulas or to a rate of 80 percent of established flat fee amount for certain individual formulas or billed charges whichever is the lesser amount.

This action is necessary in order to avoid a budget deficit in the medical assistance programs. This emergency rule is being adopted to continue the provisions of the February 8, 2000, rule.

Emergency Rule

Effective for dates of service June 8, 2000 and after, the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing reduces reimbursement for enteral formulas by 20 percent. Reimbursement will be reduced to 80 percent of the Medicare Fee Schedule for various groupings of enteral formulas or to a rate of 80 percent of established flat fee amount for certain individual formulas or billed charges whichever is the lesser amount.

Interested persons may submit written comments to the following address: Ben A. Bearden, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is the person 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.

David W. Hood
Secretary

0006#056

DECLARATION OF EMERGENCY
Department of Health and Hospitals
Office of the Secretary
Bureau of Health Services Financing

Durable Medical Equipment Equipment
and Supplies Delivery Reimbursement

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing has adopted the following emergency rule under the Medical Assistance Program as authorized by R.S. 46:153 and 36:254 and pursuant to Title XIX of the Social Security Act and as directed by the 1999-2000 General Appropriation Act, which states: "The Secretary shall implement reductions in the Medicaid program as necessary to control expenditures to the level approved in this schedule. The Secretary is hereby directed to utilize various cost containment measures to accomplish these reductions, including but not limited to pre-certification, pre-admission screening and utilization review, and other measures as allowed by federal law." This emergency rule is adopted in accordance with the Administrative Procedure Act, R.S. 49:950, et seq. and shall be in effect for the maximum period allowed under the Administrative Procedure Act or until adoption of the rule, whichever occurs first.

The Department of Health and Hospitals, Bureau of Health Services Financing provides reimbursement in the Durable Medical Equipment Program for the delivery of medical equipment and supplies. The reimbursement is either the lesser of billed charges or 10 percent of the total shipping amount of the prior authorized medical equipment and supplies up to a maximum amount of \$75. As a result of a budgetary shortfall, the Bureau has determined it is necessary to reduce the reimbursement rate for delivery of medical equipment and supplies to either the lesser of billed charges or 5 percent of the total shipping amount of the prior authorized medical equipment and supplies up to a maximum of \$50. This action is necessary in order to avoid

a budget deficit in the medical assistance programs. This emergency rule is being adopted to continue the provisions of the February 8, 2000, rule.

Emergency Rule

Effective for dates of service June 8, 2000 and after, the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing reduces the reimbursement rate for delivery of medical equipment and supplies to either the lesser of billed charges or 5 percent of the total shipping amount of the prior authorized medical equipment and supplies up to a maximum of \$50.

Interested persons may submit written comments to the following address: Ben A. Bearden, Office of the Secretary, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is the person responsible for responding to inquiries regarding this emergency rule. A copy of this emergency rule is available at the parish Medicaid office for review by interested parties.

David W. Hood
Secretary

0006#055

DECLARATION OF EMERGENCY

**Department of Health and Hospitals
Office of the Secretary
Bureau of Health Services Financing**

Durable Medical Equipment
Flat Fee Reimbursement

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing has adopted the following emergency rule under the Medical Assistance Program as authorized by R.S. 46:153 and 36:254 and pursuant to Title XIX of the Social Security Act and as directed by the 1999-2000 General Appropriation Act, which states: "The Secretary shall implement reductions in the Medicaid program as necessary to control expenditures to the level approved in this schedule. The Secretary is hereby directed to utilize various cost containment measures to accomplish these reductions, including but not limited to pre-certification, pre-admission screening and utilization review, and other measures as allowed by federal law." This emergency rule is adopted in accordance with the Administrative Procedure Act, R.S. 49:950, et seq. and shall be in effect for the maximum period allowed under the Administrative Procedure Act or until adoption of the rule, whichever occurs first.

The Department of Health and Hospitals, Bureau of Health Services Financing currently provides reimbursement for the certain durable medical equipment items at a rate of 80 percent of the Medicare allowable fee. As a result of a budgetary shortfall, the Bureau has determined it is necessary to change the reimbursement methodology for these items from a percentage of the Medicare allowable fee to a Medicaid established flat fee amount. Reimbursement for these durable medical equipment items will be as follows:

Enteral infusion pumps

B9000, B9002	\$595 purchase	\$92 rental per month
B0777, B0778		

Standard type wheelchairs

E1130 and K0001	\$250 purchase	\$35 rental per month
E1140	\$412.50 purchase	\$38.50 rental per month
E1150	\$453.75 purchase	\$42.35 rental per month
E1160	\$375 purchase	\$50 rental per month

Hospital beds

E0255	\$650 purchase	\$75 rental per month
E0265	\$1250 purchase	\$75 rental per month

Artificial eyes

V2623	\$500 purchase	
-------	----------------	--

Commode chairs

E0163	\$55 purchase	
E0164	\$83.55 purchase	
E0165	\$85 purchase	
E0166	\$142.80 purchase	

Stationary suction machines

Z0500	\$225 purchase	\$35 rental per month
-------	----------------	-----------------------

This action is necessary in order to avoid a budget deficit in the medical assistance programs. This emergency rule is being adopted to continue the provisions of the February 8, 2000, rule.

Emergency Rule

Effective for dates of service June 8, 2000 and after, the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing changes the reimbursement methodology for the following durable medical equipment items from 80 percent of the Medicare allowable fee to a Medicaid established flat fee amount:

Enteral infusion pumps

B9000, B9002	\$595 purchase	\$92 rental per month
B0777, B0778		

Standard type wheelchairs

E1130 and K0001	\$250 purchase	\$35 rental per month
E1140	\$412.50 purchase	\$38.50 rental per month
E1150	\$453.75 purchase	\$42.35 rental per month
E1160	\$375 purchase	\$50 rental per month

Hospital beds

E0255	\$650 purchase	\$75 rental per month
E0265	\$1250 purchase	\$75 rental per month

Artificial eyes

V263	\$500 purchase
------	----------------

Commode chairs

E0163	\$55 purchase
E0164	\$83.55 purchase
E0165	\$85 purchase
E0166	\$142.80 purchase

Stationary suction machines

Z0500	\$225 purchase	\$35 rental per month
-------	----------------	-----------------------

Interested persons may submit written comments to the following address: Ben A. Bearden, Office of the Secretary, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is the person responsible for responding to inquiries regarding this emergency rule. A copy of this emergency rule is available at the parish Medicaid office for review by interested parties.

David W. Hood
Secretary

0006#054

DECLARATION OF EMERGENCY

**Department of Health and Hospitals
Office of the Secretary
Bureau of Health Services Financing**

Durable Medical Equipment Medicare Part B Claims

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing has adopted the following emergency rule under the Medical Assistance Program as authorized by R.S. 46:153 and 36:254 and pursuant to Title XIX of the Social Security Act and as directed by the 1999-2000 General Appropriation Act, which states: "The Secretary shall implement reductions in the Medicaid program as necessary to control expenditures to the level approved in this schedule. The Secretary is hereby directed to utilize various cost containment measures to accomplish these reductions, including but not limited to pre-certification, pre-admission screening and utilization review, and other measures as allowed by federal law." This emergency rule is adopted in accordance with the Administrative Procedure Act, R.S. 49:950, et seq. and shall be in effect for the maximum period allowed under the Administrative Procedure Act or until adoption of the rule, whichever occurs first.

The Department of Health and Hospitals, Bureau of Health Services Financing currently provides reimbursement for full co-insurance and deductibles for Medicare Part B claims for durable medical equipment and supplies. Section 1902(a)(10) of the Social Security Act provides states flexibility in the payment of Medicare cost sharing for dually eligible Medicare/Medicaid recipients who are not Qualified Medicare Beneficiaries (QMBs). Section 4714 of the Balanced Budget Act of 1997 clarifies that states have flexibility in complying with the requirements to pay Medicare cost-sharing for Qualified Medicare Beneficiaries and the protections against payment liability for QMBs. Section 4714 states that "a state is not required to provide any payment for any expenses incurred relating to payment for deductibles, coinsurance, or co-payments for Medicare cost sharing to the extent that payment under Title XVIII for the service would exceed the payment amount that otherwise would be made under the state plan under this title for service if provided to an eligible recipient other than a Medicare beneficiary."

When a state's payment for Medicare cost sharing for an item or service rendered to a dually eligible Medicare/Medicaid recipient or a Qualified Medicare Beneficiary is reduced or eliminated to limit the amount under Title XVIII that the beneficiary may be billed or charged for the service, the amount of payment made under Title XVIII plus the amount of payment (if any) under the Medicaid State Plan shall be considered to be payment in full for the service. The beneficiary does not have any legal liability to make payment for the service.

As a result of a budgetary shortfall, the Bureau has determined that it is necessary to compare the Medicare payment and the Medicaid rate on file for Medicare Part B claims for medical equipment or supply items. If the Medicare payment exceeds the Medicaid rate, the claim will be adjudicated as a paid claim with a zero payment. If the Medicaid rate would exceed the Medicare payment, the claim will be reimbursed at the lesser of the co-insurance and deductible or up to the Medicaid maximum payment. This action is necessary in order to avoid a budget deficit in the medical assistance programs. This emergency rule is being adopted to continue the provisions of the February 8, 2000, rule.

Emergency Rule

Effective with dates of service June 8, 2000, and thereafter, the Department of Health and Hospitals, Bureau of Health Services Financing shall compare the Medicare payment to the Medicaid rate on file for Medicare Part B claims for medical equipment or supply items. If the Medicare payment exceeds the Medicaid rate, the claim will be adjudicated as a paid claim with a zero payment. If the Medicaid rate would exceed the Medicare payment, the claim will be reimbursed at the lesser of the co-insurance and deductible or up to the Medicaid maximum payment. If the Medicaid payment is reduced or eliminated as a result of the Medicare/Medicaid payment comparison, the amount of the Medicare payment plus the amount of the Medicaid payment (if any) shall be considered to be payment in full for the service. The recipient does not have any legal liability to make payment for the service.

Interested persons may submit written comments to the following address: Ben A. Bearden, Office of the Secretary, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is the person responsible for responding to inquiries regarding this emergency rule. A copy of this emergency rule is available at parish Medicaid offices for review by interested parties.

David W. Hood
Secretary

0006#053

DECLARATION OF EMERGENCY

**Department of Health and Hospitals
Office of the Secretary
Bureau of Health Services Financing**

Durable Medical Equipment Orthotics
and Prosthetics Reimbursement

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing has adopted the following emergency rule in the Medical Assistance Program as authorized by R.S. 46:153 and 36:254 and pursuant to Title XIX of the Social Security Act and as directed by the 1999-2000 General Appropriation Act, which states: "The Secretary shall implement reductions in the Medicaid program as necessary to control expenditures to the level approved in this schedule. The Secretary is hereby directed to utilize various cost containment measures to accomplish these reductions, including but not limited to pre-certification, pre-admission screening and utilization review, and other measures as allowed by federal law." This emergency rule is adopted in accordance with the Administrative Procedure Act, R.S. 49:950, et seq. and shall be in effect for the maximum period allowed under the Administrative Procedure Act or until adoption of the rule, whichever occurs first.

The Department of Health and Hospitals, Bureau of Health Services Financing reimburses certain durable medical equipment items identified by specific Health Care Financing Administration Common Procedure Codes (HCPC) at 80 percent of the Medicare Fee Schedule amount or billed charges, whichever is the lesser amount. As a result of a budgetary shortfall, the Bureau has determined it is necessary to reduce reimbursement for orthotic and prosthetic items by 10 percent. Reimbursement will be reduced to 70 percent of the Medicare Fee Schedule amount or billed charges, whichever is the lesser amount, for the following HCPC procedure codes:

L0100-L2999	Orthotics
L3650-L4380	
L5000-L7499	Prosthetics

This action is necessary in order to avoid a budget deficit in the medical assistance programs. This emergency rule is being adopted to continue the provisions of the February 8, 2000, rule.

Emergency Rule

Effective for dates of service June 8, 2000 and after, the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing reduces the reimbursement for certain durable medical equipment items identified by specific HCPC procedure codes by 10 percent. Reimbursement will be reduced to 70 percent of the Medicare Fee Schedule amount or billed charges, whichever is the lesser amount, for the following HCPC procedure codes:

L0100-L2999	Orthotics
L3650-L4380	
L5000-L7499	Prosthetics

Interested persons may submit written comments to the following address: Ben A. Bearden, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is the person 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.

David W. Hood
Secretary

0006#052

DECLARATION OF EMERGENCY

**Department of Health and Hospitals
Office of the Secretary
Bureau of Health Services Financing**

Durable Medical Equipment
COSTomy and
Urological Supplies Reimbursement

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing has adopted the following emergency rule under the Medical Assistance Program as authorized by R.S. 46:153 and 36:254 et seq. and pursuant to Title XIX of the Social Security Act and as directed by the 1999-2000 General Appropriation Act, which states: "The Secretary shall implement reductions in the Medicaid program as necessary to control expenditures to the level approved in this schedule. The Secretary is hereby directed to utilize various cost containment measures to accomplish these reductions, including but not limited to pre-certification, pre-admission screening and utilization review, and other measures as allowed by federal law." This emergency rule is adopted in accordance with the Administrative Procedure Act, R.S. 49:950, et seq. and shall be in effect for the maximum period allowed under the Administrative Procedure Act or until adoption of the rule, whichever occurs first.

The Department of Health and Hospitals, Bureau of Health Services Financing reimburse certain durable medical equipment items identified by specific Health Care Financing Administration Common Procedure Codes (HCPC) at either 80 percent of the Medicare Fee Schedule, 80 percent of the Manufacturer's Suggested Retail Price

(MSRP) or billed charges, whichever is the lesser amount. As a result of a budgetary shortfall, the Bureau has determined it is necessary to reduce the reimbursement rate for these items by 10 percent. The reimbursement will be reduced to 70 percent of the Medicare Fee Schedule, 70 percent of the MSRP amount or billed charges, whichever is the lesser amount for the following HCPC codes:

A4200- A4460	Ostomy and Urological supplies
A4927-A5149	
K0133-K0139	
A6020-A6406	Wound dressings and supplies
K0216-K0437	

This action is necessary in order to avoid a budget deficit in the medical assistance programs. This emergency rule is being adopted to continue the provisions of the February 8, 2000, rule.

Emergency Rule

Effective for dates of service June 8, 2000 and after, the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing reduces the reimbursement for certain durable medical equipment items identified by specific Health Care Financing Administration Common Procedure Codes by 10 percent. The reimbursement will be reduced to 70 percent of the Medicare Fee Schedule, 70 percent of the Manufacturer's Suggested Retail Price (MSRP) amount or billed charges, whichever is the lesser amount for the following HCPC codes:

A4200- A4460	Ostomy and Urological supplies
A4927-A5149	
K0133-K0139	
A6020-A6406	Wound dressings and supplies
K0216-K0437	

Interested persons may submit written comments to the following address: Ben A. Bearden, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is the person 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.

David W. Hood
Secretary

0006#051

DECLARATION OF EMERGENCY

**Department of Health and Hospitals
Office of the Secretary
Bureau of Health Services Financing**

Durable Medical EquipmentCOxygen
Concentrators and Glucometers Reimbursement

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing has adopted the following emergency rule under the Medical Assistance

Program as authorized by R.S. 46:153 and 36:254 and pursuant to Title XIX of the Social Security Act and as directed by the 1999-2000 General Appropriation Act, which states: "The Secretary shall implement reductions in the Medicaid program as necessary to control expenditures to the level approved in this schedule. The Secretary is hereby directed to utilize various cost containment measures to accomplish these reductions, including but not limited to pre-certification, pre-admission screening and utilization review, and other measures as allowed by federal law." This emergency rule is adopted in accordance with the Administrative Procedure Act, R.S. 49:950, et seq. and shall be in effect for the maximum period allowed under the Administrative Procedure Act or until adoption of the rule, whichever occurs first.

The Department of Health and Hospitals, Bureau of Health Services Financing provides reimbursement for oxygen concentrators and glucometers in the Durable Medical Equipment (DME) Program. Currently, oxygen concentrators are reimbursed at a flat fee of \$1500 for purchase and \$175 per month rental. Glucometers are reimbursed at a flat fee of \$100 for purchase (rental is not applicable). As a result of a budgetary shortfall, the Bureau has determined it is necessary to reduce the reimbursement fees for oxygen concentrators to \$1250 for purchase and \$150 per month for rental and for glucometers to \$30 for purchase. This action is necessary in order to avoid a budget deficit in the medical assistance programs. This emergency rule is being adopted to continue the provisions of the February 8, 2000, rule.

Emergency Rule

Effective for dates of service June 8, 2000 and after, the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing reduces the reimbursement provided under the Durable Medical Equipment Program for oxygen concentrators to \$1250 for purchase and \$150 per month for rental and for glucometers to \$30 for purchase.

Interested persons may submit written comments to the following address: Ben A. Bearden, Office of the Secretary, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is the person responsible for responding to inquiries regarding this emergency rule. A copy of this emergency rule is available at the parish Medicaid office for review by interested parties.

David W. Hood
Secretary

0006#050

DECLARATION OF EMERGENCY

**Department of Health and Hospitals
Office of the Secretary
Bureau of Health Services Financing**

Durable Medical EquipmentCParenteral
and Enteral Supplies Reimbursement

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing has adopted

the following emergency rule under the Medical Assistance Program as authorized by R.S. 46:153 and 36:254 et seq., and pursuant to Title XIX of the Social Security Act and as directed by the 1999-2000 General Appropriation Act, which states: "The Secretary shall implement reductions in the Medicaid program as necessary to control expenditures to the level approved in this schedule. The Secretary is hereby directed to utilize various cost containment measures to accomplish these reductions, including but not limited to pre-certification, pre-admission screening, and utilization review, and other measures as allowed by federal law." This emergency rule is adopted in accordance with the Administrative Procedure Act, R.S. 49:950, et seq. and shall be in effect for the maximum period allowed under the Administrative Procedure Act or until adoption of the rule, whichever occurs first.

The Department of Health and Hospitals, Bureau of Health Services Financing reimburses certain durable medical equipment items identified by specific Health Care Financing Administration Common Procedure Codes (HCPC) at 80 percent or 100 percent of the Medicare Fee Schedule. As a result of a budgetary shortfall, the Bureau has determined it is necessary to reduce the reimbursement rate for these items by 10 percent. The reimbursement will be reduced to 70 percent of the Medicare Fee Schedule amount for the following HCPC codes:

B4034-B4084, B9004-B9999	Parenteral and Enteral supplies
E0776, E0791	
A4624-A4625	Suction Catheters
A4621	Tracheostomy masks or collars
A4623	Tracheostomy cannulas

The reimbursement will be reduced to 90 percent of the Medicare Fee Schedule amount for the following HCPC codes:

A4622	Tracheostomy tubes
A4629	Tracheostomy care kits

This action is necessary in order to avoid a budget deficit in the medical assistance programs. This emergency rule is being adopted to continue the provisions of the February 8, 2000, rule.

Emergency Rule

Effective for dates of service June 8, 2000 and after, the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing reduces the reimbursement for certain durable medical equipment items identified by specific Health Care Financing Administration Common Procedure Codes by 10 percent. The reimbursement will be reduced to 70 percent of the Medicare Fee Schedule amount for the following HCPC codes:

B4034-B4084, B9004-B9999	Parenteral and Enteral supplies
E0776, E0791	
A4624-A4625	Suction Catheters
A4621	Tracheostomy masks or collars

A4623	Tracheostomy cannulas
-------	-----------------------

The reimbursement will be reduced to 90 percent of the Medicare Fee Schedule amount for the following HCPC codes:

A4622	Tracheostomy tubes
A4629	Tracheostomy care kits (HCPC) codes

Interested persons may submit written comments to the following address: Ben A. Bearden, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is the person 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.

David W. Hood
Secretary

0006#049

DECLARATION OF EMERGENCY
Department of Health and Hospitals
Office of the Secretary
Bureau of Health Services Financing

Durable Medical Equipment CZ and E Procedure Codes

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing has adopted the following emergency rule under the Medical Assistance Program as authorized by R.S. 46:153 and 36:254 et seq. and pursuant to Title XIX of the Social Security Act and as directed by the 1999-2000 General Appropriation Act, which states: "The Secretary shall implement reductions in the Medicaid program as necessary to control expenditures to the level approved in this schedule. The Secretary is hereby directed to utilize various cost containment measures to accomplish these reductions, including but not limited to pre-certification, pre-admission screening and utilization review, and other measures as allowed by federal law." This emergency rule is adopted in accordance with the Administrative Procedure Act, R.S. 49:950, et seq. and shall be in effect for the maximum period allowed under the Administrative Procedure Act or until adoption of the rule, whichever occurs first.

The Department of Health and Hospitals, Bureau of Health Services Financing provides a flat fee reimbursement for all durable medical equipment items identified by Health Care Financing Administration Common Procedure Codes (HCPC) beginning with the letter "Z"; all miscellaneous equipment items identified with the HCPC code E1399; and all home health supply items and other miscellaneous supplies identified with the HCPC code Z1399. As a result of a budgetary shortfall, the Bureau has determined it is necessary to reduce the reimbursement for medical equipment and home health supply items in the Durable Medical Equipment Program that are identified by a HCPC code beginning with the letter "Z" or HCPC code E1399 or

Z1399 by 30 percent. This action is necessary in order to avoid a budget deficit in the medical assistance programs. This emergency rule is being adopted to continue the provisions of the February 8, 2000, rule.

Emergency Rule

Effective for dates of service June 8, 2000 and after, the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing reduces the reimbursement for all durable medical equipment items identified by Health Care Financing Administration Common Procedure Codes (HCPC) beginning with the letter "Z"; all miscellaneous equipment items authorized with the HCPC codes E1399; and all home health supply items and other miscellaneous supplies identified with the HCPC code Z1399 by 30 percent.

Interested persons may submit written comments to the following address: Ben A. Bearden, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is the person 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.

David W. Hood
Secretary

0006#048

DECLARATION OF EMERGENCY
Department of Health and Hospitals
Office of the Secretary
Bureau of Health Services Financing

Early Periodic Screening Diagnosis and Treatment (EPSDT)CDental Services Reimbursement

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing has adopted the following emergency rule under the Medical Assistance Program as authorized by R.S. 46:153 and 36:254 and pursuant to Title XIX of the Social Security Act and as directed by the 1999-2000 General Appropriation Act, which states: "The Secretary shall implement reductions in the Medicaid program as necessary to control expenditures to the level approved in this schedule. The Secretary is hereby directed to utilize various cost containment measures to accomplish these reductions, including but not limited to pre-certification, pre-admission screening, and utilization review, and other measures as allowed by federal law." This emergency rule is adopted in accordance with the Administrative Procedure Act, R.S. 49:950, et seq. and shall be in effect for the maximum period allowed under the Administrative Procedure Act or until adoption of the rule, whichever occurs first.

The Department of Health and Hospitals, Bureau of Health Services Financing provides reimbursement for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) dental services under the Medicaid Program. Reimbursement for these services is a flat fee established by the Bureau minus the amount which any third party coverage would pay. As a result of a budgetary shortfall, the Bureau has

determined it is necessary to reduce the reimbursement fees for EPSDT Dental services by 7 percent. This action is necessary in order to avoid a budget deficit in the medical assistance programs. This emergency rule is being adopted to continue the provisions of the February 1, 2000, rule.

Emergency Rule

Effective for dates of service June 1, 2000 and after, the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing reduces the reimbursement fees for the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Dental services by 7 percent.

Interested persons may submit written comments to the following address: Ben A. Bearden, Office of the Secretary, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is the person responsible for responding to inquiries regarding this emergency rule. A copy of this emergency rule is available at the parish Medicaid office for review by interested parties.

David W. Hood
Secretary

0006#047

DECLARATION OF EMERGENCY
Department of Health and Hospitals
Office of the Secretary
Bureau of Health Services Financing

Early Periodic Screening Diagnosis and Treatment (EPSDT)CKidMed Services

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing has adopted the following emergency rule under the Medical Assistance Program as authorized by R.S. 46:153 and 36:254 and pursuant to Title XIX of the Social Security Act and as directed by the 1999-2000 General Appropriation Act, which states: "The Secretary shall implement reductions in the Medicaid program as necessary to control expenditures to the level approved in this schedule. The Secretary is hereby directed to utilize various cost containment measures to accomplish these reductions, including but not limited to pre-certification, pre-admission screening, and utilization review, and other measures as allowed by federal law." This emergency rule is adopted in accordance with the Administrative Procedure Act, R.S. 49:950, et seq. and shall be in effect for the maximum period allowed under the Administrative Procedure Act or until adoption of the rule, whichever occurs first.

The Department of Health and Hospitals, Bureau of Health Services Financing provides reimbursement for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) KidMed Services under the Medicaid Program. Reimbursement for these services is the flat fee established by the Bureau minus the amount which any third party coverage would pay. As a result of a budgetary shortfall, the Bureau has determined it is necessary to reduce the reimbursement fees for EPSDT KidMed services by 7 percent. This action is necessary in order to avoid a budget

deficit in the medical assistance programs. This emergency rule is being adopted to continue the provisions of the February 1, 2000, rule.

Emergency Rule

Effective for dates of service June 1, 2000 and after, the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing reduces the reimbursement fees for the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) KidMed services by 7 percent.

Interested persons may submit written comments to the following address: Ben A. Bearden, Office of the Secretary, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is the person responsible for responding to inquiries regarding this emergency rule. A copy of this emergency rule is available at the parish Medicaid office for review by interested parties.

David W. Hood
Secretary

0006#046

DECLARATION OF EMERGENCY

**Department of Health and Hospitals
Office of the Secretary
Bureau of Health Services Financing**

Early Periodic Screening Diagnosis and
Treatment (EPSDT) Rehabilitation
Services Reimbursement

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing has adopted the following emergency rule under the Medical Assistance Program as authorized by R.S. 46:153 and 36:254 and as directed by the 1999-2000 General Appropriation Act, which states: "The Secretary shall implement reductions in the Medicaid program as necessary to control expenditures to the level approved in this schedule. The Secretary is hereby directed to utilize various cost containment measures to accomplish these reductions, including but not limited to pre-certification, pre-admission screening, and utilization review, and other measures as allowed by federal law." This emergency rule is adopted in accordance with the Administrative Procedure Act, R.S. 49:950, et seq. and shall be in effect for the maximum period allowed under the Administrative Procedure Act or until adoption of the rule, whichever occurs first.

The Department of Health and Hospitals, Bureau of Health Services Financing provides reimbursement for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Rehabilitation services under the Medicaid Program. Reimbursement for these services is a flat fee established by the Bureau minus the amount which any third party coverage would pay. As a result of a budgetary shortfall, the Bureau has determined it is necessary to reduce the fees for EPSDT Rehabilitation services by 7 percent. This action is necessary in order to avoid a budget deficit in the medical assistance programs. This emergency rule is being adopted to continue the provisions of the February 1, 2000, rule.

Emergency Rule

Effective for dates of service June 1, 2000 and after, the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing reduces the reimbursement rates for the Early Periodic Screening Diagnosis and Treatment (EPSDT) Rehabilitation services by 7 percent.

Interested persons may submit written comments to the following address: Ben A. Bearden, Office of the Secretary, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is the person responsible for responding to inquiries regarding this emergency rule. A copy of this emergency rule is available at the parish Medicaid office for review by interested parties.

David W. Hood
Secretary

0006#045

DECLARATION OF EMERGENCY

**Department of Health and Hospitals
Office of the Secretary
Bureau of Health Services Financing**

Emergency Ambulance Transportation
Services Medicare Crossover

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing has adopted the following emergency rule under the Medical Assistance Program as authorized by R.S. 46:153 and 36:254 and pursuant to Title XIX of the Social Security Act and as directed by the 1999-2000 General Appropriation Act, which states: "The Secretary shall implement reductions in the Medicaid program as necessary to control expenditures to the level approved in this schedule. The Secretary is hereby directed to utilize various cost containment measures to accomplish these reductions, including but not limited to pre-certification, pre-admission screening and utilization review, and other measures as allowed by federal law." This emergency rule is adopted in accordance with the Administrative Procedure Act, R.S. 49:950, et seq. and shall be in effect for the maximum period allowed under the Administrative Procedure Act or until adoption of the rule, whichever occurs first.

The Department of Health and Hospitals, Bureau of Health Services Financing currently provides reimbursement for full co-insurance and deductibles for Medicare Part B claims for emergency ambulance services. Section 1902(a)(10) of the Social Security Act provides States flexibility in the payment of Medicare cost sharing for dually eligible Medicare/Medicaid recipients who are not Qualified Medicare Beneficiaries (QMBs). Section 4714 of the Balanced Budget Act of 1997 clarifies that States have flexibility in complying with the requirements to pay Medicare cost sharing for Qualified Medicare Beneficiaries and the protections against payment liability for QMBs. Section 4714 states that "a State is not required to provide any payment for any expenses incurred relating to payment for deductibles, coinsurance, or copayments for Medicare

cost-sharing to the extent that payment under Title XVIII for the service would exceed the payment amount that otherwise would be made under the State plan under this title for service if provided to an eligible recipient other than a Medicare beneficiary."

When a State's payment for Medicare cost sharing for an item or service rendered to a dually eligible Medicare/Medicaid recipient or a Qualified Medicare Beneficiary is reduced or eliminated to limit the amount under Title XVIII that the beneficiary may be billed or charged for the service, the amount of payment made under Title XVIII plus the amount of payment (if any) under the Medicaid State Plan shall be considered to be payment in full for the service. The beneficiary does not have any legal liability to make payment for the service.

As a result of a budgetary shortfall, the Bureau has determined it is necessary to compare the Medicare payment and the Medicaid rate on file for emergency ambulance services. If the Medicare payment exceeds the Medicaid rate, the claim will be adjudicated as a paid claim with a zero payment. If the Medicaid rate would exceed the Medicare payment, the claim will be reimbursed at the lesser of the co-insurance and deductible or up to the Medicaid maximum payment. This action is being taken in order to avoid a budget deficit in the medical assistance programs. This emergency rule is being adopted to continue the provisions of the March 1, 2000, rule.

Emergency Rule

Effective for dates of services on or after June 30, 2000, the Department of Health and Hospitals, Bureau of Health Services Financing shall compare the Medicare payment and the Medicaid rate on file for emergency ambulance services. If the Medicare payment exceeds the Medicaid rate, the claim will be adjudicated as a paid claim with a zero payment. If the Medicaid rate would exceed the Medicare payment, the claim will be reimbursed at the lesser of the co-insurance and deductible or up to the Medicaid maximum payment. If the Medicaid payment is reduced or eliminated as a result of applying the limit of the Medicaid maximum payment, the amount of the Medicare payment plus the amount of the Medicaid payment (if any) shall be considered to be payment in full for the service. The recipient does not have any legal liability to make payment for the service.

Interested persons may submit written comments to the following address: Ben A. Bearden, Office of the Secretary, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is the person responsible for responding to inquiries regarding this emergency rule. A copy of this emergency rule is available at parish Medicaid offices for review by interested parties.

David W. Hood
Secretary

0006#044

DECLARATION OF EMERGENCY

Department of Health and Hospitals Office of the Secretary Bureau of Health Services Financing

Emergency Medical Transportation Program Emergency Ambulance Transportation Services

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing has adopted the following emergency rule in the Medical Assistance Program as authorized by R.S. 46:153 and 36:254 and pursuant to Title XIX of the Social Security Act and as directed by the 1999-2000 General Appropriation Act, which states: "The Secretary shall implement reductions in the Medicaid program as necessary to control expenditures to the level approved in this schedule. The Secretary is hereby directed to utilize various cost containment measures to accomplish these reductions, including but not limited to pre-certification, pre-admission screening, and utilization review, and other measures as allowed by federal law." This emergency rule is adopted in accordance with the Administrative Procedure Act, R.S. 49:950, et seq. and shall be in effect for the maximum period allowed under the Administrative Procedure Act or until adoption of the rule whichever occurs first.

The Department of Health and Hospitals, Bureau of Health Services Financing provides reimbursement for emergency ambulance transportation services. Reimbursement for these services is the base rate established by the Bureau minus the amount which any third party coverage would pay. As a result of a budgetary shortfall, the Bureau has determined it is necessary to reduce the base rate for emergency ambulance transportation services by 7 percent. This action is necessary in order to avoid a budget deficit in the medical assistance programs. This emergency rule is being adopted to continue the provisions of the February 1, 2000, rule

Emergency Rule

Effective for dates of service June 1, 2000 and after, the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing reduces the base rate for emergency ambulance transportation services by 7 percent.

Interested persons may submit written comments to the following address: Ben A. Bearden, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is the person 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.

David W. Hood
Secretary

0006#043

DECLARATION OF EMERGENCY

**Department of Health and Hospitals
Office of the Secretary
Bureau of Health Services Financing**

Emergency Medical Transportation
Program
Nonemergency Ambulance
Transportation Services

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing has adopted the following emergency rule in the Medical Assistance Program as authorized by R.S. 46:153 and 36:254 and pursuant to Title XIX of the Social Security Act and as directed by the 1999-2000 General Appropriation Act, which states: "The Secretary shall implement reductions in the Medicaid program as necessary to control expenditures to the level approved in this schedule. The Secretary is hereby directed to utilize various cost containment measures to accomplish these reductions, including but not limited to pre-certification, pre-admission screening, and utilization review, and other measures as allowed by federal law." This emergency rule is adopted in accordance with the Administrative Procedure Act, R.S. 49:950, et seq. and shall be in effect for the maximum period allowed under the Administrative Procedure Act or until adoption of the rule whichever occurs first.

The Department of Health and Hospitals, Bureau of Health Services Financing provides reimbursement for nonemergency ambulance transportation services. Reimbursement for these services is the base rate established by the Bureau minus the amount which any third party coverage would pay. As a result of a budgetary shortfall the Bureau has determined it is necessary to reduce the base rate for nonemergency ambulance transportation services to the rate that was in effect prior to July 1, 1999. This action is necessary in order to avoid a budget deficit in the medical assistance programs. This emergency rule is being adopted to continue the provisions of the February 1, 2000, rule.

Emergency Rule

Effective for dates of service June 1, 2000 and after, the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing reduces the base rate for nonemergency ambulance transportation services to the rate that was in effect prior to July 1, 1999.

Interested persons may submit written comments to the following address: Ben A. Bearden, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is the person 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.

David W. Hood
Secretary

0006#042

DECLARATION OF EMERGENCY

**Department of Health and Hospitals
Office of the Secretary
Bureau of Health Services Financing**

Family Planning Clinics
Reimbursement Reduction

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing has adopted the following emergency rule under the Medical Assistance Program as authorized by R.S. 46:153 and 36:254 and pursuant to Title XIX of the Social Security Act and as directed by the 1999-2000 General Appropriation Act, which states: "The Secretary shall implement reductions in the Medicaid program as necessary to control expenditures to the level approved in this schedule. The Secretary is hereby directed to utilize various cost containment measures to accomplish these reductions, including but not limited to pre-certification, pre-admission screening, and utilization review, and other measures as allowed by federal law." This emergency rule is adopted in accordance with the Administrative Procedure Act, R.S. 49:950, et seq. and shall be in effect for the maximum period allowed under the Administrative Procedure Act or until adoption of the rule, whichever occurs first.

The Department of Health and Hospitals, Bureau of Health Services Financing provides coverage for family planning clinic services. Reimbursement for these services is a flat fee established by the Bureau minus the amount which any third party coverage would pay. As a result of a budgetary shortfall, the Bureau has determined it is necessary to reduce the reimbursement rate for family planning services by 7 percent. This action is necessary in order to avoid a budget deficit in the medical assistance programs. This emergency rule is being adopted to continue the provisions of the February 8, 2000, rule.

Emergency Rule

Effective for dates of service June 8, 2000 and after, the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing reduces the reimbursement to family planning clinics by 7 percent.

Interested persons may submit written comments to the following address: Ben A. Bearden, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is the person 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.

David W. Hood
Secretary

0006#041

DECLARATION OF EMERGENCY

Department of Health and Hospitals Office of the Secretary Bureau of Health Services Financing

Hemodialysis Centers Medicare Part B Claims

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing has adopted the following emergency rule under the Medical Assistance Program as authorized by R.S. 46:153 and 36:254 and pursuant to Title XIX of the Social Security Act and as directed by the 1999-2000 General Appropriation Act, which states: "The Secretary shall implement reductions in the Medicaid program as necessary to control expenditures to the level approved in this schedule. The Secretary is hereby directed to utilize various cost containment measures to accomplish these reductions, including but not limited to pre-certification, pre-admission screening and utilization review, and other measures as allowed by federal law." This emergency rule is adopted in accordance with the Administrative Procedure Act, R.S. 49:950, et seq. and shall be in effect for the maximum period allowed under the Administrative Procedure Act or until adoption of the rule, whichever occurs first.

The Department of Health and Hospitals, Bureau of Health Services Financing currently provides reimbursement for full co-insurance and deductibles for Medicare Part B claims for hemodialysis services. Section 1902(a)(10) of the Social Security Act provides states flexibility in the payment of Medicare cost sharing for dually eligible Medicare/Medicaid recipients who are not Qualified Medicare Beneficiaries (QMBs). Section 4714 of the Balanced Budget Act of 1997 clarifies that states have flexibility in complying with the requirements to pay Medicare cost-sharing for Qualified Medicare Beneficiaries and the protections against payment liability for QMBs. Section 4714 states that "a state is not required to provide any payment for any expenses incurred relating to payment for deductibles, co-insurance, or co-payments for Medicare cost sharing to the extent that payment under Title XVIII for the service would exceed the payment amount that otherwise would be made under the state plan under this title for service if provided to an eligible recipient other than a Medicare beneficiary."

When a state's payment for Medicare cost sharing for an item or service rendered to a dually eligible Medicare/Medicaid recipient or a Qualified Medicare Beneficiary is reduced or eliminated to limit the amount under Title XVIII that the beneficiary may be billed or charged for the service, the amount of payment made under Title XVIII plus the amount of payment (if any) under the Medicaid State Plan shall be considered to be payment in full for the service. The beneficiary does not have any legal liability to make payment for the service.

As a result of a budgetary shortfall, the Bureau has determined that it is necessary to do a comparison of the Medicare payment and the Medicaid rate on file for hemodialysis services. If the Medicare payment exceeds the Medicaid rate, the claim will be adjudicated as a paid claim

with a zero payment. If the Medicaid rate would exceed the Medicare payment, the claim will be reimbursed at the lesser of the co-insurance and deductible or up to the Medicaid maximum payment. This action is necessary in order to avoid a budget deficit in the medical assistance programs. This emergency rule is being adopted to continue the provisions of the February 8, 2000, rule.

Emergency Rule

Effective with date of service June 8, 2000, and thereafter, the Department of Health and Hospitals, Bureau of Health Services Financing shall compare the Medicare payment to the Medicaid rate on file for hemodialysis services. If the Medicare payment exceeds the Medicaid rate, the claim will be adjudicated as a paid claim with a zero payment. If the Medicaid rate would exceed the Medicare payment, the claim will be reimbursed at the lesser of the co-insurance and deductible or up to the Medicaid maximum payment. If the Medicaid payment is reduced or eliminated as a result of the Medicare/Medicaid payment comparison, the amount of the Medicare payment plus the amount of the Medicaid payment (if any) shall be considered to be payment in full for the service. The recipient does not have any legal liability to make payment for the service.

Interested persons may submit written comments to the following address: Ben A. Bearden, Office of the Secretary, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is the person responsible for responding to inquiries regarding this emergency rule. A copy of this emergency rule is available at parish Medicaid offices for review by interested parties.

David W. Hood
Secretary

0006#040

DECLARATION OF EMERGENCY

Department of Health and Hospitals Office of the Secretary Bureau of Health Services Financing

Home Health Extended Skilled Nursing Visits Reimbursement

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Service Financing has adopted the following emergency rule under the Medical Assistance Program as authorized by R.S. 46:153 and 36:254 and pursuant to Title XIX of the Social Security Act and as directed by the 1999-2000 General Appropriation Act, which states: "The Secretary shall implement reductions in the Medicaid program as necessary to control expenditures to the level approved in this schedule. The Secretary is hereby directed to utilize various cost containment measures to accomplish these reductions, including but not limited to pre-certification, pre-admission screening, and utilization review, and other measures as allowed by federal law." This emergency rule is adopted in accordance with the Administrative Procedure Act, R.S. 49:950, et seq. and shall be in effect of the maximum period allowed under the

Administrative Procedure Act or until adoption of the rule, whichever occurs first.

The Department of Health and Hospitals, Bureau of Health Services Financing provides reimbursement for Home Health extended skilled nursing visits provided to medically fragile Medicaid recipients under the age of 21. Reimbursement is made at a prospective rate established by the Bureau. As a result of a budgetary shortfall, the Bureau has determined it is necessary to reduce the reimbursement rate for the first hour of the Home Health extended skilled nursing visit to \$20. The first hour of care must be included in the prior authorization request for extended skilled nursing visits. This action is necessary in order to avoid a budget deficit in the medical assistance programs. This emergency rule is being adopted to continue the provisions of the February 1, 2000, rule.

Emergency Rule

Effective for dates of service June 1, 2000 and after, the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing reduces the reimbursement rate for the first hour of the Home Health extended skilled nursing visit to \$20. The first hour of care must be included in the prior authorization request for extended skilled nursing visits.

Interested persons may submit written comments to the following address: Ben A. Bearden, Office of the Secretary, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is the person responsible for responding to inquiries regarding this emergency rule. A copy of this emergency rule is available at the parish Medicaid office for review by interested parties.

David W. Hood
Secretary

0006#039

DECLARATION OF EMERGENCY

**Department of Health and Hospitals
Office of the Secretary
Bureau of Health Services Financing**

Home Health Services
Skilled Nursing
and Physical Therapy Reimbursement

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing has adopted the following emergency rule under the Medical Assistance Program as authorized by R.S. 46:153 and 36:254 and pursuant to Title XIX of the Social Security Act and as directed by the 1999-2000 General Appropriation Act, which states: "The Secretary shall implement reductions in the Medicaid program as necessary to control expenditures to the level approved in this schedule. The Secretary is hereby directed to utilize various cost containment measures to accomplish these reductions, including but not limited to pre-certification, pre-admission screening, and utilization review, and other measures as allowed by federal law." This emergency rule is adopted in accordance with the Administrative Procedure Act, R.S. 49:950, et seq. and shall be in effect of the maximum period allowed under the

Administrative Procedure Act or until adoption of the rule, whichever occurs first.

The Department of Health and Hospitals, Bureau of Health Services Financing provides reimbursement for skilled nursing and physical therapy services provided by home health agencies. Reimbursement is made at a prospective rate established by the Bureau. As a result of a budgetary shortfall, the Bureau has determined it is necessary to create a separate reimbursement rate of 80 percent of the current skilled nursing rate when services are performed by a licensed practical nurse (LPN). However, the current fee on file will continue to be paid when a registered nurse (RN) provides the skilled nursing service. In addition, it is necessary to establish a separate reimbursement rate of 80 percent of the current physical therapy rate when services are provided by a physical therapist assistant. However, the current fee on file will continue to be paid when a licensed physical therapist provides the physical therapy services. This action is necessary in order to avoid a budget deficit in the medical assistance programs. This emergency rule is being adopted to continue the provisions of the February 1, 2000, rule.

Emergency Rule

Effective for dates of service June 1, 2000 and after, the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing establishes a separate reimbursement rate of 80 percent of the current Home Health skilled nursing rate when the skilled nursing service is provided by a licensed practical nurse (LPN). However, the current fee on file will continue to be paid when a licensed registered nurse (RN) provides the skilled nursing service. In addition, a separate reimbursement rate of 80 percent of the current Home Health physical therapy rate is established when the physical therapy services are provided by a physical therapist assistant. However, the current fee on file will continue to be paid when a licensed physical therapist provides the physical therapy services.

Interested persons may submit written comments to the following address: Ben A. Bearden, Office of the Secretary, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is the person responsible for responding to inquiries regarding this emergency rule. A copy of this emergency rule is available at the parish Medicaid office for review by interested parties.

David W. Hood
Secretary

0006#038

DECLARATION OF EMERGENCY

**Department of Health and Hospitals
Office of the Secretary
Bureau of Health Services Financing**

Hospital Program
Outpatient Services Reimbursement

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing adopts the following emergency rule under the Medical Assistance Program as authorized by R.S. 46:153 and 36:254 and

pursuant to Title XIX of the Social Security Act and as directed by the 1999-2000 General Appropriation Act, which states: "The Secretary shall implement reductions in the Medicaid program as necessary to control expenditures to the level approved in this schedule. The Secretary is hereby directed to utilize various cost containment measures to accomplish these reductions, including but not limited to pre-certification, pre-admission screening, and utilization review, and other measures as allowed by federal law." This emergency rule is adopted in accordance with the Administrative Procedure Act, R.S. 49:950, et seq. and shall be in effect for the maximum period allowed under the Administrative Procedure Act or until adoption of the rule, whichever occurs first.

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing adopted a rule in January of 1996 which established the reimbursement methodology for outpatient hospital services at an interim rate of 60 percent of billed charges and cost settlement adjusted to 83 percent of allowable costs documented in the cost report, except for laboratory services subject to the Medicare Fee Schedule and outpatient surgeries (*Louisiana Register*, Volume 22, Number 1).

As a result of a budgetary shortfall, the Bureau has determined it is necessary to reduce the interim reimbursement rate for hospital outpatient services to a hospital specific cost to charge ratio calculation based on filed cost reports for the period ending in state fiscal year 1997. The final reimbursement for these services will continue to be cost settlement at 83 percent of allowable costs. This action is necessary in order to avoid a budget deficit in the medical assistance programs. This emergency rule is being adopted to continue the provisions of the March 8, 2000, rule.

Emergency Rule

Effective for dates of service on or after July 7, 2000, the Department of Health and Hospitals, Bureau of Health Services Financing amends the interim payment for outpatient hospital services not subject to a fee schedule in private hospitals to a hospital specific cost to charge ratio calculation based on filed cost reports for the period ending in state fiscal year 1997. The final reimbursement for these services will continue to be cost settlement at 83 percent of allowable costs.

Interested persons may submit written comments to the following address: Ben A. Bearden, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is the person 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.

David W. Hood
Secretary

0006#037

DECLARATION OF EMERGENCY

Department of Health and Hospitals Office of the Secretary Bureau of Health Services Financing

Inpatient Hospital Services Medicare Part A

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing has adopted the following emergency rule under the Medical Assistance Program as authorized by R.S. 46:153 and 36:254 and pursuant to Title XIX of the Social Security Act and as directed by the 1999-2000 General Appropriation Act, which states: "The Secretary shall implement reductions in the Medicaid program as necessary to control expenditures to the level approved in this schedule. The Secretary is hereby directed to utilize various cost containment measures to accomplish these reductions, including but not limited to pre-certification, pre-admission screening, and utilization review, and other measures as allowed by federal law." This emergency rule is adopted in accordance with the Administrative Procedure Act, R.S. 49:950, et seq. and shall be in effect for the maximum period allowed under the Administrative Procedure Act or until adoption of the rule, whichever occurs first.

Section 1902(a)(10) of the Social Security Act provides States flexibility in the payment of Medicare cost sharing for dually eligible Medicare/Medicaid recipients who are not Qualified Medicare Beneficiaries (QMBs). Section 4714 of the Balanced Budget Act of 1997 clarifies that states have flexibility in complying with the requirements to pay Medicare cost-sharing for Qualified Medicare Beneficiaries and the protections against payment liability for QMBs. Section 4714 states that a state is not required to provide any payment for any expenses incurred relating to payment for deductibles, co-insurance, or co-payments for Medicare cost sharing to the extent that payment under Title XVIII for the service would exceed the payment amount that otherwise would be made under the state plan under this title for service if provided to an eligible recipient other than a Medicare beneficiary.

When a state's payment for Medicare cost-sharing for an item or service rendered to a dually eligible Medicare/Medicaid recipient or a Qualified Medicare Beneficiary is reduced or eliminated to limit the amount under Title XVIII that the beneficiary may be billed or charged for the service, the amount of payment made under Title XVIII plus the amount of payment (if any) under the Medicaid State Plan shall be considered to be payment in full for the service. The recipient does not have any legal liability to make payment for the service.

Act 10 of the 1999 Regular Session of the Louisiana Legislature contained provisions limiting the payment of co-insurance and deductibles for inpatient hospital services rendered to dually eligible Medicare/Medicaid recipients to

the Medicaid maximum payment effective July 1, 1999. The provisions of Act 10 specifically excluded small rural hospitals from this limitation of payment to the Medicaid maximum. As a result of a budgetary shortfall, the Bureau has determined it is necessary to do comparison of the Medicare payment and the Medicaid rate on file for the revenue code(s) on Medicare Part A claims for services provided in small rural hospitals and hospital skilled nursing units. If the Medicare payment exceeds the Medicaid rate, the claim will be adjudicated as a paid claim with a zero payment. If the Medicaid rate would exceed the Medicare payment, the claim will be reimbursed at the lesser of the co-insurance and deductible or up to the Medicaid maximum payment. This action is being taken in order to avoid a budget deficit in the medical assistance programs. This emergency rule is being adopted to continue the provisions of the February 2000 Rule.

Emergency Rule

Effective for dates of service on or after June 1, 2000, the Department of Health and Hospitals, Bureau of Health Services Financing shall compare the Medicare payment to the Medicaid rate on file for the revenue code(s) on Medicare Part A claims for services provided in small rural hospitals and hospital skilled nursing units. If the Medicare payment exceeds the Medicaid rate, the claim will be adjudicated as a paid claim with a zero payment. If the Medicaid rate would exceed the Medicare payment, the claim will be reimbursed at the lesser of the co-insurance and deductible or up to the Medicaid maximum payment. If the Medicaid payment is reduced or eliminated as a result of the Medicare/Medicaid payment comparison, the amount of the Medicare payment plus the amount of the Medicaid payment (if any) shall be considered to be payment in full for the service. The recipient does not have any legal liability to make payment for the service.

Interested persons may submit written comments to the following address: Ben A Bearden, Office of the Secretary, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is the person responsible for responding to inquiries regarding this emergency rule. A copy of this emergency rule is available at parish Medicaid offices for review by interested parties.

David W. Hood
Secretary

0006#010

DECLARATION OF EMERGENCY

**Department of Health and Hospitals
Office of the Secretary
Bureau of Health Services Financing**

Inpatient Psychiatric Services Medicare Part A

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing has adopted the following emergency rule under the Medical Assistance Program as authorized by R.S. 46:153 and 36:254 and pursuant to Title XIX of the Social Security Act and as directed by the 1999-2000 General Appropriation Act,

which states: "The Secretary shall implement reductions in the Medicaid program as necessary to control expenditures to the level approved in this schedule. The Secretary is hereby directed to utilize various cost containment measures to accomplish these reductions, including but not limited to pre-certification, pre-admission screening and utilization review, and other measures as allowed by federal law." This emergency rule is adopted in accordance with the Administrative Procedure Act, R.S. 49:950, et seq. and shall be in effect for the maximum period allowed under the Administrative Procedure Act or until adoption of the rule, whichever occurs first.

The Department of Health and Hospitals, Bureau of Health Services Financing currently provides reimbursement for full co-insurance and deductibles for inpatient services provided in a free-standing psychiatric hospital or a distinct-part psychiatric unit of an acute care hospital. Section 1902(a)(10) of the Social Security Act provides states flexibility in the payment of Medicare cost sharing for dually eligible Medicare/Medicaid recipients who are not Qualified Medicare Beneficiaries (QMBs). Section 4714 of the Balanced Budget Act of 1997 clarifies that states have flexibility in complying with the requirements to pay Medicare cost-sharing for Qualified Medicare Beneficiaries and the protections against payment liability for QMBs. Section 4714 states that "a state is not required to provide any payment for any expenses incurred relating to payment for deductibles, co-insurance, or co-payments for Medicare cost sharing to the extent that payment under Title XVIII for the service would exceed the payment amount that otherwise would be made under the state plan under this title for service if provided to an eligible recipient other than a Medicare beneficiary."

When a state's payment for Medicare cost-sharing for an item or service rendered to a dually eligible Medicare/Medicaid recipient or a Qualified Medicare Beneficiary (QMB) is reduced or eliminated to limit the amount under Title XVIII that the beneficiary may be billed or charged for the service, the amount of payment made under Title XVIII plus the amount of payment (if any) under the Medicaid State Plan shall be considered to be payment in full for the service. The beneficiary does not have any legal liability to make payment for the service.

As a result of a budgetary shortfall, the Bureau has determined it is necessary to compare the Medicare payment and the Medicaid rate on file for the revenue code(s) on the Medicare Part A claim for inpatient psychiatric services. If the Medicare payment exceeds the Medicaid rate, the claim will be adjudicated as a paid claim with a zero payment. If the Medicaid rate would exceed the Medicare payment, the claim will be reimbursed at the lesser of the co-insurance and deductible or up to the Medicaid maximum payment. This action is being taken in order to avoid a budget deficit in the medical assistance programs. This emergency rule is being adopted to continue the provisions of the February 8, 2000, rule.

Emergency Rule

Effective for dates of service on or after June 8, 2000, the Department of Health and Hospitals, Bureau of Health Services Financing shall compare the Medicare payment and

the Medicaid rate on file for the revenue code(s) on the Medicare Part A claim for inpatient psychiatric services. If the Medicare payment exceeds the Medicaid rate, the claim will be adjudicated as a paid claim with a zero payment. If the Medicaid rate would exceed the Medicare payment, the claim will be reimbursed at the lesser of the co-insurance and deductible or up to the Medicaid maximum payment. If the Medicaid payment is reduced or eliminated as a result of applying the limit of the Medicaid maximum payment, the amount of the Medicare payment plus the amount of the Medicaid payment (if any) shall be considered to be payment in full for the service. The recipient does not have any legal liability to make payment for the service.

Interested persons may submit written comments to the following address: Ben A. Bearden, Office of the Secretary, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is the person responsible for responding to inquiries regarding this emergency rule. A copy of this emergency rule is available at parish Medicaid offices for review by interested parties.

David W. Hood
Secretary

0006#036

DECLARATION OF EMERGENCY

**Department of Health and Hospitals
Office of the Secretary
Bureau of Health Services Financing**

Inpatient Psychiatric Services Reimbursement

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing adopts the following emergency rule under the Medical Assistance Program as authorized by R.S. 46:153 and 36:254 and pursuant to Title XIX of the Social Security Act and as directed by the 1999-2000 General Appropriation Act, which states: "The Secretary shall implement reductions in the Medicaid program as necessary to control expenditures to the level approved in this schedule. The Secretary is hereby directed to utilize various cost containment measures to accomplish these reductions, including but not limited to pre-certification, pre-admission screening, and utilization review, and other measures as allowed by federal law." This emergency rule is adopted in accordance with the Administrative Procedure Act, R.S. 49:950, et seq. and shall be in effect for the maximum period allowed under the Administrative Procedure Act or until adoption of the rule, whichever occurs first.

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing adopted a rule which established the prospective reimbursement methodology for inpatient psychiatric hospital services provided in either a free-standing psychiatric hospital or distinct part psychiatric unit of an acute care general hospital (*Louisiana Register*, Volume 19, Number 6). This rule was subsequently amended by a rule adopted to discontinue the practice of automatically applying an inflation adjustment to the reimbursement rates for inpatient psychiatric services in

those years when the rates are not rebased (*Louisiana Register*, Volume 25, Number 5).

As a result of a budgetary shortfall, the Bureau has determined it is necessary to reduce the Medicaid prospective per diem rates for inpatient psychiatric services by 7 percent. This action is being taken in order to avoid a budget deficit in the medical assistance program. Taking into consideration the 7 percent reduction in per diem rates in state fiscal year 2000, the Department has carefully reviewed the proposed rates and is satisfied that they are consistent with efficiency, economy and quality of care and are sufficient to enlist enough providers so that inpatient psychiatric services under the state plan are available at least to the extent that they are available to the general population in the state. This emergency rule is being adopted to continue the provisions of the March 1, 2000, rule.

Emergency Rule

Effective for dates of service on or after June 30, 2000 the Department of Health and Hospitals, Bureau of Health Services Financing reduces the reimbursement for inpatient psychiatric services by 7 percent.

Interested persons may submit written comments to the following address: Ben A. Bearden, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is the person 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.

David W. Hood
Secretary

0006#011

DECLARATION OF EMERGENCY

**Department of Health and Hospitals
Office of the Secretary
Bureau of Health Services Financing**

Laboratory and Portable X-Ray Services Medicare Part B

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing has adopted the following emergency rule under the Medical Assistance Program as authorized by R.S. 46:153 and 36:254 and pursuant to Title XIX of the Social Security Act and as directed by the 1999-2000 General Appropriation Act, which states: "The Secretary shall implement reductions in the Medicaid program as necessary to control expenditures to the level approved in this schedule. The Secretary is hereby directed to utilize various cost containment measures to accomplish these reductions, including but not limited to pre-certification, pre-admission screening, and utilization review, and other measures as allowed by federal law." This emergency rule is adopted in accordance with the Administrative Procedure Act, R.S. 49:950, et seq. and shall be in effect for the maximum period allowed under the Administrative Procedure Act or until adoption of the rule, whichever occurs first.

The Department of Health and Hospitals, Bureau of Health Services Financing provides reimbursement for full co-insurance and deductibles for Medicare Part B claims for laboratory and portable x-ray services. Section 1902(a)(10) of the Social Security Act provides states flexibility in the payment of Medicare cost sharing for dually eligible Medicare/Medicaid recipients who are not Qualified Medicare Beneficiaries (QMBs). Section 4714 of the Balanced Budget Act of 1997 clarifies that states have flexibility in complying with the requirements to pay Medicare cost-sharing for Qualified Medicare Beneficiaries and the protections against payment liability for QMBs. Section 4714 states that a state is not required to provide any payment for any expenses incurred relating to payment for deductibles, co-insurance, or copayments for Medicare cost-sharing to the extent that payment under Title XVIII for the service would exceed the payment amount that otherwise would be made under the state plan under this title for service if provided to an eligible recipient other than a Medicare beneficiary.

When a state's payment for Medicare cost-sharing for an item or service rendered to a dually eligible Medicare/Medicaid recipient or a Qualified Medicare Beneficiary is reduced or eliminated to limit the amount under Title XVIII that the beneficiary may be billed or charged for the service, the amount of payment made under Title XVIII plus the amount of payment (if any) under the Medicaid State Plan shall be considered to be payment in full for the service. The beneficiary does not have any legal liability to make payment for the service.

As a result of a budgetary shortfall, the Bureau has determined it is necessary to do comparison of the Medicare payment and the Medicaid rate on file for the procedure code on Medicare Part B claims for laboratory and portable x-ray services. If the Medicare payment exceeds the Medicaid rate, the claim will be adjudicated as a paid claim with a zero payment. If the Medicaid rate would exceed the Medicare payment, the claim will be reimbursed at the lesser of the co-insurance and deductible or up to the Medicaid maximum payment. This action is being taken in order to avoid a budget deficit in the medical assistance programs. This emergency rule is being adopted to continue the provisions of the February 1, 2000, rule.

Emergency Rule

Effective for dates of services on or after June 1, 2000, the Department of Health and Hospitals, Bureau of Health Services Financing shall compare the Medicare payment to the Medicaid rate on file for the procedure code on Medicare Part B claims for laboratory and portable x-ray services. If the Medicare payment exceeds the Medicaid rate, the claim will be adjudicated as a paid claim with a zero payment. If the Medicaid rate would exceed the Medicare payment, the claim will be reimbursed at the lesser of the co-insurance and deductible or up to the Medicaid maximum payment. If the Medicaid payment is reduced or eliminated as a result of applying the limit of the Medicaid maximum payment, the amount of the Medicare payment plus the amount of the Medicaid payment (if any) shall be considered to be payment in full for the service. The recipient does not have any legal liability to make payment for the service.

Interested persons may submit written comments to the following address: Ben A. Bearden, Office of the Secretary, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is the person responsible for responding to inquiries regarding this emergency rule. A copy of this emergency rule is available at parish Medicaid offices for review by interested parties.

David W. Hood
Secretary

0006#009

DECLARATION OF EMERGENCY

**Department of Health and Hospitals
Office of the Secretary
Bureau of Health Services Financing**

Laboratory and Portable X-Ray Services Reimbursement

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Service Financing has adopted the following emergency rule under the Medical Assistance Program as authorized by R.S. 46:153 and 36:254 and as directed by the 1999-2000 General Appropriation Act, which states: "The Secretary shall implement reductions in the Medicaid program as necessary to control expenditures to the level approved in this schedule. The Secretary is hereby directed to utilize various cost containment measures to accomplish these reductions, including but not limited to pre-certification, pre-admission screening, and utilization review, and other measures as allowed by federal law." This emergency rule is adopted in accordance with the Administrative Procedure Act, R.S. 49:950, et seq. and shall be in effect of the maximum period allowed under the Administrative Procedure Act or until adoption of the rule, whichever occurs first.

The Department of Health and Hospitals, Bureau of Health Services Financing provides coverage for laboratory and portable x-ray services under the Medicaid Program. Reimbursement for laboratory services is made on the basis of either the lower of billed charges, the state maximum amount, or the Medicare fee schedule amount. Reimbursement for portable x-ray services is on a flat fee basis. As a result of a budgetary shortfall, the Bureau has determined it is necessary to reduce the reimbursement rates for laboratory and portable x-ray services by 7 percent. This action is necessary in order to avoid a budget deficit in the medical assistance programs. This emergency rule is being adopted to continue the provisions of the February 1, 2000, rule.

Emergency Rule

Effective for dates of service June 1, 2000 and after, the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing reduces the reimbursement for laboratory and portable x-ray services by 7 percent.

Interested persons may submit written comments to the following address: Ben A. Bearden, Office of the Secretary, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is the person responsible

for responding to inquiries regarding this emergency rule. A copy of this emergency rule is available at the parish Medicaid office for review by interested parties.

David W. Hood
Secretary

0006#012

DECLARATION OF EMERGENCY

**Department of Health and Hospitals
Office of the Secretary
Bureau of Health Services Financing**

Long Term Hospital Reimbursement Methodology

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing adopts the following emergency rule under the Medical Assistance Program as authorized by R.S. 46:153 and 36:254 and pursuant to Title XIX of the Social Security Act and as directed by the 1999-2000 General Appropriation Act, which states: "The Secretary shall implement reductions in the Medicaid program as necessary to control expenditures to the level approved in this schedule. The Secretary is hereby directed to utilize various cost containment measures to accomplish these reductions, including but not limited to pre-certification, pre-admission screening, and utilization review, and other measures as allowed by federal law." This emergency rule is adopted in accordance with the Administrative Procedure Act, R.S. 49:950, et seq. and shall be in effect for the maximum period allowed under the Administrative Procedure Act or until adoption of the rule, whichever occurs first.

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing adopted a rule in June 20, 1994 which established the reimbursement methodology for inpatient hospital services, including long-term acute hospitals under the specialty hospital peer groups (*Louisiana Register*, Volume 20, Number 6) and subsequently adopted a rule which amended the peer group rate payment to the lowest blended per diem rate for each specialty hospital category without otherwise changing the methodology (*Louisiana Register*, Volume 22, Number 1). The reimbursement methodology for psychiatric treatment was later disjoined from the methodology for other types of services in a long-term acute hospitals in order to reimburse these services at the same prospective per diem rate established for psychiatric treatment facilities (*Louisiana Register*, Volume 23, Number 2). The June 20, 1994 rule was subsequently amended to restructure the prospective reimbursement methodology for inpatient services provided in long-term acute hospitals (*Louisiana Register*, Volume 23, Number 12).

As a result of a budgetary shortfall, the Bureau has determined it is necessary to reduce Medicaid prospective per diem rates for inpatient long term hospital services by 7 percent. This action is being taken in order to avoid a budget deficit in the medical assistance program. Taking into consideration the 7 percent reduction in per diem rates in state fiscal year 2000, the Department has carefully reviewed

the proposed rates and is satisfied that they are consistent with efficiency, economy and quality of care and are sufficient to enlist enough providers so that long term hospital services under the state plan are available at least to the extent that they are available to the general population in the state. This emergency rule is being adopted to continue the provisions of the March 1, 2000, rule.

Emergency Rule

Effective for dates of service on or after June 30, 2000, the Department of Health and Hospitals, Bureau of Health Services Financing reduces the reimbursement to long term hospitals by 7 percent.

Interested persons may submit written comments to the following address: Ben A. Bearden, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is the person 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.

David W. Hood
Secretary

0006#034

DECLARATION OF EMERGENCY

**Department of Health and Hospitals
Office of the Secretary
Bureau of Health Services Financing**

Mental Health Rehabilitation Services Reimbursement

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Service Financing has adopted the following emergency rule under the Medical Assistance Program as authorized by R.S. 46:153 and 36:254 and pursuant to Title XIX of the Social Security Act and as directed by the 1999-2000 General Appropriation Act, which states: "The Secretary shall implement reductions in the Medicaid program as necessary to control expenditures to the level approved in this schedule. The Secretary is hereby directed to utilize various cost containment measures to accomplish these reductions, including but not limited to pre-certification, pre-admission screening, and utilization review, and other measures as allowed by federal law." This emergency rule is adopted in accordance with the Administrative Procedure Act, R.S. 49:950, et seq. and shall be in effect of the maximum period allowed under the Administrative Procedure Act or until adoption of the rule, whichever occurs first.

The Department of Health and Hospitals, Bureau of Health Services Financing provides reimbursement for mental health rehabilitation services under the Medicaid Program. Reimbursement for these services is a prospective, negotiated and noncapitated rate based on the delivery of services as specified in the service agreement and the service package required for the adult and child/youth populations. As a result of a budgetary shortfall, the Bureau has determined it is necessary to reduce the established reimbursement rates for high need services for adults and children as well as moderate need services for children by 7

percent. This action is necessary in order to avoid a budget deficit in the medical assistance programs. This emergency rule is being adopted to continue the provisions of the February 1, 2000, rule.

Emergency Rule

Effective for dates of service June 1, 2000 and after, the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing reduces the reimbursement rates in the Mental Health Rehabilitation Program for high need services for adults and children as well as moderate need services for children by 7 percent.

Interested persons may submit written comments to the following address: Ben A. Bearden, Office of the Secretary, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is the person responsible for responding to inquiries regarding this emergency rule. A copy of this emergency rule is available at the parish Medicaid office for review by interested parties.

David W. Hood
Secretary

0006#033

DECLARATION OF EMERGENCY

**Department of Health and Hospitals
Office of the Secretary
Bureau of Health Services Financing**

Out-of-State Hospitals CInpatient Reimbursement

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing adopts the following emergency rule under the Medical Assistance Program as authorized by R.S. 46:153 and 36:254 and pursuant to Title XIX of the Social Security Act and as directed by the 1999-2000 General Appropriation Act, which states: "The Secretary shall implement reductions in the Medicaid program as necessary to control expenditures to the level approved in this schedule. The Secretary is hereby directed to utilize various cost containment measures to accomplish these reductions, including but not limited to pre-certification, pre-admission screening, and utilization review, and other measures as allowed by federal law." This emergency rule is adopted in accordance with the Administrative Procedure Act, R.S. 49:950, et seq. and shall be in effect for the maximum period allowed under the Administrative Procedure Act or until adoption of the rule, whichever occurs first.

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing adopted a rule in January of 1996 which established the reimbursement methodology for inpatient hospital services provided in out-of-state hospitals at the lower of 50 percent of billed charges or the Medicaid per diem rate of the state wherein the services are provided (*Louisiana Register*, Volume 22, Number 1). This rule was subsequently amended in September of 1997 to increase the reimbursement to 72 percent of billed charges for inpatient services provided in out-of-state hospitals to recipients up to age 21 (*Louisiana Register*, Volume 23, Number 9)

As a result of a budgetary shortfall, the Bureau has determined it is necessary to amend the reimbursement methodology for out-of-state hospitals that have provided at least 500 inpatient hospital days in State Fiscal Year 1999 to Louisiana Medicaid recipients and are located in border cities. Border cities are defined as cities that are located within a 50 mile trade area of the Louisiana state border. The following two cities meet the criteria for number of inpatient hospital days provided to Louisiana Medicaid recipients and the definition of border cities: Natchez, Mississippi and Vicksburg, Mississippi. Louisiana Medicaid reimbursement for inpatient services provided in all hospitals located in these two border cities will be at the lesser of each hospital's actual cost per day as calculated from the 1998 filed Medicaid cost report or the Mississippi Medicaid per diem rate. The actual cost per day is calculated by dividing total Medicaid inpatient cost by total Medicaid inpatient days, including nursery days. This reimbursement methodology is applicable for all Louisiana Medicaid recipients who receive inpatient services in an out-of-state hospital located in a border city, including those recipients up to the age of 21. This action is necessary in order to avoid a budget deficit in the medical assistance programs. This emergency rule is being adopted to continue the provisions of the March 8, 2000, rule.

Emergency Rule

Effective for dates of service on or after July 7, 2000, the Department of Health and Hospitals, Bureau of Health Services Financing amends the reimbursement methodology for out-of-state hospitals that provided at least 500 inpatient hospital days in State Fiscal Year 1999 to Louisiana Medicaid recipients and are located in border cities. Border cities are defined as cities that are located within a 50 mile trade area of the Louisiana state border. The following two cities meet the criteria for number of inpatient hospital days provided to Louisiana Medicaid recipients and the definition of border cities: Natchez, Mississippi and Vicksburg, Mississippi. Louisiana Medicaid reimbursement for inpatient services provided in all hospitals located in these two border cities will be at the lesser of each hospital's actual cost per day as calculated from the 1998 filed Medicaid cost report or the Mississippi Medicaid per diem rate. The actual cost per day is calculated by dividing total Medicaid inpatient cost by total Medicaid inpatient days, including nursery days. This reimbursement methodology is applicable for all Louisiana Medicaid recipients who receive inpatient services in an out-of-state hospital located in a border city, including those recipients up to the age of 21.

Interested persons may submit written comments to the following address: Ben A. Bearden, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is the person 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.

David W. Hood
Secretary

0006#032

DECLARATION OF EMERGENCY

Department of Health and Hospitals
Office of the Secretary
Bureau of Health Services Financing

Outpatient Hospital Laboratory Reimbursement

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing adopts the following emergency rule under the Medical Assistance Program as authorized by R.S. 46:153 and 36:254 and pursuant to Title XIX of the Social Security Act and as directed by the 1999-2000 General Appropriation Act, which states: "The Secretary shall implement reductions in the Medicaid program as necessary to control expenditures to the level approved in this schedule. The Secretary is hereby directed to utilize various cost containment measures to accomplish these reductions, including but not limited to pre-certification, pre-admission screening, and utilization review, and other measures as allowed by federal law." This emergency rule is adopted in accordance with the Administrative Procedure Act, R.S. 49:950, et seq. and shall be in effect for the maximum period allowed under the Administrative Procedure Act or until adoption of the rule, whichever occurs first.

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing adopted a rule in April of 1997 that established a uniform reimbursement methodology for all laboratory services subject to the Medicare Fee Schedule regardless of the setting in which the services are performed, outpatient hospital or a non-hospital setting. Outpatient hospital laboratory services are reimbursed at the same reimbursement rate as laboratory services performed in non-hospital setting (*Louisiana Register*, Volume 23, Number 4).

As a result of a budgetary shortfall, the Bureau has determined it is necessary to reduce the reimbursement rates for outpatient hospital laboratory services by 7 percent. This action is necessary in order to avoid a budget deficit in the medical assistance programs. Taking into consideration the 7 percent reduction in reimbursement rates in state fiscal year 2000, the Department has carefully reviewed the proposed rates and is satisfied that they are consistent with efficiency, economy and quality of care and are sufficient to enlist enough providers so that outpatient hospital laboratory services under the state plan are available at least to the extent that they are available to the general population in the state. This emergency rule is being adopted to continue the provisions of the March 8, 2000, rule.

Emergency Rule

Effective for dates of service on or after July 7, 2000 the Department of Health and Hospitals, Bureau of Health Services Financing reduces the reimbursement for outpatient hospital laboratory services by 7 percent.

Interested persons may submit written comments to the following address: Ben A. Bearden, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA

70821-9030. He is the person responsible for responding to all inquiries regarding this emergency rule. A copy of this emergency rule notice is available for review by interested parties at parish Medicaid offices.

David W. Hood
Secretary

0006#030

DECLARATION OF EMERGENCY

Department of Health and Hospitals
Office of the Secretary
Bureau of Health Services Financing

Outpatient Hospital Rehabilitation Reimbursement

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing adopts the following emergency rule under the Medical Assistance Program as authorized by R.S. 46:153 and 36:254 and pursuant to Title XIX of the Social Security Act and as directed by the 1999-2000 General Appropriation Act, which states: "The Secretary shall implement reductions in the Medicaid program as necessary to control expenditures to the level approved in this schedule. The Secretary is hereby directed to utilize various cost containment measures to accomplish these reductions, including but not limited to pre-certification, pre-admission screening, and utilization review, and other measures as allowed by federal law." This emergency rule is adopted in accordance with the Administrative Procedure Act, R.S. 49:950, et seq. and shall be in effect for the maximum period allowed under the Administrative Procedure Act or until adoption of the rule, whichever occurs first.

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing adopted a rule in June of 1997 which established a uniform reimbursement methodology for all rehabilitation services regardless of the setting in which the services are performed, outpatient hospital or a free-standing rehabilitation center (*Louisiana Register*, Volume 23, Number 6). Rehabilitation services include physical, occupational, speech, hearing, and language therapies.

As a result of a budgetary shortfall, the Bureau has determined it is necessary to reduce the reimbursement rates for outpatient hospital rehabilitation services by 7 percent. This action is necessary in order to avoid a budget deficit in the medical assistance programs. Taking into consideration the 7 percent reduction in reimbursement rates in state fiscal year 2000, the Department has carefully reviewed the proposed rates and is satisfied that they are consistent with efficiency, economy and quality of care and are sufficient to enlist enough providers so that outpatient hospital rehabilitation services under the state plan are available at least to the extent that they are available to the general population in the state. This emergency rule is being adopted to continue the provisions of the March 8, 2000, rule.

Emergency Rule

Effective for dates of service on or after July 7, 2000 the Department of Health and Hospitals, Bureau of Health Services Financing reduces the reimbursement for outpatient hospital rehabilitation services by 7 percent. Outpatient hospital rehabilitation services include physical, occupational, speech, hearing, and language therapies.

Interested persons may submit written comments to the following address: Ben A. Bearden, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is the person 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.

David W. Hood
Secretary

0006#029

DECLARATION OF EMERGENCY

**Department of Health and Hospitals
Office of the Secretary
Bureau of Health Services Financing**

Outpatient Hospital Services Medicare Part B

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing has adopted the following emergency rule under the Medical Assistance Program as authorized by R.S. 46:153 and 36:254 and pursuant to Title XIX of the Social Security Act and as directed by the 1999-2000 General Appropriation Act, which states: "The Secretary shall implement reductions in the Medicaid program as necessary to control expenditures to the level approved in this schedule. The Secretary is hereby directed to utilize various cost containment measures to accomplish these reductions, including but not limited to pre-certification, pre-admission screening and utilization review, and other measures as allowed by federal law." This emergency rule is adopted in accordance with the Administrative Procedure Act, R.S. 49:950(B)(1) et seq. and shall be in effect for the maximum period allowed under the Administrative Procedure Act or until adoption of the rule, whichever occurs first.

The Department of Health and Hospitals, Bureau of Health Services Financing currently provides reimbursement for full co-insurance and deductibles for Medicare Part B claims for outpatient hospital services. Section 1902(a)(10) of the Social Security Act provide states flexibility in the payment of Medicare cost sharing for dually eligible Medicare/Medicaid recipients who are not Qualified Medicare Beneficiaries (QMBs). Section 4714 of the Balanced Budget Act of 1997 clarifies that states have flexibility in complying with the requirements to pay Medicare cost sharing for Qualified Medicare Beneficiaries and the protections against payment liability for QMBs. Section 4714 states that "a state is not required to provide

any payment for any expenses incurred relating to payment for deductibles, co-insurance, or copayments for Medicare cost-sharing to the extent that payment under Title XVIII for the service would exceed the payment amount that otherwise would be made under the state plan under this title for service if provided to an eligible recipient other than a Medicare beneficiary."

When a state's payment for Medicare cost-sharing for an item or service rendered to a dually eligible Medicare/Medicaid recipient or a Qualified Medicare Beneficiary is reduced or eliminated to limit the amount under Title XVIII that the beneficiary may be billed or charged for the service, the amount of payment made under Title XVIII plus the amount of payment (if any) under the Medicaid State Plan shall be considered to be payment in full for the service. The beneficiary does not have any legal liability to make payment for the service.

As a result of a budgetary shortfall, the Bureau has determined it is necessary to do comparison of the Medicare payment and the Medicaid rate on file for the applicable revenue code. If the Medicare payment exceeds the Medicaid rate, the claim will be adjudicated as a paid claim with a zero payment. If the Medicaid rate would exceed the Medicare payment, the claim will be reimbursed at the lesser of the co-insurance and deductible or up to the Medicaid maximum payment. This action is necessary in order to avoid a budget deficit in the medical assistance programs. This emergency rule is being adopted to continue the provisions of the February 8, 2000, rule.

Emergency Rule

Effective for dates of admission on or after June 8, 2000, the Department of Health and Hospitals, Bureau of Health Services Financing shall compare the Medicare payment to the Medicaid rate on file for the applicable revenue code. If the Medicare payment exceeds the Medicaid rate, the claim will be adjudicated as a paid claim with a zero payment. If the Medicaid rate would exceed the Medicare payment, the claim will be reimbursed at the lesser of the co-insurance and deductible or up to the Medicaid maximum payment. If the Medicaid payment is reduced or eliminated as a result of the Medicare/Medicaid payment comparison, the amount of the Medicare payment plus the amount of the Medicaid payment (if any) shall be considered to be payment in full for the service. The recipient does not have any legal liability to make payment for the service.

Interested persons may submit written comments to the following address: Ben A. Bearden, Office of the Secretary, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is the person responsible for responding to inquiries regarding this emergency rule. A copy of this emergency rule is available at parish Medicaid offices for review by interested parties.

David W. Hood
Secretary

0006#028

DECLARATION OF EMERGENCY

Department of Health and Hospitals Office of the Secretary Bureau of Health Services Financing

Outpatient Surgery Services Reimbursement

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing adopts the following emergency rule under the Medical Assistance Program as authorized by R.S. 46:153 and 36:254 and pursuant to Title XIX of the Social Security Act and as directed by the 1999-2000 General Appropriation Act, which states: "The Secretary shall implement reductions in the Medicaid program as necessary to control expenditures to the level approved in this schedule. The Secretary is hereby directed to utilize various cost containment measures to accomplish these reductions, including but not limited to pre-certification, pre-admission screening, and utilization review, and other measures as allowed by federal law." This emergency rule is adopted in accordance with the Administrative Procedure Act, R.S. 49:950, et seq. and shall be in effect for the maximum period allowed under the Administrative Procedure Act or until adoption of the rule, whichever occurs first.

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing adopted a rule in December of 1985 that established the criteria and reimbursement for certain surgical procedures when performed in an outpatient setting. Reimbursement for these surgical procedures was set at a flat fee per service if the procedure code is included in one of the four Medicaid established payment groups. Reimbursement for those surgical procedures not included in the Medicaid outpatient surgery list was not changed from the established methodology (*Louisiana Register*, Volume 11, Number 12). A rule was subsequently adopted in January of 1996 which established the reimbursement methodology for outpatient hospital services at an interim rate of 60 percent of billed charges, except for those outpatient surgeries subject to the Medicaid outpatient surgery list (*Louisiana Register*, Volume 22, Number 1).

As a result of a budgetary shortfall, the Bureau has determined it is necessary to assign the highest flat fee in the four Medicaid established payment groups for outpatient surgery to those surgical procedures that are not included in the Medicaid outpatient surgery list. This action is necessary in order to avoid a budget deficit in the medical assistance programs. This emergency rule is being adopted to continue the provisions of the March 8, 2000, rule.

Emergency Rule

Effective for dates of service on or after July 7, 2000, the Department of Health and Hospitals, Bureau of Health Services Financing amends the reimbursement methodology for those surgical procedures that are not included in the Medicaid outpatient surgery list to the highest flat fee in the four Medicaid established payment groups for outpatient surgery.

Interested persons may submit written comments to the following address: Ben A. Bearden, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is the person 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.

David W. Hood
Secretary

0006#027

DECLARATION OF EMERGENCY

Department of Health and Hospitals Office of the Secretary Bureau of Health Services Financing

Pharmacy Program Average Wholesale Price

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing has adopted the following emergency rule under the Medical Assistance Program as authorized by R.S. 46:153 and 36:254 and pursuant to Title XIX of the Social Security Act and as directed by the 1999-2000 General Appropriation Act, which states: "The Secretary shall implement reductions in the Medicaid program as necessary to control expenditures to the level approved in this schedule. The Secretary is hereby directed to utilize various cost containment measures to accomplish these reductions, including but not limited to pre-certification, pre-admission screening, and utilization review, and other measures as allowed by federal law." This emergency rule is adopted in accordance with the Administrative Procedure Act, R.S. 49:950, et seq. and shall be in effect for the maximum period allowed under the Administrative Procedure Act or until adoption of the rule, whichever occurs first.

Act 10 of the 1999 Regular Session of the Louisiana Legislature contained provisions that amended the reimbursement methodology for prescription drugs under the Medicaid Program. The provisions of Act 10 limited the payments for prescription drugs by amending the Estimated Acquisition Cost formula from Average Wholesale Price (AWP) minus 10.5 percent for single source drugs (brand name), multiple source drugs which do not have a state Maximum Allowable Cost (MAC) or Federal Upper Limit and those prescriptions subject to MAC overrides based on the physician's certification that a brand name product is medically necessary to AWP minus 10.5 percent for independent pharmacies and 13.5 percent for chain pharmacies. Chain pharmacies were defined as five or more Medicaid enrolled pharmacies under common ownership. All other Medicaid enrolled pharmacies were defined as independent pharmacies.

As a result of a budgetary shortfall, the Bureau has determined it is necessary to amend the current reimbursement methodology for prescription drugs by changing the Estimated Acquisition Cost formula from AWP

minus 10.5 percent to AWP minus 15 percent for independent pharmacies and from AWP minus 13.5 percent to AWP minus 16.5 percent for chain pharmacies for single source drugs (brand name), multiple source drugs which do not have a state Maximum Allowable Cost (MAC) or Federal Upper Limit and those prescriptions subject to MAC overrides based on the physician's certification that a brand name product is medically necessary.

The Bureau has also determined that chain pharmacies shall be defined as more than 15 Medicaid enrolled pharmacies under common ownership. All other Medicaid enrolled pharmacies are defined as independent pharmacies. This action is necessary in order to avoid a budget deficit in the Medical Assistance Program. This emergency rule is being adopted to continue the provisions of the February 1, 2000, rule.

Emergency Rule

Effective for dates of services on or after June 1, 2000, the Department of Health and Hospitals, Bureau of Health Services Financing limits payments for prescription drugs to the lower of:

1) Average Wholesale Price (AWP) minus 15 percent for independent pharmacies (all other Medicaid enrolled pharmacies) and 16.5 percent for chain pharmacies (more than 15 Medicaid enrolled pharmacies under common ownership);

2) Louisiana's Maximum Allowable Cost limitation plus the Maximum Allowable Overhead Cost;

3) Federal Upper Limits plus the Maximum Allowable Overhead Cost; or

4) provider's usual and customary charges to the general public. General public is defined as all other non-Medicaid prescriptions including third-party insurance, pharmacy benefit management plans and cash.

Interested persons may submit written comments to the following address: Ben A. Bearden, Office of the Secretary, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is the person responsible for responding to inquiries regarding this emergency rule. A copy of this emergency rule is available at parish Medicaid offices for review by interested parties.

David W. Hood
Secretary

0006#026

DECLARATION OF EMERGENCY

Department of Health and Hospitals Office of the Secretary Bureau of Health Services Financing

Private Hospital-Inpatient Services Reimbursement

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing adopts the following emergency rule under the Medical Assistance Program as authorized by R.S. 46:153 and 36:254 and pursuant to Title XIX of the Social Security Act and as

directed by the 1999-2000 General Appropriation Act, which states: "The Secretary shall implement reductions in the Medicaid program as necessary to control expenditures to the level approved in this schedule. The Secretary is hereby directed to utilize various cost containment measures to accomplish these reductions, including but not limited to pre-certification, pre-admission screening, and utilization review, and other measures as allowed by federal law." This emergency rule is adopted in accordance with the Administrative Procedure Act, R.S. 49:950, et seq. and shall be in effect for the maximum period allowed under the Administrative Procedure Act or until adoption of the rule, whichever occurs first.

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing adopted a rule in June of 1994 which established the prospective reimbursement methodology for inpatient services provided in private (non-state) acute care general hospitals (*Louisiana Register*, Volume 20, Number 6). The reimbursement methodology was subsequently amended in a rule adopted in January of 1996 which established a weighted average per diem for each hospital peer group (*Louisiana Register*, Volume 22, Number 1). This rule was later amended by a rule adopted in May of 1999 which discontinued the practice of automatically applying an inflation adjustment to the reimbursement rates in those years when the rates are not rebased (*Louisiana Register*, Volume 25, Number 5).

As a result of a budgetary shortfall, the Bureau has determined it is necessary to reduce the prospective per diem rates for private (non-state) acute hospital inpatient services by 7 percent. This action is being taken in order to avoid a budget deficit in the medical assistance program. Taking into consideration the 7 percent reduction in per diem rates in state fiscal year 2000, the Department has carefully reviewed the proposed rates and is satisfied that they are consistent with efficiency, economy and quality of care and are sufficient to enlist enough providers so that private (non-state) inpatient hospital services under the state plan are available at least to the extent that they are available to the general population in the state. This emergency rule is being adopted to continue the provisions of the March 8, 2000, rule.

Emergency Rule

Effective for dates of service on or after July 7, 2000 the Department of Health and Hospitals, Bureau of Health Services Financing reduces the reimbursement for private (non-state) hospital inpatient services by 7 percent.

Interested persons may submit written comments to the following address: Ben A. Bearden, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is the person 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.

David W. Hood
Secretary

0006#008

DECLARATION OF EMERGENCY

**Department of Health and Hospitals
Office of the Secretary
Bureau of Health Services Financing**

Private Intermediate Care Facilities for the Mentally Retarded
Leave of Absence Reimbursement

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing adopts the following emergency rule under the Medical Assistance Program as authorized by R.S. 46:153 and 36:254 and pursuant to Title XIX of the Social Security Act and as directed by the 1999-2000 General Appropriation Act, which states: "The Secretary shall implement reductions in the Medicaid program as necessary to control expenditures to the level approved in this schedule. The Secretary is hereby directed to utilize various cost containment measures to accomplish these reductions, including but not limited to pre-certification, pre-admission screening, and utilization review, and other measures as allowed by federal law." This emergency rule is adopted in accordance with the Administrative Procedure Act, R.S. 49:950, et seq. and shall be in effect for the maximum period allowed under the Administrative Procedure Act or until adoption of the rule, whichever occurs first.

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing adopted a rule which established the reimbursement methodology for private intermediate care facilities for the mentally retarded (ICF/MR) on October 20, 1989 (*Louisiana Register*, Volume 15, Number 10). The reimbursement methodology contained provisions governing payment to private ICFs/MR when the recipient is absent from the facility due to hospitalization or visits with family. A rule was subsequently adopted in April of 1999 to expand the number of payable hospital leave of absence days from five to seven days per hospitalization for treatment of an acute condition (*Louisiana Register*, Volume 25, Number 4).

As a result of a budgetary shortfall, the Bureau has determined it is necessary to reduce the payment to private ICFs/MR for hospital leave days by 25 percent. The reimbursement for hospital leave days will be 75 percent of the applicable per diem rate. This action is being taken in order to avoid a budget deficit in the medical assistance programs. This emergency rule is being adopted to continue the provisions of the March 8, 2000, rule.

Emergency Rule

Effective for dates of service on or after July 7, 2000, the Department of Health and Hospitals, Bureau of Health Services Financing reduces the payment to private intermediate care facilities for the mentally retarded for hospital leave days by 25 percent. The reimbursement for hospital leave days will be 75 percent of the applicable ICF/MR per diem rate.

Interested persons may submit written comments to the following address: Ben A. Bearden, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is the person 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.

David W. Hood
Secretary

0006#025

DECLARATION OF EMERGENCY

**Department of Health and Hospitals
Office of the Secretary
Bureau of Health Services Financing**

Private Intermediate Care Facilities for the Mentally Retarded
Reimbursement Methodology

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing adopts the following emergency rule under the Medical Assistance Program as authorized by R.S. 46:153 and 36:254 and pursuant to Title XIX of the Social Security Act and as directed by the 1999-2000 General Appropriation Act, which states: "The Secretary shall implement reductions in the Medicaid program as necessary to control expenditures to the level approved in this schedule. The Secretary is hereby directed to utilize various cost containment measures to accomplish these reductions, including but not limited to pre-certification, pre-admission screening, and utilization review, and other measures as allowed by federal law." This emergency rule is adopted in accordance with the Administrative Procedure Act, R.S. 49:950, et seq. and shall be in effect for the maximum period allowed under the Administrative Procedure Act or until adoption of the rule, whichever occurs first.

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing adopted a rule on October 20, 1989 which established the reimbursement methodology for private intermediate care facilities for the mentally retarded (*Louisiana Register*, Volume 15, Number 10). This rule was subsequently amended by a rule adopted to discontinue the practice of automatically applying an inflation adjustment to the reimbursement rates in those years when the rates are not rebased (*Louisiana Register*, Volume 25, Number 6).

As a result of a budgetary shortfall, the Bureau has determined it is necessary to reduce the Medicaid prospective per diem rates for private intermediate care facilities for the mentally retarded (ICF-MR) by 7 percent. This action is being taken in order to avoid a budget deficit in the medical assistance programs. Taking into consideration the 7 percent reduction in per diem rates in state fiscal year 2000, the Department has carefully reviewed the proposed rates and is satisfied that they are consistent with efficiency, economy and quality of care and are sufficient to enlist enough providers so that private intermediate care facilities for the mentally retarded (ICF-MR) services under the state plan are available at least to the extent that they are available to the general population in the state. This emergency rule is being adopted to continue the provisions of the March 1, 2000, rule.

Emergency Rule

Effective for dates of service on or after June 30, 2000 the Department of Health and Hospitals, Bureau of Health Services Financing reduces the reimbursement for private intermediate care facilities for the mentally retarded by 7 percent.

Interested persons may submit written comments to the following address: Ben A. Bearden, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is the person 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.

David W. Hood
Secretary

0006#024

DECLARATION OF EMERGENCY

**Department of Health and Hospitals
Office of the Secretary
Bureau of Health Services Financing**

Private Nursing Facilities
Leave of Absence Reimbursement

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing adopts the following emergency rule under the Medical Assistance Program as authorized by R.S. 46:153 and 36:254 and pursuant to Title XIX of the Social Security Act and as directed by the 1999-2000 General Appropriation Act, which states: "The Secretary shall implement reductions in the Medicaid program as necessary to control expenditures to the level approved in this schedule. The Secretary is hereby directed to utilize various cost containment measures to accomplish these reductions, including but not limited to pre-certification, pre-admission screening, and utilization review, and other measures as allowed by federal law." This emergency rule is adopted in accordance with the Administrative Procedure Act, R.S. 49:950, et seq. and shall be in effect for the maximum period allowed under the Administrative Procedure Act or until adoption of the rule, whichever occurs first.

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing adopted a rule which established the reimbursement methodology for private nursing facilities on June 20, 1984 (*Louisiana Register*, Volume 10, Number 6). The reimbursement methodology contained provisions governing payment to private nursing facilities when the recipient is absent from the faculty due to hospitalization or visits with family. A rule was subsequently adopted in May of 1998 to expand the number of payable hospital leave of absence days from five to seven per hospitalization for treatment of an acute condition (*Louisiana Register*, Volume 24, Number 5)

As a result of a budgetary shortfall, the Bureau has determined it is necessary to reduce the payment to private nursing facilities for hospital leave days by 25 percent. The reimbursement for hospital leave days will be 75 percent of

the applicable per diem rate. This action is being taken in order to avoid a budget deficit in the medical assistance program. This emergency rule is being adopted to continue the provisions of the March 8, 2000, rule.

Emergency Rule

Effective for dates of service on or after July 7, 2000 the Department of Health and Hospitals, Bureau of Health Services Financing reduces the payment to private nursing facilities for hospital leave days by 25 percent. The reimbursement for hospital leave days will be 75 percent of the applicable private nursing facility per diem rate.

Interested persons may submit written comments to the following address: Ben A. Bearden, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is the person 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.

David W. Hood
Secretary

0006#023

DECLARATION OF EMERGENCY

**Department of Health and Hospitals
Office of the Secretary
Bureau of Health Services Financing**

Private Nursing Facilities Reimbursement Methodology

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing adopts the following emergency rule under the Medical Assistance Program as authorized by R.S. 46:153 and 36:254 and pursuant to Title XIX of the Social Security Act and as directed by the 1999-2000 General Appropriation Act, which states: "The Secretary shall implement reductions in the Medicaid program as necessary to control expenditures to the level approved in this schedule. The Secretary is hereby directed to utilize various cost containment measures to accomplish these reductions, including but not limited to pre-certification, pre-admission screening, and utilization review, and other measures as allowed by federal law." This emergency rule is adopted in accordance with the Administrative Procedure Act, R.S. 49:950, et seq. and shall be in effect for the maximum period allowed under the Administrative Procedure Act or until adoption of the rule, whichever occurs first.

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing adopted a rule on June 20, 1984 which established the reimbursement methodology for private nursing facilities (*Louisiana Register*, Volume 10, Number 6). This rule was subsequently amended by a rule adopted to discontinue the practice of automatically applying an inflation adjustment to the reimbursement rates in those years when the rates are not rebased (*Louisiana Register*, Volume 25, Number 6).

As a result of a budgetary shortfall, the Bureau has determined it is necessary to reduce Medicaid prospective per diem rates for private nursing facilities by 7 percent.

This action is being taken in order to avoid a budget deficit in the medical assistance program. Taking into consideration the 7 percent reduction in per diem rates in state fiscal year 2000, the Department has carefully reviewed the proposed rates and is satisfied that they are consistent with efficiency, economy and quality of care and are sufficient to enlist enough providers so that private nursing facilities services under the state plan are available at least to the extent that they are available to the general population in the state. This emergency rule is being adopted to continue the provisions of the March 1, 2000, rule.

Emergency Rule

Effective for dates of service on or after June 30, 2000 the Department of Health and Hospitals, Bureau of Health Services Financing reduces the reimbursement to private nursing facilities by 7 percent.

Interested persons may submit written comments to the following address: Ben A. Bearden, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is the person 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.

David W. Hood
Secretary

0006#022

DECLARATION OF EMERGENCY

**Department of Health and Hospitals
Office of the Secretary
Bureau of Health Services Financing**

Professional Services Program Medicare Part B Claims

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing has adopted the following emergency rule under the Medical Assistance Program as authorized by R.S. 46:153 and 36:254 and pursuant to Title XIX of the Social Security Act and as directed by the 1999-2000 General Appropriation Act, which states: "The Secretary shall implement reductions in the Medicaid program as necessary to control expenditures to the level approved in this schedule. The Secretary is hereby directed to utilize various cost containment measures to accomplish these reductions, including but not limited to pre-certification, pre-admission screening, and utilization review, and other measures as allowed by federal law." This emergency rule is adopted in accordance with the Administrative Procedure Act, R.S. 49:950, et seq. and shall be in effect for the maximum period allowed under the Administrative Procedure Act or until adoption of the rule, whichever occurs first.

The Department of Health and Hospitals, Bureau of Health Services Financing currently provides reimbursement for full co-insurance and deductibles for Medicare Part B claims for professional services. Section 1902(a)(10) of the Social Security Act provides states flexibility in the payment of Medicare cost sharing for dually eligible Medicare/Medicaid recipients who are not Qualified Medicare

Beneficiaries (QMBs). Section 4714 of the Balanced Budget Act of 1997 clarifies that states have flexibility in complying with the requirements to pay Medicare cost-sharing for Qualified Medicare Beneficiaries and the protections against payment liability for QMBs. Section 4714 states that a state is not required to provide any payment for any expenses incurred relating to payment for deductibles, co-insurance, or co-payments for Medicare cost sharing to the extent that payment under Title XVIII for the service would exceed the payment amount that otherwise would be made under the state plan under this title for service if provided to an eligible recipient other than a Medicare beneficiary.

When a state's payment for Medicare cost sharing for an item or service rendered to a dually eligible Medicare/Medicaid recipient or a Qualified Medicare Beneficiary is reduced or eliminated to limit the amount under Title XVIII that the beneficiary may be billed or charged for the service, the amount of payment made under Title XVIII plus the amount of payment (if any) under the Medicaid State Plan shall be considered to be payment in full for the service. The recipient does not have any legal liability to make payment for the service.

As a result of a budgetary shortfall, the Bureau has determined that it is necessary to do comparison of the Medicare payment and the Medicaid rate on file for the procedure code(s) indicated on the Medicare Part B claims for professional services. If the Medicare payment exceeds the Medicaid rate, the claim will be adjudicated as a paid claim with a zero payment. If the Medicaid rate would exceed the Medicare payment, the claim will be reimbursed at the lesser of the co-insurance and deductible or up to the Medicaid maximum payment. However, claims for hemodialysis and transplantation services are excluded from this limitation. This action is necessary in order to avoid a budget deficit in the medical assistance programs. This emergency rule is being adopted to continue the provisions of the February 1, 2000, rule.

Emergency Rule

Effective with date of service June 1, 2000 and thereafter, the Department of Health and Hospitals, Bureau of Health Services Financing shall compare the Medicare payment to the Medicaid rate on file for the procedure code(s) indicated on the Medicare Part B claims for professional services. If the Medicare payment exceeds the Medicaid rate, the claim will be adjudicated as a paid claim with a zero payment. If the Medicaid rate would exceed the Medicare payment, the claim will be reimbursed at the lesser of the co-insurance and deductible or up to the Medicaid maximum payment. However, claims for hemodialysis and transplantation services are excluded from this limitation. If the Medicaid payment is reduced or eliminated as a result of the Medicare/Medicaid payment comparisons, the amount of the Medicare payment plus the amount of the Medicaid payment (if any) shall be considered to be payment in full for the service. The recipient does not have any legal liability to make payment for the service.

Interested persons may submit written comments to the following address: Ben A. Bearden, Office of the Secretary, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is the person responsible

for responding to inquiries regarding this emergency rule. A copy of this emergency rule is available at parish Medicaid offices for review by interested parties.

David W. Hood
Secretary

0006#021

DECLARATION OF EMERGENCY
Department of Health and Hospitals
Office of the Secretary
Bureau of Health Services Financing

Professional Services Program
Neonatal Care Reimbursement

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing has adopted the following emergency rule under the Medical Assistance Program as authorized by R.S. 46:153 and 36:254 and pursuant to Title XIX of the Social Security Act and as directed by the 1999-2000 General Appropriation Act, which states: "The Secretary shall implement reductions in the Medicaid program as necessary to control expenditures to the level approved in this schedule. The Secretary is hereby directed to utilize various cost containment measures to accomplish these reductions, including but not limited to pre-certification, pre-admission screening, and utilization review, and other measures as allowed by federal law." This emergency rule is adopted in accordance with the Administrative Procedure Act, R.S. 49:950, et seq. and shall be in effect for the maximum period allowed under the Administrative Procedure Act or until adoption of the rule, whichever occurs first.

The Department of Health and Hospitals, Bureau of Health Services Financing provides reimbursement for neonatal care. Reimbursement for these services is the flat fee established by the Bureau minus the amount which any third party coverage would pay. As a result of a budgetary shortfall, the Bureau has determined it is necessary to reduce the reimbursement of neonatal care services for the following Current Procedural Terminology (CPT) procedure codes: CPT code 99295 to \$496.85 and CPT code 99298 to \$100.10. This action is necessary in order to avoid a budget deficit in the medical assistance programs. This emergency rule is being adopted to continue the provisions of the February 1, 2000, rule.

Emergency Rule

Effective for dates of service June 1, 2000 and after, the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing reduces the reimbursement of neonatal care services for the following Current Procedural Terminology (CPT) procedure codes: CPT code 99295 to \$496.85 and CPT code 99298 to \$100.10.

Interested persons may submit written comments to the following address: Ben A. Bearden, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is the person 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.

David W. Hood
Secretary

0006#020

DECLARATION OF EMERGENCY
Department of Health and Hospitals
Office of the Secretary
Bureau of Health Services Financing

Professional Services Program
Physician Services Reimbursement

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing has adopted the following emergency rule under the Medical Assistance Program as authorized by R.S. 46:153 and 36:254 and pursuant to Title XIX of the Social Security Act and as directed by the 1999-2000 General Appropriation Act, which states: "The Secretary shall implement reductions in the Medicaid program as necessary to control expenditures to the level approved in this schedule. The Secretary is hereby directed to utilize various cost containment measures to accomplish these reductions, including but not limited to pre-certification, pre-admission screening, and utilization review, and other measures as allowed by federal law." This emergency rule is adopted in accordance with the Administrative Procedure Act, R.S. 49:950, et seq. and shall be in effect for the maximum period allowed under the Administrative Procedure Act or until adoption of the rule, whichever occurs first.

The Department of Health and Hospitals, Bureau of Health Services Financing reimburses professional services in accordance with an established fee schedule for Current Procedural Terminology (CPT) codes, locally assigned codes and Health Care Financing Administration (HCFA) Common Procedure Codes (HCPC). Reimbursement for these services is a flat fee established by the Bureau minus the amount which any third party coverage would pay. As a result of a budgetary shortfall, the Bureau has determined it is necessary to reduce the reimbursement fees for surgery codes (CPT codes 10040-69979), medicine codes (CPT codes 90281-99199), evaluation and management codes (CPT codes 99201-99499) fees for radiology services codes (CPT codes 70010-79999), pathology and laboratory services codes (CPT codes 80048-89399), and selected locally-assigned HCPCS by 7 percent. Excluded from this reduction will be the reimbursement fees for chemotherapy medications, prenatal and postnatal visits (CPT codes Z9004, Z9005 and Z9006), vaginal and cesarean deliveries, tubal ligations, anesthesia services for vaginal and cesarean deliveries, hemodialysis, tonsillectomies and adenoidectomies, neonatal care, and radiology oncology services. This action is necessary in order to avoid a budget deficit in the medical assistance programs. This emergency rule is being adopted to continue the provisions of the February 1, 2000, rule.

Emergency Rule

Effective for dates of service June 1, 2000 and after, the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing reduces the reimbursement fees for surgery codes (CPT codes 10040-69979), medicine codes (CPT codes 90281-99199), evaluation and management codes (CPT codes 99201-99499) fees for radiology services codes (CPT codes 70010-79999), pathology and laboratory services codes (CPT codes 80048-89399) and selected locally-assigned Health Care Financing Administration (HCFA) Common Procedure Codes (HCPC) by 7 percent. Excluded from this reduction will be reimbursement fees for chemotherapy medications, prenatal and postnatal visits (CPT codes Z9004, Z9005 and Z9006), vaginal and cesarean deliveries, tubal ligations, anesthesia services for vaginal and cesarean deliveries, hemodialysis, tonsillectomies and adenoidectomies, neonatal care, and radiology oncology services.

Interested persons may submit written comments to the following address: Ben A. Bearden, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is the person 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.

David W. Hood
Secretary

0006#019

DECLARATION OF EMERGENCY
Department of Health and Hospitals
Office of the Secretary
Bureau of Health Services Financing

Professional Services Program
Tonsillectomy and Adenoidectomy Services Reimbursement

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing has adopted the following emergency rule under the Medical Assistance Program as authorized by R.S. 46:153 and 36:254 and pursuant to Title XIX of the Social Security Act and as directed by the 1999-2000 General Appropriation Act, which states: "The Secretary shall implement reductions in the Medicaid program as necessary to control expenditures to the level approved in this schedule. The Secretary is hereby directed to utilize various cost containment measures to accomplish these reductions, including but not limited to pre-certification, pre-admission screening, and utilization review, and other measures as allowed by federal law." This emergency rule is adopted in accordance with the Administrative Procedure Act, R.S. 49:950, et seq. and shall be in effect for the maximum period allowed under the Administrative Procedure Act or until adoption of the rule, whichever occurs first.

The Department of Health and Hospitals, Bureau of Health Services Financing provides reimbursement for tonsillectomy and adenoidectomy services. Reimbursement for these services is the flat fee established by the Bureau

minus the amount which any third party coverage would pay. As a result of a budgetary shortfall, the Bureau has determined it is necessary to reduce the professional fees for the performance of tonsillectomies and adenoidectomies for the following Current Procedural Terminology (CPT) procedure codes:

CPT code 42820	\$425.25
CPT code 42821	\$425.25
CPT code 42825	\$405.00
CPT code 42826	\$438.75
CPT code 42830	\$408.38
CPT code 42831	\$388.13

This action is necessary in order to avoid a budget deficit in the medical assistance programs. This emergency rule is being adopted to continue the provisions of the February 1, 2000, rule.

Emergency Rule

Effective for dates of service June 1, 2000 and after, the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing reduces the professional fees for the performance of tonsillectomies and adenoidectomies for the following Current Procedural Terminology (CPT) procedure codes:

CPT code 42820	\$425.25
CPT code 42821	\$425.25
CPT code 42825	\$405.00
CPT code 42826	\$438.75
CPT code 42830	\$408.38
CPT code 42831	\$388.13

Interested persons may submit written comments to the following address: Ben A. Bearden, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is the person 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.

David W. Hood
Secretary

0006#018

DECLARATION OF EMERGENCY
Department of Health and Hospitals
Office of the Secretary
Bureau of Health Services Financing

Rehabilitation Centers Services Reimbursement

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Service Financing has adopted the following emergency rule under the Medical Assistance Program as authorized by R.S. 46:153 and 36:254 and pursuant to Title XIX of the Social Security Act and as directed by the 1999-2000 General Appropriation Act, which states: "The Secretary shall implement reductions in

the Medicaid program as necessary to control expenditures to the level approved in this schedule. The Secretary is hereby directed to utilize various cost containment measures to accomplish these reductions, including but not limited to pre-certification, pre-admission screening, and utilization review, and other measures as allowed by federal law." This emergency rule is adopted in accordance with the Administrative Procedure Act, R.S. 49:950, et seq. and shall be in effect of the maximum period allowed under the Administrative Procedure Act or until adoption of the rule, whichever occurs first.

The Department of Health and Hospitals, Bureau of Health Services Financing provides coverage and reimbursement for services delivered by rehabilitation centers that are not part of a hospital, but are organized to provide a variety of outpatient rehabilitative services including physical, occupational, speech, hearing, and language therapies. As a result of a budgetary shortfall, the Bureau has determined it is necessary to reduce the reimbursement rates for services provided in a rehabilitation center by 7 percent. This action is being taken in order to avoid a budget deficit in the medical assistance programs. This emergency rule is being adopted to continue the provisions of the February 1, 2000, rule.

Emergency Rule

Effective for dates of service June 1, 2000 and after, the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing reduces the reimbursement rates for services provided in rehabilitation centers by 7 percent. Rehabilitation centers are facilities that are not part of a hospital, but are organized to provide a variety of outpatient rehabilitative services including physical, occupational, speech, hearing, and language therapies.

Interested persons may submit written comments to the following address: Ben A. Bearden, Office of the Secretary, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is the person responsible for responding to inquiries regarding this emergency rule. A copy of this emergency rule is available at the parish Medicaid office for review by interested parties.

David W. Hood
Secretary

0006#017

DECLARATION OF EMERGENCY

**Department of Health and Hospitals
Office of the Secretary
Bureau of Health Services Financing**

Rehabilitation Services Medicare Crossover

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing has adopted the following emergency rule under the Medical Assistance Program as authorized by R.S. 46:153 and 36:254 and pursuant to Title XIX of the Social Security Act and as directed by the 1999-2000 General Appropriation Act, which states: "The Secretary shall implement reductions in

the Medicaid program as necessary to control expenditures to the level approved in this schedule. The Secretary is hereby directed to utilize various cost containment measures to accomplish these reductions, including but not limited to pre-certification, pre-admission screening, and utilization review, and other measures as allowed by federal law." This emergency rule is adopted in accordance with the Administrative Procedure Act, R.S. 49:950, et seq. and shall be in effect for the maximum period allowed under the Administrative Procedure Act or until adoption of the rule, whichever occurs first.

The Department of Health and Hospitals, Bureau of Health Services Financing currently provides reimbursement for full co-insurance and deductibles for Medicare Part B claims for rehabilitation services. Section 1902(a)(10) of the Social Security Act provides states flexibility in the payment of Medicare cost-sharing for dually eligible Medicare/Medicaid recipients who are not Qualified Medicare Beneficiaries (QMBs). Section 4714 of the Balanced Budget Act of 1997 clarifies that states have flexibility in complying with the requirements to pay Medicare cost-sharing for Qualified Medicare Beneficiaries and the protections against payment liability for QMBs. Section 4714 states that "a state is not required to provide any payment for any expenses incurred relating to payment for deductibles, coinsurance, or copayments for Medicare cost-sharing to the extent that payment under Title XVIII for the service would exceed the payment amount that otherwise would be made under the state plan under this title for service if provided to an eligible recipient other than a Medicare beneficiary."

When a state's payment for Medicare cost-sharing for an item or service rendered to a dually eligible Medicare/Medicaid recipient or a Qualified Medicare Beneficiary is reduced or eliminated to limit the amount under Title XVIII that the beneficiary may be billed or charged for the service, the amount of payment made under Title XVIII plus the amount of payment (if any) under the Medicaid State Plan shall be considered to be payment in full for the service. The recipient does not have any legal liability to make payment for the service.

As a result of a budgetary shortfall, the Bureau has determined it is necessary to compare the Medicare payment and the Medicaid rate on file for the revenue code(s) on the Medicare Part B claim for rehabilitation services. If the Medicare payment exceeds the Medicaid rate, the claim will be adjudicated as a paid claim with a zero payment. If the Medicaid rate would exceed the Medicare payment, the claim will be reimbursed at the lesser of the co-insurance and deductible or up to the Medicaid maximum payment. This action is being taken in order to avoid a budget deficit in the medical assistance programs. This emergency rule is being adopted to continue the provisions of the February 8, 2000, rule.

Emergency Rule

Effective for dates of service on or after June 8, 2000, the Department of Health and Hospitals, Bureau of Health Services Financing shall compare the Medicare payment and the Medicaid rate on file for the revenue code(s) on the Medicare Part B claims for rehabilitation services. If the Medicare payment exceeds the Medicaid rate, the claim will

be adjudicated as a paid claim with a zero payment. If the Medicaid rate would exceed the Medicare payment, the claim will be reimbursed at the lesser of the co-insurance and deductible or up to the Medicaid maximum payment. If the Medicaid payment is reduced or eliminated as a result of applying the limit of the Medicaid maximum payment, the amount of the Medicare payment plus the amount of the Medicaid payment (if any) shall be considered to be payment in full for the service. The recipient does not have any legal liability to make payment for the service.

Interested persons may submit written comments to the following address: Ben A. Bearden, Office of the Secretary, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is the person responsible for responding to inquiries regarding this emergency rule. A copy of this emergency rule is available at parish Medicaid offices for review by interested parties.

David W. Hood
Secretary

0006#016

DECLARATION OF EMERGENCY

**Department of Health and Hospitals
Office of the Secretary
Bureau of Health Services Financing**

Substance Abuse Clinics Medicare Part B

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Service Financing has adopted the following emergency rule under the Medical Assistance Program as authorized by R.S. 46:153 and 36:254 and pursuant to Title XIX of the Social Security Act and as directed by the 1999-2000 General Appropriation Act, which states: "The Secretary shall implement reductions in the Medicaid program as necessary to control expenditures to the level approved in this schedule. The Secretary is hereby directed to utilize various cost containment measures to accomplish these reductions, including but not limited to pre-certification, pre-admission screening, and utilization review, and other measures as allowed by federal law." This emergency rule is adopted in accordance with the Administrative Procedure Act, R.S. 49:953(B)(1) et seq. and shall be in effect of the maximum period allowed under the Administrative Procedure Act or until adoption of the rule, whichever occurs first.

The Department of Health and Hospitals, Bureau of Health Services Financing currently provides reimbursement for full co-insurance and deductibles for Medicare Part B claims for substance abuse clinic services. Section 1902(a)(10) of the Social Security Act provide states flexibility in the payment of Medicare cost sharing for dually eligible Medicare/Medicaid recipients who are not Qualified Medicare Beneficiaries (QMBs). Section 4714 of the Balanced Budget Act of 1997 clarifies that states have flexibility in complying with the requirements to pay Medicare cost sharing for Qualified Medicare Beneficiaries and the protections against payment liability for QMBs. Section 4714 states that a state is not required to provide any

payment for any expenses incurred relating to payment for deductibles, co-insurance, or copayments for Medicare cost-sharing to the extent that payment under Title XVIII for the service would exceed the payment amount that otherwise would be made under the state plan under this title for service if provided to an eligible recipient other than a Medicare beneficiary.

When a state's payment for Medicare cost-sharing for an item or service rendered to a dually eligible Medicare/Medicaid recipient or a Qualified Medicare Beneficiary is reduced or eliminated to limit the amount under Title XVIII that the beneficiary may be billed or charged for the service, the amount of payment made under Title XVIII plus the amount of payment (if any) under the Medicaid State Plan shall be considered to be payment in full for the service. The beneficiary does not have any legal liability to make payment for the service.

As a result of a budgetary shortfall, the Bureau has determined it is necessary to do comparison of the Medicare payment and the Medicaid rate on file for the applicable procedure code on the Medicare Part B claim for substance abuse clinic services. If the Medicare payment exceeds the Medicaid rate, the claim will be adjudicated as a paid claim with a zero payment. If the Medicaid rate would exceed the Medicare payment, the claim will be reimbursed at the lesser of the co-insurance and deductible or up to the Medicaid maximum payment. This action is necessary in order to avoid a budget deficit in the medical assistance programs. This emergency rule is being adopted to continue the provisions of the February 1, 2000, rule.

Emergency Rule

Effective for dates of admission on or after June 1, 2000, the Department of Health and Hospitals, Bureau of Health Services Financing shall compare the Medicare payment to the Medicaid rate on file for the procedure code on the Medicare Part B claim for substance abuse clinic services. If the Medicare payment exceeds the Medicaid rate, the claim will be adjudicated as a paid claim with a zero payment. If the Medicaid rate would exceed the Medicare payment, the claim will be reimbursed at the lesser of the co-insurance and deductible or up to the Medicaid maximum payment. If the Medicaid payment is reduced or eliminated as a result of the Medicare/Medicaid payment comparison, the amount of the Medicare payment plus the amount of the Medicaid payment (if any) shall be considered to be payment in full for the service. The recipient does not have any legal liability to make payment for the service.

Interested persons may submit written comments to the following address: Ben A. Bearden, Office of the Secretary, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is the person responsible for responding to inquiries regarding this emergency rule. A copy of this emergency rule is available at parish Medicaid offices for review by interested parties.

David W. Hood
Secretary

0006#015

DECLARATION OF EMERGENCY

Department of Health and Hospitals
Office of the Secretary
Bureau of Health Services Financing

Substance Abuse Clinics C Termination of Services

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing has adopted the following emergency rule in the Medical Assistance Program as authorized by R.S. 46:153 and 36:254 and pursuant to Title XIX of the Social Security Act and as directed by the 1999-2000 General Appropriation Act, which states: "The Secretary shall implement reductions in the Medicaid program as necessary to control expenditures to the level approved in this schedule. The Secretary is hereby directed to utilize various cost containment measures to accomplish these reductions, including but not limited to pre-certification, pre-admission screening, and utilization review, and other measures as allowed by federal law." This emergency rule is adopted in accordance with the Administrative Procedure Act, R.S. 49:950, et seq. and shall be in effect for the maximum period allowed under the Administrative Procedure Act or until adoption of the rule whichever occurs first.

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing currently provides coverage for Substance Abuse Clinic services under the Medicaid Program. As a result of a budgetary shortfall, the Bureau has determined it is necessary to terminate coverage of this optional services program under its Title XIX State Plan. This action is necessary in order to avoid a budget deficit in the medical assistance programs. This emergency rule is being adopted to continue the provisions of the February 21, 2000, rule.

Emergency Rule

Effective June 21, 2000, the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing terminates coverage and reimbursement for Substance Abuse Clinic services under the Medicaid Program.

Interested persons may submit written comments to the following address: Ben A. Bearden, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is the person 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.

David W. Hood
Secretary

0006#014

DECLARATION OF EMERGENCY

Department of Health and Hospitals
Office of the Secretary
Bureau of Health Services Financing

Targeted Case Management Services Reimbursement

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing has adopted the following emergency rule under the Medical Assistance Program as authorized by R.S. 46:153 and 36:254 et seq. and pursuant to Title XIX of the Social Security Act and as directed by the 1999-2000 General Appropriation Act, which states: "The Secretary shall implement reductions in the Medicaid program as necessary to control expenditures to the level approved in this schedule. The Secretary is hereby directed to utilize various cost containment measures to accomplish these reductions, including but not limited to pre-certification, pre-admission screening, and utilization review, and other measures as allowed by federal law." This emergency rule is adopted in accordance with the Administrative Procedure Act, R.S. 49:950, et seq. and shall be in effect for the maximum period allowed under the Administrative Procedure Act or until adoption of the rule, whichever occurs first.

The Department of Health and Hospitals, Bureau of Health Services Financing provides reimbursement for targeted case management services rendered to the following targeted populations: Infants and Toddlers, High Risk Pregnant Women, HIV-Infected Persons and Elderly and Disabled Adult Waiver recipients. Reimbursement for these services is a fixed monthly rate for the provision of the core elements of case management services. As a result of a budgetary shortfall, the Bureau has determined it is necessary to reduce the fixed monthly reimbursement rate for case management services provided to the above-referenced targeted populations by 7 percent. This action is necessary in order to avoid a budget deficit in the medical assistance programs. This emergency rule is being adopted to continue the provisions of the February 8, 2000, rule.

Emergency Rule

Effective for dates of service June 8, 2000 and after, the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing reduces the fixed monthly reimbursement rate for targeted case management services by 7 percent for services provided to the following targeted populations: Infants and Toddlers, High Risk Pregnant Women, HIV-Infected Persons and Elderly and Disabled Adult Waiver recipients.

Interested persons may submit written comments to the following address: Ben A. Bearden, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA

70821-9030. He is the person 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.

David W. Hood
Secretary

0006#013

DECLARATION OF EMERGENCY

Department of Natural Resources Office of Conservation

Pollution ControlCStatewide Order No. 29-B
(LAC 43:XIX.129)

Order requiring testing of exploration and production (E&P) waste upon receipt by a commercial facility, and identification of acceptable storage, treatment and disposal methods for certain E&P waste types.

Pursuant to the power delegated under the laws of the state of Louisiana, and particularly Title 30 of the Revised Statutes of 1950, as amended, and in conformity with the provisions of the Administrative Procedure Act, Title 49, Sections 953(B)(1) and (2), 954(B)(2), as amended, the following Emergency Rule and reasons therefor are now adopted and promulgated by the commissioner of conservation as being necessary to protect the public health, safety and welfare of the people of the state of Louisiana, as well as the environment generally, by continuing a procedure for testing E&P waste after receipt at a commercial facility and identifying acceptable storage, treatment and disposal methods for certain E&P wastes at commercial facilities.

Need and Purpose

Certain oil and gas exploration and production waste (E&P waste) is exempt from the hazardous waste regulations under the Resource Conservation and Recovery Act (RCRA). This exemption is based on findings from a 1987-1988 Environmental Protection Agency (EPA) study and other studies that determined this type of waste does not pose a significant health or environmental threat when properly managed. The EPA, in its regulatory determination, found that these wastes are adequately regulated under existing federal and state programs.

Existing state regulations governing the operations of commercial E&P waste disposal facilities (Statewide Order No. 29-B) require only very limited testing of the waste received for storage, treatment and disposal at each commercial facility. Such limited testing finds its basis in the above-mentioned national exemption for E&P waste recognized by the EPA. However, public concern warranted the commissioner of conservation to issue a first Emergency Rule effective May 1, 1998 (May 1, 1998 Emergency Rule), the purpose of which was to gather technical data regarding the chemical and physical makeup of E&P waste disposed of at permitted commercial E&P waste disposal facilities within the state of Louisiana. The May 1, 1998 Emergency Rule had an effective term of 120 days. However, technical experts under contract with the Office of Conservation determined during the term of the May 1, 1998 Emergency Rule that sampling and testing should be extended for an

additional 30 days for the purpose of receiving additional data in order to strengthen the validity of the inferred concentration distributions within the various E&P waste types. Therefore, a second Emergency Rule was issued on August 29, 1998, and effective through September 30, 1998.

The second Emergency Rule required continued comprehensive analytical testing of E&P waste at the site of generation together with verification testing at the commercial E&P waste disposal facility. During the terms of the first and second Emergency Rules, approximately 1,800 E&P waste testing batches were analyzed, with the raw data results being filed with the Office of Conservation. Technical experts under contract with the Office of Conservation, together with staff of the Office of Conservation, determined that the number of raw data sets of E&P waste types, along with other published analytical results of E&P waste testing, provided adequate numbers of validated test results of the various generic E&P waste types to reach statistically valid conclusions regarding the overall chemical and physical composition of each type of E&P waste.

Therefore, continued testing of E&P waste at the site of generation was unnecessarily redundant, and was discontinued. The third Emergency Rule adopted on October 1, 1998 required continued testing of each E&P waste shipment at the commercial disposal facility according to procedures described in Section D. Such continued testing was required to assure that E&P waste shipments received for disposal at commercial facilities were consistent with evolving E&P waste profiles.

A fourth Emergency Rule, adopted January 29, 1999, a fifth Emergency Rule, adopted May 29, 1999, a sixth Emergency Rule, adopted September 26, 1999, and a seventh Emergency Rule, adopted January 24, 2000 provided requirements for continued testing of all E&P waste shipments received for disposal at commercial E&P waste disposal facilities, as well as identifying acceptable methods of storage, treatment and disposal of certain E&P waste types at such commercial facilities. However, since evaluation of data generated by Emergency Rules 1 and 2 has not been completed and a permanent rule has not been promulgated, it is necessary to adopt an eighth Emergency Rule, effective May 23, 2000, to continue the requirements of the fourth Emergency Rule.

Concurrent with implementation of this Emergency Rule, the Office of Conservation will continue development of a permanent rule for the management and disposal of E&P waste at commercial facilities within the state of Louisiana. Best E&P waste management practices, based on established E&P waste profiles, will be incorporated into the permanent rule. Such permanent rule will also address specific storage, treatment and disposal options for the various categories of E&P waste.

Synopsis

1. E&P waste will be transported with identification.

Each load of E&P waste transported from the site of generation to a commercial facility for disposal will be accompanied by an Oilfield Waste Shipping Control Ticket (Form UIC-28) and presented to the operator before offloading. Copies of completed Form UIC-28 are required to be timely filed with the Office of Conservation.

Produced water, produced formation fresh water and other E&P waste fluids are exempt from certain provisions of the testing requirements provided they are:

- 1) transported in enclosed tank trucks, barges, or other enclosed containers;
- 2) stored in enclosed tanks at a commercial facility; and
- 3) disposed by deepwell injection. Such provision is reasonable because, provided the above conditions are met, exposure to the public and to the environment would be minimal.

2. Each Load of E&P Waste Will Be Tested At Commercial Facility

Before offloading at a commercial E&P waste disposal facility and in order to verify that the waste qualifies for the E&P category, each load of E&P waste shall be sampled for required parameters. Additionally, the presence and concentration of BTEX (benzene, toluene, ethyl benzene and xylene) compounds and hydrogen sulfide must be determined. Appropriate records of tests shall be kept at each commercial facility for review by the Office of Conservation.

3. Identification of Acceptable Storage, Treatment and Disposal Methods (Options) for E&P Waste

It is required that all offsite storage, treatment and disposal methods for E&P waste utilize approved technologies that are protective of public health and the environment. The fifth Emergency Rule required that injection in Class II wells, after storage in a closed system, shall be utilized for Waste Types 01 and 14. The remainder of the E&P waste types are currently under study to confirm acceptable storage, treatment and disposal methods. Any additional acceptable storage, treatment and disposal methods will be promulgated in the near future.

Reasons

Recognizing the potential advantages of a testing program that is fully protective of public health and the environment and that adequately characterizes such waste as to its potentially toxic constituents, and by the identification of acceptable storage, treatment and disposal methods for certain types of E&P waste, it has been determined that failure to establish such procedures and requirements in the form of an administrative rule may lead to the existence of an imminent peril to the public health, safety and welfare of the people of the state of Louisiana, as well as the environment generally.

Protection of the public and our environment therefore requires the commissioner of conservation to take immediate steps to assure that adequate testing is performed and acceptable storage, treatment and disposal methods for certain types of E&P waste are employed at commercial facilities. The Emergency Rule, Amendment to Statewide Order No. 29-B (Emergency Rule) set forth hereinafter, is now adopted by the Office of Conservation.

Title 43

NATURAL RESOURCES

Part XIX. Office of ConservationCGeneral Operations

Subpart 1. Statewide Order No. 29-B

Chapter 1. General Provisions

§129. Pollution Control

A. - L. ...

M. Off-site Storage, Treatment and/or Disposal of E &P Waste Generated From Drilling and Production of Oil and Gas Wells

1. Definitions

*Commercial Facility*Ca legally permitted waste storage, treatment and/or disposal facility which receives, treats, reclaims, stores, or disposes of exploration and production waste for a fee or other consideration, and shall include the term *transfer station*.

*Exploration and Production (E&P) Waste*Cdrilling fluids, produced water, and other waste associated with the exploration, development, or production of crude oil or natural gas and which is not regulated by the provisions of the Louisiana Hazardous Waste Regulations and the Louisiana Solid Waste Regulations. Such wastes include, but are not limited to, the following:

Waste Type	Waste Description
01	salt water (produced brine or produced water), except for salt water whose intended and actual use is in drilling, workover or completion fluids or in enhanced mineral recovery operations
02	oil-base drilling mud and cuttings
03	water-base drilling mud and cuttings
04	completion, workover and stimulation fluids
05	production pit sludges
06	production storage tank sludges
07	produced oily sands and solids
08	produced formation fresh water
09	rainwater from ring levees and pits at production and drilling facilities
10	washout water generated from the cleaning of containers that transport E&P waste and are not contaminated by hazardous waste or material
11	washout pit water and solids from oilfield related carriers that are not permitted to haul hazardous waste or material
12	natural gas plant processing (E&P) waste which is or may be commingled with produced formation water
13	waste from approved salvage oil operators who only receive oil (BS&W) from oil and gas leases
14	pipeline test water which does not meet discharge limitations established by the appropriate state agency, or pipeline pigging waste, i.e., waste fluids/solids generated from the cleaning of a pipeline
15	wastes from permitted commercial facilities
16	crude oil spill clean-up waste
50	salvageable hydrocarbons
99	other approved E&P waste

*NOW*Cexploration and production waste

M.2. - 5.i. ...

- i. Receipt, Sampling and Testing of E&P Waste

ii. ...

iii. Testing Requirements

(a). Before offloading E&P waste at a commercial facility, including a transfer station, each load of E&P waste shall be sampled and analyzed by commercial facility personnel for the following:

(i). pH, electrical conductivity (EC-mmhos/cm) and chloride (Cl) content; and

(ii). the presence and concentration of BTEX (benzene, toluene, ethyl benzene, and xylene) compounds using an organic vapor monitor or other procedures sufficient to identify and quantify BTEX;

(iii). the sample temperature (degrees Fahrenheit) representing actual testing conditions of the sample obtained for BTEX analysis by methodology that will assure sufficient accuracy; and

(iv). the presence and concentration of hydrogen sulfide (H₂S) using a portable gas monitor.

(b). The commercial facility operator shall enter the pH, electrical conductivity, chloride (Cl) content, BTEX, BTEX sample temperature and hydrogen sulfide measurements on the manifest (Form UIC-28) which accompanies each load of E&P waste.

(c). Produced water, produced formation fresh water, and other E&P waste fluids are exempt from organic vapor monitoring measurement (BTEX), and the H₂S measurement in (a) above if the following conditions are met:

(i). if transported by the generator or transporter in enclosed tank trucks, barges, or other enclosed containers; and

(ii). if stored in an enclosed container at a commercial facility; and

(iii). if disposed by deep well injection.

(d). Records of these tests shall be kept on file at each commercial facility for a period of three years and be available for review by the commissioner or his designated representative. Copies of completed Form UIC-28 shall be filed with the Office of Conservation as provided in §129.M.6.d.

M.5.i.iii. - 5.1. ...

m. It is required that all offsite storage, treatment and disposal methods for E&P waste utilize approved technologies that are protective of public health and the environment. The following chart includes acceptable and required storage, treatment and disposal methods for each type of E&P waste disposed of at commercial facilities within the state of Louisiana:

Waste Type	Required Storage, Treatment and Disposal Method(s)
01	Injection in Class II well utilizing a closed system
02	(reserved)
03	(reserved)
04	(reserved)
05	(reserved)
06	(reserved)
07	(reserved)
08	(reserved)
09	(reserved)

10	(reserved)
11	(reserved)
12	(reserved)
13	(reserved)
14	Pipeline test water - Injection in Class II well utilizing a closed system Pipeline pigging waste - (reserved)
15	(reserved)
16	(reserved)
50	Commercial salvage oil facility
99	(reserved)

M.6. - S. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 30.4 et seq.

HISTORICAL NOTE: Adopted by the Department of Conservation (August 1943), promulgated by the Department of Natural Resources, Office of Conservation, LR 6:307 (July 1980), amended LR 8:79 (February 1982), LR 9:337 (May 1983), LR 10:210 (March 1984), LR 12:26 (January 1986), LR 16:855 (October 1990), LR 17:382 (April 1991), LR 26:

Summary

The Emergency Rule herein above adopted evidences the finding of the commissioner of conservation that failure to adopt the above rules may lead to an imminent risk to public health, safety and welfare of the citizens of Louisiana, and that there is not time to provide adequate notice to interested parties. However, the commissioner of conservation notes again that a copy of the permanent amendment to Statewide Order No. 29-B will be developed in the immediate future, with a public hearing to be held as per the requirements of the Administrative Procedure Act.

The commissioner of conservation concludes that the above Emergency Rule will better serve the purposes of the Office of Conservation as set forth in Title 30 of the Revised Statutes, and is consistent with legislative intent. The adoption of the above Emergency Rule meets all the requirements provided by Title 49 of the Louisiana Revised Statutes. The adoption of the above Emergency Rule is not intended to affect any other provisions, rules, orders, or regulations of the Office of Conservation, except to the extent specifically provided for in this Emergency Rule.

Within five days from date hereof, notice of the adoption of this Emergency Rule shall be given to all parties on the mailing list of the Office of Conservation by posting a copy of this Emergency Rule with reasons therefor to all such parties. This Emergency Rule with reasons therefor shall be published in full in the *Louisiana Register* as prescribed by law. Written notice has been given contemporaneously herewith notifying the governor of the state of Louisiana, the attorney general of the state of Louisiana, the speaker of the House of Representatives, the president of the Senate and the State Register of the adoption of this Emergency Rule and reasons for adoption.

Effective Date and Duration

1. The effective date for this emergency rule shall be May 23, 2000.

2. The Emergency Rule herein adopted as a part thereof, shall remain effective for a period of not less than 120 days hereafter, or until the adoption of the final version of an

amendment to Statewide Order No. 29-B as noted herein, whichever occurs first.

Philip N. Asprodites
Commissioner of Conservation

0006#059

DECLARATION OF EMERGENCY

**Department of Public Safety and Corrections
Office of the State Fire Marshal**

Manufactured Housing
(LAC 55:V.521, 535 and 543)

Act 92 of the First Extraordinary Session of 2000 amended and reenacted R.S. 51:912.21 and R.S. 51:912.27 to provide for installation permit stickers to prevent unlicensed persons from installing manufactured homes and to provide penalties for unlicensed installation. The present Emergency Rule is intended to accompany Act 92 of the First Extraordinary Session, which is effective June 6, 2000. The effective date for this Emergency Rule is June 6, 2000.

Title 55

PUBLIC SAFETY

Part V. Fire Protection

Chapter 5. Manufactured Housing (Installation)

§521. Definitions

*Installation Permit*Ca permit issued by the fire marshal to a licensed installer or the homeowner who must certify that the home is in compliance with this part.

*Installation Permit Sticker*Ca sticker issued by the fire marshal, along with an installation permit, which is to be affixed to the home to signify that the home is in compliance with R.S. 51:912.22. Installation standards for manufactured homes and mobile homes.

*Transporter*Can individual who transports the manufactured home or mobile home to the site of installation but does not perform the blocking and/or anchoring of the home.

AUTHORITY NOTE: Promulgated in accordance with R.S.51:911.32.A(2).

HISTORICAL NOTE: Promulgated by Department of Public Safety and Corrections, Office of the State Fire Marshal, LR 24:695 (April 1998), amended LR 26:

§535. Monthly Report

A. An installer shall submit a monthly installation report to the Fire Marshal by the 20th day of the following month on forms provided by the fire marshal and provide all information requested thereon.

B. - C. ...

AUTHORITY NOTE: Promulgated in accordance with R.S.51:911.32.A(2).

HISTORICAL NOTE: Promulgated by Department of Public Safety and Corrections, Office of the State Fire Marshal, LR 24:697 (April 1998), amended LR 26:

§543. License Suspension or Revocation; Imposition of Civil Penalties

A. - B.4.g. ...

C. The schedule of fines shall be as follows:

1. Performance of any installation services under "Uniform Standards Code for mobile homes and manufactured housing" by a non-licensed person excluding a homeowner:

- \$250 1st
- \$500 2nd
- \$1,000 3rd.

2. Failure to provide a valid installer's license to a Fire Marshal Inspector upon demand at jobsite:

- \$100 1st 2nd 3rd.

3. Failure to install the permit sticker on the mobile home and manufactured home:

- \$100 1st 2nd 3rd.

4. Installation commencement or completion of the installation without a permit sticker:

- \$100 1st
- \$250 2nd
- \$500 3rd.

5. Unauthorized transfer improper transfer of permit sticker:

- \$1,000.

6. Soliciting or contracting for service by non licensed installer:

- \$250 1st
- \$500 2nd
- \$1,000 3rd.

7. Failure to notify Fire Marshals Office of lost or damaged permit sticker:

- \$100 1st 2nd 3rd.

8. False statement by homeowner as to identity of installer:

- \$1,000.

9. False statement by dealer as to identity of installer:

- \$1,000.

10. Installation of home on improper site:

- \$250.

AUTHORITY NOTE: Promulgated in accordance with R.S.51:911.32.A(2).

HISTORICAL NOTE: Promulgated by Department of Public Safety and Corrections, Office of the State Fire Marshal., LR 24:697 (April 1998), amended LR 26:

Nancy VanNortwick
Undersecretary

0006#073

DECLARATION OF EMERGENCY

**Department of Wildlife and Fisheries
Wildlife and Fisheries Commission**

Commercial King Mackerel Season
and Possession Limit-2000

In accordance with the emergency provisions of R.S. 49:953(B), the Administrative Procedure Act, R.S. 49:967 which allows the Wildlife and Fisheries Commission to use emergency procedures to set finfish seasons and all rules and regulations pursuant thereto by emergency rule, and R.S. 56:6(25)(a) and 56:326.3 which provide that the Wildlife and Fisheries Commission may set seasons for saltwater finfish; the Wildlife and Fisheries Commission hereby sets

the following season and trip limit for the commercial harvest of king mackerel in Louisiana state waters:

The commercial season for king mackerel in Louisiana state waters will open at 12 p.m., July 1, 2000, and remain open until the allotted portion of the commercial king mackerel quota for the western Gulf of Mexico has been harvested or projected to be harvested; there will be a possession limit of 3,000 pounds.

The commission grants authority to the secretary of the Department of Wildlife and Fisheries to close the commercial king mackerel season in Louisiana state waters when he is informed by the National Marine Fisheries Service (NMFS) that the commercial king mackerel quota for the western Gulf of Mexico has been harvested or is projected to be harvested, such closure order shall close the season until 12 p.m., July 1, 2001, which is the date expected to be set for the re-opening of the 2001 commercial king mackerel season in Federal waters.

The commission also authorizes the secretary to open an additional commercial king mackerel season in Louisiana state waters if he is informed that NMFS has opened an additional season and to close such season when he is

informed that the commercial king mackerel quota for the western Gulf of Mexico has been filled, or is projected to be filled.

Nothing herein shall preclude the legal harvest of king mackerel by legally licensed recreational fishermen. Effective with any closure, no person shall commercially harvest, transport, purchase, barter, trade, sell or attempt to purchase, barter, trade or sell king mackerel. Effective with the closure, no person shall possess king mackerel in excess of a daily bag limit. Provided however that fish in excess of the daily bag limit which were legally taken prior to the closure may be purchased, possessed, transported, and sold by a licensed wholesale/retail dealer if appropriate records in accordance with R.S. 56:306.5 and R.S. 56:306.6 are properly maintained. Those other than wholesale/retail dealers may purchase such fish in excess of the daily bag limit from wholesale/retail dealers for their own use or for sale by a restaurant as prepared fish.

Thomas M. Gattle, Jr.
Chairman

0006#071