

Emergency Rules

DECLARATION OF EMERGENCY

Department of Agriculture and Forestry Office of Agriculture and Environmental Sciences

Application of Azinphos-methyl (LAC 7:XXIII.143)

In accordance with the Administrative Procedures 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 use of the pesticide, azinphos-methyl.

Azinphos-methyl is an essential pesticide in the control of sugarcane pests. Without its use a substantial portion of the sugarcane crop in Louisiana could be damaged by pests. Because of its effectiveness as a pesticide Azinphos-methyl poses a substantial threat to the environment if it is misapplied. It was the cause of substantial fish kills in 1991. Because of its substantial threat to the environment the Department has severely limited the use of Azinphos-methyl, even though its label allows a wider use. The application of Azinphos-methyl in accordance with its label, but inconsistent with the Department's rules and regulation and the misuse of this pesticide poses an imminent peril to the public health, safety and welfare and to the environment, especially if it gets into the waterways of this state.

The Department has, therefore, determined that these emergency rules are necessary in order to implement a monitoring program and registration and permitting requirements during the current crop year. Information will be gathered to determine whether the effectiveness of this chemical outweighs any potential risk to the public or the environment. The rule becomes effective upon signature and will remain in effect 120 days.

Title 7

AGRICULTURE AND ANIMALS

Part XXIII. Pesticide

Chapter 1. Advisory Commission on Pesticides

Subchapter I. Regulations Governing Application of Pesticides

§143. Restrictions on Application of Certain Pesticides

A. - M. ...

N. 1999 Regulations Governing Application of Azinphos-methyl

1. Registration Requirements

a. The Commissioner hereby declares that prior to making any aerial application of azinphos-methyl to sugarcane, the aerial owner/operator must first register such intent by notifying the Division of Pesticides and Environmental Programs ("DPEP") in writing.

b. The Commissioner hereby declares that prior to selling azinphos-methyl to be applied on sugarcane, the dealer must first register such intent by notifying the DPEP in writing.

c. The Commissioner hereby declares that prior to making recommendation for application of azinphos-methyl to sugarcane, the agricultural consultant must first register such intent by notifying the DPEP in writing.

2. Grower Liability

Growers of sugarcane shall not force or coerce applicators to apply azinphos-methyl to their crops when the applicators, conforming to the Louisiana Pesticide Laws and Rules and Regulations or to the pesticide label, deem it unsafe to make such applications. Growers found to be in violation of this section shall forfeit their right to use azinphos-methyl on their crops, subject to appeal to the Advisory Commission on Pesticides.

3. Azinphos-methyl Application Restriction

a. Application of Azinphos-methyl on sugarcane is limited to one (1) application per season.

b. Do not apply by ground within 25 feet, or by air within 150 feet of lakes; reservoirs; rivers; permanent streams, marshes or natural ponds; estuaries and commercial fish farm ponds.

4. Procedures for Permitting Applications of Azinphos-methyl

a. Prior to any application or recommendation for application of Azinphos-methyl, approval shall be obtained in writing from the Louisiana Department of Agriculture and Forestry ("LDAF"). Such approval is good for five (5) days from the date issued. Approval may be obtained by certified agricultural consultants from the DPEP. Where farmers do not use agricultural consultants, approval must be obtained by the private applicator or aerial applicators employed by such farmers from DPEP.

b. The determination as to whether a permit for application is to be given shall be based on criteria including but not limited to:

- i. weather patterns and predictions;
- ii. soil moisture;
- iii. propensity for run-off;
- iv. drainage patterns;
- v. quantity of acreage to be treated;
- vi. extent and presence of vegetation in the buffer zone between application site and water body;
- vii. water monitoring results;
- viii. targeted pest must exceed the following prescribed thresholds:

(a). Yellow sugarcane aphid, 20 - 25 live aphids per leaf or sugarcane borer - a three-fold threshold (15%) i.e. 1 or more live borers in 15 different stalks per 100 stalks;

ix. Azinphos-methyl total acreage target shall not exceed 80,000 acres; and

x. any other relevant data.

5. Monitoring of Azinphos-methyl

a. Agricultural consultants registered to recommend azinphos-methyl on sugarcane shall report daily to the DPEP, on forms prescribed by the Commissioner, all

recommendations for applications of azinphos-methyl to sugarcane.

b. Certified applicators registered to apply azinphos-methyl on sugarcane shall maintain a daily record of azinphos-methyl applications and provide a summary to the DPEP within 60 days of the end of the application season.

6. Determination of Appropriate Action

a. Upon determination by the Commissioner that a threat or reasonable expectation of a threat to human health or to the environment exists, he may consider:

- i. stop orders for use, sales, or application;
- ii. label changes;
- iii. remedial or protective orders;
- iv. any other relevant remedies.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:3203.

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 25:

Bob Odom
Commissioner

9906#031

DECLARATION OF EMERGENCY

Student Financial Assistance Commission Office of Student Financial Assistance

Student Tuition and Revenue Trust (START Saving)
Program (LAC 28:VI.107, 301, 307)

The Louisiana Tuition Trust Authority (LATTA) is exercising the emergency provisions of the Administrative Procedure Act [R.S. 49:953(B)] to amend rules of the Student Tuition Assistance and Revenue Trust (START Saving) Program (R.S. 17:3091-3099.2).

The emergency rules are necessary to allow the Louisiana Office of Student Financial Assistance and 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 11, 1999, and shall remain in effect for the maximum period allowed under the Administrative Procedure Act.

Title 28 EDUCATION

Part VI. Student Financial Assistance—Higher Education Savings

Chapter 1. General Provisions

Subchapter A. Student Tuition Trust Authority

§107. Applicable Definitions

Tuition Assistance Grant—a payment allocated to an education assistance account, on behalf of the beneficiary of the account, by the state. The grant amount is calculated based upon the account owner's annual federal adjusted gross income and total annual deposits of principal. The grant and interest earned may only be used to pay the beneficiary's tuition, or portion thereof, at an eligible educational institution.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:3091-3099.2.

HISTORICAL NOTE: Promulgated by the Tuition Trust Authority, Office of Student Financial Assistance, LR 23:712 (June 1997), amended LR 24:1268 (July 1998), LR 25:

Chapter 3. Education Savings Account

§301. Education Assistance Accounts (EAA)

A. ...

B. Program Enrollment Period. An account may be opened and an eligible beneficiary may be enrolled at any time during the calendar year. Tuition Assistance Grants shall be allocated only to those accounts which have been opened by November 1 of the calendar year preceding the allocation.

C. - J. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:3091-3099.2.

HISTORICAL NOTE: Promulgated by the Tuition Trust Authority, Office of Student Financial Assistance, LR 23:713 (June 1997), amended LR 24:1269 (July 1998), LR 25:

§307. Allocation of Tuition Assistance Grants

A. - D. ...

E.1. - 3. ...

4. have an account owner who is a resident of the State of Louisiana, as defined in §107 in the year for which a tuition assistance grant is disbursed.

F. - G. ...

H. Restriction on Use of Tuition Assistance Grants

1. Tuition assistance grants, and any interest which may accrue thereon, may only be expended in payment of the beneficiary's tuition, or a portion thereof, at an eligible educational institution.

2. Tuition assistance grants may not be used to pay for any qualified higher education expenses other than tuition.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:3091-3099.2.

HISTORICAL NOTE: Promulgated by the Tuition Trust Authority, Office of Student Financial Assistance, LR 23:715 (June 1997), amended LR 24:1271 (July 1998), LR 25:

Jack L. Guinn
Executive Director

9906#019

DECLARATION OF EMERGENCY

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

Tuition Opportunity Program for Students
(TOPS) (LAC 28:IV.301, 703, 803, 2115)

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 (R.S. 17:3042.1 and R.S. 17:3048.1).

The emergency rules are necessary 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 11, 1999, and shall remain in effect for the maximum period allowed under the Administrative Procedure Act.

**Title 28
EDUCATION**

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

Chapter 3. Definitions

§301. Definitions

Eligible Non-Louisiana High School and Eligible Out of State High School—see §1701.A.3 and 1701.A.4, respectively.

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 24:632 (April 1998), amended LR 24:1898 (October 1998), LR 25:

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

§703. Establishing Eligibility

A. To establish eligibility for a TOPS Opportunity, Performance or Honors Award, the student applicant must meet all of the following criteria:

1. - 5.a. ...

i. at the time of high school graduation, an applicant must have successfully completed 16.5 units of high school course work constituting a core curriculum as follows:

Units	Course
1	English I
1	English II
1	English III
1	English IV
1	Algebra I (one unit) or Applied Algebra 1A and 1B (two units)
1	Algebra II
1	Geometry, Trigonometry, Calculus or Comparable Advanced Math
1	Biology I
1	Chemistry I
1	Earth Science, Environmental Science, Physical Science, Biology II, Chemistry II or Physics, Physics II or Physics for Technology
1	American History
1	World History, World Culture, Western Civilization or World Geography
1	Civics and Free Enterprise (one unit combined) or Civics (one unit, nonpublic)
1	Fine Arts Survey; (or substitute two units Performance courses in Music, Dance and/or Theater; or two units of Studio Art or Visual Art; or one elective from among the other subjects listed in this core curriculum)
2	In the Same Foreign Language (one unit or credit for three or more hours of college foreign language for students graduating from high school during the 1996-97 and 1997-98 school years).
½	Computer Science, Computer Literacy or Business Computer Applications (or substitute at least one-half unit of an elective course related to computers that is approved by the State Board of Elementary and Secondary Education; (or substitute at least one-half unit of an elective from among the other subjects listed in this core curriculum)

or

b. graduate from a BESE approved, provisionally-approved or probationally-approved public or nonpublic Louisiana high school or eligible non-Louisiana high school as defined in §1701.A.3 and have completed the core curriculum defined in §703.A.5.a.i, unless the following exceptions apply:

i. ...

ii. for a Disabled Student or an Exceptional Child, as defined in §301, who have met the criteria set forth in §2115, one or more core units are waived;

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 24:632 (April 1998), amended LR 24:1898 (October 1998), LR 24: 2237 (December 1998), LR 25:

**Chapter 8. TOPS-TECH Award
§803. Establishing Eligibility**

A.1 - 6.b. ...

c. for a student who is a Disabled Student or an Exceptional Child, as defined in §301, one or more core units may be waived if the student has met the criteria set forth in §2115;

A.1 - 7.a. ...

b. if qualifying under §703.A.5.b, c, or d, the state's reported prior year average ACT composite score, rounded, plus 3 points, but never less than 22; and

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,

Chapter 21. Miscellaneous Provisions and Exceptions
§2115. Procedures for Disabled Students and Exceptional Children

A. As provided for in §703.A.5.b.ii, a core curriculum course shall be waived for a student who is a Disabled Student or an Exceptional Child, as defined in §301, whose school certifies that it has the following documentation:

1. For a student claiming the status of a Disabled Student:

a. a written diagnosis from a person licensed or certified to diagnose the disability of the student, which diagnosis specifies the need for special accommodation by the student's high school; and

b. a written statement from the principal of the high school that a plan of accommodation under Section 504 of the Rehabilitation Act of 1973 (§504 Plan) has been established, and the high school was unable to provide the special accommodation, or, if the special accommodation was provided by the high school, the failure to complete the specified core curriculum course was due solely to the student's diagnosed disability.

2. For a student claiming the status of an Exceptional Child:

a. a written Individual Education Program (IEP) in accordance with R.S. 17:1941 et seq. and Louisiana Department of Education Bulletin 1706; and

b. a written statement from the principal of the high school that the failure to complete the specified core curriculum course was due solely to the student's exceptionality.

B. For Disabled Students graduating prior to the 1999-2000 high school academic year and who are requesting a waiver of a core curriculum course based upon their status as a Disabled Student, those students must provide the documentation provided in §2115.A.1, above, however, those students need not establish the existence of a 504 Plan.

C. A school official must obtain the consent from the student's parent or legal guardian, as required by law, prior to the release of information concerning a student who is requesting a waiver of a core course by reason of that student being a Disabled Student or an Exception Child.

D. If a core curriculum course is waived based upon the determination that a student's disability or exceptionality, then the grade achieved for that course will not be included in the determination of the student's grade point average for purposes of qualifying for a TOPS award.

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 25:

Jack L. Guinn
Executive Director

9906#003

DECLARATION OF EMERGENCY

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

EPO Plan Document

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 La R.S. 49:953(B).

The text of this emergency rule may be viewed in its entirety at the office of Board of Trustees for the State Employees Group Benefits Program, 5825 Florida Boulevard, Second Floor, Baton Rouge, Louisiana, or the Office of the State Register, 1051 N. Third Street, Baton Rouge, Louisiana.

The Board finds that it is necessary to adopt an entire new Plan Document for the State Employees Group Benefits Program, designating it as the EPO Plan Document. The EPO Plan Document sets forth the terms and conditions pursuant to which eligibility and benefit determinations are made with regard to the self-insured health and accident benefits plan, designated as the EPO Plan, to be implemented July 1, 1999, for state employees and their dependents pursuant to R.S. 42:851 et seq. Failure to adopt this rule on an emergency basis will result in a financial impact adversely affecting 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, 1999, and shall remain in effect for a maximum of 120 days or until promulgation of the final Rule, whichever occurs first.

Jack W. Walker, Ph.D.
Chief Executive Officer

9906#037

DECLARATION OF EMERGENCY

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

Fee Schedule

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, and in order to comply with R.S. 42:851.5 which requires the Board to adopt and promulgate a schedule of maximum fees for medical and surgical services and for professional services provided in hospitals, the Board of Trustees hereby invokes the Emergency Rule provisions of La R.S. 49:953(B).

Failure to adopt this rule on an emergency basis will result in a financial impact adversely affecting 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, 1999, and shall remain in effect for a maximum of 120 days or until promulgation of the final Rule, whichever occurs first.

The maximum fees for medical and surgical services and for professional services provided in hospitals, when such medical, surgical, or professional services are rendered by providers who have not entered into contracts with the State Employees Group Benefits Program establishing the allowed charges for the services, shall be the 60th percentile of MDR's MediCode allowed charge. In the event that an allowed fee for the CPT code is not found in MDR's Medicode schedule, the maximum fee will be 75 percent of the provider's billed charge.

Jack W. Walker, Ph.D.
Chief Executive Officer

9906#039

DECLARATION OF EMERGENCY

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

PPO Plan Document

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, and in accordance with R.S. 40:2204(D), the Board of Trustees hereby invokes the Emergency Rule provisions of La R. S. 49:953(B).

The text of this emergency rule may be viewed in its entirety at the office of the Board of Trustees for State Employees Group Benefits Program, 5825 Florida Boulevard, Second Floor, Baton Rouge, Louisiana, and the Office of the State Register, 1051 N. Third Street, Baton Rouge, Louisiana.

The Board finds that it is necessary to repeal the previous Plan Document and promulgate the new Plan Document for the State Employees Group Benefits Program, designating it as the PPO Plan Document. The PPO Plan Document sets forth the terms and conditions pursuant to which eligibility and benefit determinations are made with regard to the self-insured health and accident benefits plan, designated as the

PPO Plan, effective July 1, 1999, provided for state employees and their dependents pursuant to R.S. 42:851 et seq. Failure to adopt this rule on an emergency basis will result in a financial impact adversely affecting 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 January 1, 1999, and shall remain in effect for a maximum of 120 days or until promulgation of the final Rule, whichever occurs first.

Jack W. Walker, Ph.D.
Chief Executive Officer

9906#038

DECLARATION OF EMERGENCY

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

Disproportionate Share Hospital Payment Methodologies

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing will adopt the following emergency rule in the Medical Assistance Program as authorized by LA. R.S. 46:153 and pursuant to Title XIX of the Social Security Act. This rule is in accordance with the Administrative Procedure Act, R.S. 49:953B(1) et seq. and shall be in effect for the maximum period allowed under the 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 March 20, 1998 governing the disproportionate share payment methodologies for hospitals (*Louisiana Register*, Volume 24, Number 3). This rule was adopted pursuant to Act 19 of 1998 (General Appropriations Act) and Act 1485 of 1997. Act 19 provides for different treatment of disproportionate share funds for uncompensated costs in small non-state operated local government hospitals and private rural hospitals with 60 beds or less. Act 1485 allows rural hospitals to meet less stringent criteria in order to receive the maximum disproportionate share funding available in accordance with the amounts appropriated by the Legislature and to the extent authorized by federal law.

The Department adopted an emergency rule effective March 1, 1999 (*Louisiana Register*, Volume 25, No. 2) which increased the disproportionate share payment for large public non-state rural hospitals for state fiscal year 1999 only, by allowing these qualifying hospitals to certify uncompensated care expenditures as match and receive the equivalent of Federal Financial Participation (FFP) in the same manner as small public non-state rural hospitals. This payment is in lieu of a lower payment that these hospitals would have otherwise been paid under the disproportionate share payment methodologies for other hospitals receiving

disproportionate share payments contained in the March 20, 1998 rule.

In addition, Senate Concurrent Resolution No. 48 directs the Department to amend the date by which hospitals qualify for status as small rural hospitals. Therefore, Item III.B.1.a) of the May 20, 1999 rule is amended to modify the date by which hospitals had no more than sixty hospital beds to October 1, 1994 (*Louisiana Register*, Volume 25, Number 5).

This action is necessary to enhance federal revenues and is in accordance with the Joint Legislative Budget Committee's directive of October 16, 1998 to change the disproportionate share payment methodology for large public non-state rural hospitals for state fiscal year 1999. It is estimated that the expenditures necessary to implement this rule will be \$3,236,885 in federal funds only for state fiscal year 1999. This rule will not require the expenditure of any additional state general funds.

Emergency Rule

Effective June 21, 1999, the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing establishes an additional disproportionate share hospital group designed for state fiscal year 1999 only, for large public non-state rural hospitals having at least twenty-five percent (25%) Medicaid inpatient days utilization, by allowing these qualifying hospitals to certify uncompensated care expenditures as match and receive the equivalent of Federal Financial Participation (FFP) in the same manner as small public non-state rural hospitals. Qualifying hospitals must meet qualifying criteria contained in II. A, B, or C and E in the May 20, 1999 rule. The provisions contained in the May 20, 1999 rule otherwise remain intact.

A large public non-state rural hospital is a hospital owned by a local government that is not included in section III.A or B of the May 20, 1999 rule and did not qualify for DSH payment in accordance with the March 1, 1999 emergency rule and meets the following criteria:

(1) is located in a parish with a population of less than fifty thousand, or

(2) is located in a municipality with a population of less than twenty thousand, and

(3) has Medicaid inpatient days utilization rate in excess of 25 percent for the hospital's fiscal year end cost report ending during the period April 1, 1997 through March 31, 1998. The Medicaid inpatient days utilization percentage is derived from Medicaid reported days per the hospital's fiscal year end cost report ending during the period April 1, 1997 through March 31, 1998. Non-covered Medicaid days or days for which another payor is primary to Medicaid coverage may not be included in order to qualify for this payment. This designation includes distinct-part psychiatric units, but excludes long-term, rehabilitation, or free-standing psychiatric hospitals.

Disproportionate share payments for state fiscal year 1999 to each qualifying large public non-state rural hospital are equal to that hospital's pro rata share of uncompensated costs for all hospitals meeting these criteria for the cost reporting period ended during the period April 1, 1997 through March 31, 1998 multiplied by the amount set for this pool. If the cost reporting period is not a full period (twelve months),

actual uncompensated cost data for the previous cost reporting period may be used on a pro rata basis to equate to a full year.

A pro rata adjustment necessitated by the conditions specified in section I.B of the May 20, 1999 rule for hospitals described in this section will be calculated using the ratio determined by dividing the qualifying hospital's uncompensated costs by the uncompensated costs for all qualifying large public non-state rural hospitals, then multiplying by the amount of disproportionate share payments calculated in excess of the federal disproportionate share allotment or the state disproportionate share appropriated amount.

In addition Item III.B.1.a) of the May 20, 1999 rule is modified to read "had no more than sixty hospital beds as of October 1, 1994; and."

Interested persons may submit written comments to the following address: Thomas D. Collins, 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

9906#041

DECLARATION OF EMERGENCY

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

Durable Medical Equipment Program—Augmentative and Alternative Communication (AAC) Devices

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing adopts the following emergency rule as authorized by LA. R.S. 46:153 and pursuant to Title XIX of the Social Security Act. 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 Service Financing currently provides coverage for durable medical equipment under the Medicaid Program. All medical equipment, appliances and supplies must be prior authorized in order to determine medical necessity. Currently, augmentative and alternative communication devices are approved for prior authorization for rental or purchase under the durable medical equipment program according to specific criteria set forth in the Medicaid Eligibility Manual. However, only recipients under the age of 21 are eligible to receive these devices (*Louisiana Register*, Volume 22, No. 5). The Department has determined that it is necessary to amend the current rule regarding prior authorization of augmentative

communication devices by removing the age restriction for rental or purchase by eligible recipients, which will ensure availability to recipients of all ages, and by expanding the criteria for consideration of these devices for prior authorization. This change is necessary to avoid imminent peril to the public health, safety or welfare. It is estimated that implementation of this rule will increase expenditures in the Durable Medical Equipment Program by approximately \$60,250 for state fiscal year 1999-2000.

Emergency Rule

Effective June 5, 1999 and after, the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing removes the age restriction for rental or purchase of augmentative and alternative communication devices by eligible recipients and expands the criteria for consideration of these devices for prior authorization under the Durable Medical Equipment Program.

I. Definitions

Augmentative and Alternative Communications (AAC) Devices—electronic or non-electronic aids, devices, or systems that assist a Medicaid beneficiary to overcome or ameliorate (reduce to the maximum degree possible) the communication limitations that preclude or interfere with meaningful participation in current and projected daily activities. Examples of AAC devices include:

1. communication boards or books, speech amplifiers, and electronic devices that produce speech and/or written output;
2. devices that are constructed for use as communication devices as well as systems that may include a computer, when the primary use of the computer serves as the beneficiary's communication device; and
3. related components and accessories, including software programs, symbol sets, overlays, mounting devices, switches, cables and connectors, auditory, visual, and tactile output devices, printers, and necessary supplies, such as rechargeable batteries.

Meaningful Participation—effective and efficient communication of messages in any form the beneficiary chooses.

Speech-Language Pathologist—an individual who has:

1. a certificate of clinical competence from the American Speech-Language-Hearing Association;
2. completed the equivalent educational requirements and work experience necessary for the certificate; or
3. completed the academic program and is acquiring supervised work experience to qualify for the certificate.

II. General Provisions

Consideration shall be given for Medicaid reimbursement for AAC devices for Medicaid recipients of all ages if the device is considered medically necessary, the recipient has the ability to physically and mentally use a device and its accessories, and if any one or more of the following criteria is met.

A. Medical Necessity Determinations

1. The following medically necessary conditions shall be established for recipients who/whose:
 - a. have a diagnosis of a significant expressive or receptive (language comprehension) communication impairment or disability;

- b. impairment or disability either temporarily or permanently causes communication limitations that preclude or interfere with the recipient's meaningful participation in current and projected daily activities; and

- c. had a speech-language pathologist (and other health professional, as appropriate):

- i. perform an assessment and submit a report pursuant to the criteria set forth in sub-section C. Assessment/Evaluation; and

- ii. recommend speech-language pathology treatment in the form of AAC devices and services; and

- iii. document the mental and physical ability of a recipient to use, or learn to use, a recommended AAC device and accessories for effective and efficient communication; and

- iv. prepare a speech-language pathology treatment plan that describes the specific components of the AAC devices and the required amount, duration, and scope of the AAC services that will overcome or ameliorate communication limitations that preclude or interfere with the beneficiary's meaningful participation in current and projected daily activities; and

- d. requested AAC devices constitute the least costly, equally effective form of treatment that will overcome or ameliorate communication limitations that preclude or interfere with the beneficiary's meaningful participation in current and projected daily activities.

2. The following are additional general principles relating to medical necessity determinations for AAC devices.

- a. The cause of the recipient's impairment or disability (e.g., congenital, developmental, or acquired), or the recipient's age at the onset of the impairment or disability, are irrelevant considerations in the determination of medical need.

- b. Recipient participation in other services or programs (e.g., school, early intervention services, adult services programs, employment) is irrelevant to medical necessity determination for AAC devices.

- c. No cognitive, language, literacy, prior treatment, or other similar prerequisites must be satisfied by a recipient in advance of a request for AAC devices.

- d. The unavailability of an AAC device, component, or accessory for rental will not serve as the basis for denying a prior approval request for that device, component, or accessory.

3. When the medical necessity cannot be determined for an AAC device pursuant to the criteria stated above and to the information submitted in support of a prior authorization request, the following steps shall be taken.

- a. If Medicaid determines that any essential information in establishing medical necessity for the AAC device is incomplete, or has been omitted in the prior authorization request as required in sub-section C. Assessment/Evaluation, Medicaid will make direct contact with the speech-language pathologist who conducted the assessment for the recipient. Medicaid will then identify the specific, additional information that is needed and request that the additional information be submitted; and/or

- b. If Medicaid determines that an additional interpretation of information in the prior authorization

request is needed by the medical reviewer in establishing medical necessity for an AAC device, Medicaid will seek the advice of speech language pathologist(s) with extensive AAC experience recommended to Medicaid by the American Speech Language & Hearing Association (ASHA), the United States Society for Augmentative & Alternative Communication (USSAAC), and/or RESNA, who shall provide the required interpretation.

i. Only one request for additional information by direct contact with the speech/language pathologist and/or only one interpretation will be made per prior authorization request;

ii. If additional information requested by Medicaid from the speech/language pathologist who conducted the assessment, or if an additional interpretation requested from a consulting speech-language pathologist, is not received by Medicaid within the 25 day time frame required of Medicaid for a prior authorization determination, a decision will be made by the medical reviewer for Medicaid based on the information that has been submitted with the prior authorization request and on the reviewer's interpretation of that information. If the additional information or additional interpretation is provided at a later time, another request will need to be submitted by the provider to the Prior Authorization Unit for additional review.

B. Assessment/Evaluation

1. An assessment, or evaluation, of individual functioning and communication limitations that preclude or interfere with meaningful participation in current and projected daily activities must be completed by a speech-language pathologist with input from other health professionals, (e.g., occupational therapists and rehabilitation engineers) based on the recommendation of the speech language pathologist and a physician's prescription, as appropriate.

2. Requests for AAC devices must include a description of the speech-language pathologist's qualifications, including a description of the speech-language pathologist's AAC services training and experience.

3. An assessment (augmentative & alternative communication evaluation) must include the following information about the recipient:

a. Identifying Information

i. name;

ii. Medicaid identification number;

iii. date of the assessment;

iv. medical and neurological; diagnoses (primary, secondary, tertiary);

v. significant medical history;

vi. mental or cognitive status; and

vii. educational level and goals;

b. Sensory Status

i. vision and hearing screening (no more than one year prior to AAC evaluation);

ii. if vision screening is failed, a complete vision evaluation;

iii. if hearing screening is failed, a complete hearing evaluation;

iv. description of how vision, hearing, tactile, and/or receptive communication impairments or disabilities affect expressive communication;

c. Postural, Mobility, & Motor Status

i. gross motor assessment;

ii. fine motor assessment;

iii. optimal positioning;

iv. integration of mobility with AAC devices;

v. beneficiary's access methods (and options) for AAC devices;

d. Current Speech, Language, & Expressive Communication Status

i. identification and description of the beneficiary's expressive or receptive (language comprehension) communication impairment diagnosis;

ii. speech skills and prognosis;

iii. language skills and prognosis;

iv. communication behaviors and interaction skills (i.e., styles and patterns);

v. functional communication assessment, including ecological inventory;

vi. indication of past treatment, if any;

vii. description of current communication strategies, including use of an AAC device, if any;

NOTE: If an AAC device is currently used, describe the device, when and by whom it was previously purchased, and why it is no longer adequate for communication needs).

e. Communication Needs Inventory

i. description of beneficiary's current and projected communication needs;

ii. communication partners and tasks, including partners' communication abilities limitations, if any;

iii. communication environments and constraints which affect AAC device selection and/or features (e.g., verbal and/or visual output and/or feedback; distance communication needs);

f. Summary of Communication Limitations.

Description of the communication limitations that preclude or interfere with meaningful participation in current and projected daily activities (i.e., why the beneficiary's current communication skills and behaviors prevent meaningful participation in the beneficiary's current and projected daily activities);

g. AAC Devices Assessment Components

i. vocabulary requirements;

ii. representational system(s);

iii. display organization and features;

iv. rate enhancement techniques;

v. message characteristics, speech synthesis, printed output, display characteristics, feedback, auditory and visual output;

vi. access techniques and strategies; and

vii. portability and durability concerns, if any;

h. Identification of AAC Devices Considered for Beneficiary

i. identification of the significant characteristics and features of the AAC devices considered for the beneficiary;

ii. identification of the cost of the AAC devices considered for the beneficiary (including all required

components, accessories, peripherals, and supplies, as appropriate);

i. AAC Device Recommendation

i. identification of the requested AAC devices including all required components, accessories, software, peripheral devices, supplies, and the device vendor;

ii. identification of the beneficiary's and communication partner's AAC devices preference, if any;

iii. assessment of the beneficiary's ability (physically and mentally) to use, or to learn to use, the recommended AAC device and accessories for effective and efficient communication;

iv. justification stating why the recommended AAC device (including description of the significant characteristics, features, and accessories) is better able to overcome or ameliorate the communication limitations that preclude or interfere with the beneficiary's meaningful participation in current and projected daily activities, as compared to the other AAC devices considered;

v. justification stating why the recommended AAC device (including description of the significant characteristics, features, and accessories) is the least costly, equally effective, alternative form of treatment to overcome or ameliorate the communication limitations that preclude or interfere with the beneficiary's meaningful participation in current and projected daily activities;

j. Treatment Plan and Follow-Up

i. description of short term communication goals (e.g., 6 months);

ii. description of long term communication goals (e.g., 1 year);

iii. assessment criteria to measure beneficiary's progress toward achieving short and long term communication goals;

iv. description of amount, duration, and scope of AAC services required for the beneficiary to achieve short and long term communication goals;

v. identification and experience of AAC service provider responsible for training (these service providers may include, e.g.: speech-language pathologists, occupational therapists, rehabilitation engineers, the beneficiary's parents, teachers and other service providers);

k. Summary of Alternative Funding Source for AAC Device;

i. description of availability or lack of availability, of purchase of AAC device through other funding sources.

C. Trial Use Periods

1. In instances where the appropriateness of a specific AAC device is not clear, a trial use period for an AAC device may be recommended (although it is not required) by the speech-language pathologist who conducts the AAC evaluation.

2. Prior authorization for rental of AAC devices shall be approved for trial use periods when the speech-language pathologist prepares a request consistent with the established requirements. The reasons for a trial use period request include, but are not limited to:

a. the characteristics of the recipient's communication limitations;

b. lack of familiarity with a specific AAC device; and

c. whether there are sufficient AAC services to support the beneficiary's use of the AAC device, or other factors.

3. If the speech-language pathologist seeks a trial use period, s/he must prepare a trial use period request that includes the following information:

a. the duration of the trial period;

b. the speech-language pathologist information and the beneficiary information as required in B. Assessment/Evaluation;

c. the AAC device to be examined during the trial period, including all the necessary components (e.g., mounting device, software, switches, or access control mechanism);

d. the identification of the AAC services provider(s) who will assist the beneficiary during the trial period;

e. the identification of the AAC services provider(s) who will assess the trial period; and

f. the evaluation criteria, specific to the beneficiary, that will be used to determine the success or failure of the trial period.

4. Trial use period requests must request Medicaid funding for the rental of all necessary components and accessories of the AAC device. If an accessory necessary for the trial use of a device by a recipient is not available for rental, but the communication device is available for rental for trial use, Medicaid may consider the purchase of the accessory for the trial use of the communication device by that recipient.

5. Trial periods may be extended and/or different AAC devices provided, when requested by the speech-language pathologist responsible for evaluating the trial use period.

6. Results of trial use periods must be included with any subsequent request for prior authorization of purchase of the AAC device. Recommendations for the purchase of an AAC device, as a result of a trial use period of the device, must clearly indicate the patient's ability to use the device during the trial period.

D. Repairs

1. Medicaid will cover repairs to keep AAC devices, accessories, and other system components in working condition. Medicaid coverage for repairs will include the cost of parts, labor, and shipping, when not otherwise available without charge pursuant to a manufacturer's warranty.

a. Providers of AAC devices are expected to comply with the Louisiana New Assistive Devices Warranty Act.

i. One of the provisions of this law is that all persons who make, sell, or lease assistive devices, including AAC devices, must provide those who buy or lease the equipment with a warranty which lasts at least one year from the time the equipment is delivered to the customer.

ii. If, during the warranty period, the equipment does not work, the manufacturer or dealer must make an attempt to repair the equipment.

b. Medicaid additionally requires providers to provide the recipient with a comparable, alternate AAC device while repairing the recipient's device during a warranty period.

c. Medicaid coverage may be provided for rental of an alternate AAC device during a repair period after expiration of the warranty.

d. Medicaid will not cover repairs, or rental of a loaner device, when repairs are made during a warranty period.

2. When a device is received by the provider for the purpose of repair, the provider will conduct an assessment of the device to determine whether it can be repaired, and if so, prepare a written estimate of the parts, labor, and total cost of the repair, as well as the effectiveness (i.e., estimated durability) of the repair. If the manufacturer or provider concludes that the device is not repairable and the replacement device is needed, written notice will be provided to the recipient.

3. Medicaid coverage for repairs greater than \$300.00 must be accompanied by a statement from the speech-language pathologist. The statement must indicate:

a. whether there have been any significant changes in the sensory status (e.g., vision, hearing, tactile); postural, mobility or motor status; speech, language, and expressive communication status; or any other communication need or limitation of the recipient as described in B.2. (b through g, and j); and

b. whether the device remains the speech language pathologist's recommendation for recipient's use.

E. Replacement or Modification

1. Modification or replacement of AAC devices will be covered by Medicaid subject to the following limitations:

a. requests for modification or replacement of AAC devices and/or accessories may be considered for coverage after the expiration of three (3) or more years from the date of purchase of the current device and accessories in use;

b. requests for modification or replacement require prior authorization and must include the recommendation of the speech-language pathologist;

c. requests for replacements of AAC devices may be submitted for identical or different devices;

d. requests for replacements of identical AAC devices must be accompanied by a statement from the provider that the current device can not be repaired or that replacement will be more cost effective than repair of the current device. Data must be provided about the following:

i. age;

ii. repair history;

(a) frequency,

(b) duration, and

(c) cost; and

iii. repair projections (estimated durability of repairs);

e. requests for modification or replacement of AAC devices with different devices must include the following additional information:

i. a significant change has occurred in the recipient's expressive communication, impairments, and/or communication limitations. Modification or replacement requests due to changed individual circumstances must be supported by a new assessment of communication limitations by a speech-language pathologist, and may be submitted at any time; or

ii. even though there has been no significant change in the recipient's communication limitations, there

has been a significant change in the features or abilities of available AAC devices (i.e., a technological change) that will overcome or permit an even greater amelioration of the recipient's communication limitations as compared to the current AAC device. A detailed description of all AAC device changes and the purpose of the changes must be provided with the results of a re-evaluation by a speech-language pathologist;

f. requests for replacements of AAC devices due to loss or damage (either for identical or different devices) must include a complete explanation of the cause of the loss or damage and a plan to prevent the recurrence of the loss or damage.

III. Prior Authorization

A. All requests for AAC devices and accessories must be prior authorized by Medicaid in accordance with the criteria described in this rule.

B. Medicaid will not consider purchase of an AAC device when an alternative means of funding through another agency or other source (e.g., Louisiana Rehabilitation Services, school systems, private insurance, etc.) is available for the recipient. All requests should indicate the availability, or lack of availability, of purchase through other funding sources.

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

David W. Hood
Secretary

9906#042

DECLARATION OF EMERGENCY

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

Inpatient Hospital Reimbursement—Medicare Part A Claims

The Department of Health and Hospitals, Bureau of Health Services Financing has adopted the following emergency rule in the Medical Assistance Program as authorized by R.S. 46:153 and pursuant to Title XIX of the Social Security Act. This emergency rule is in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

The Department of Health and Hospitals, Bureau of Health Services Financing adopted an emergency rule effective April 1, 1999 to amend the reimbursement methodology under the Louisiana Medicaid Program for Medicare Part A claims for inpatient hospital services. This rule limited the reimbursement of Medicare Part A claims for inpatient hospital services rendered to dually eligible Medicare/Medicaid recipients and Qualified Medicare Beneficiaries (QMBs) to the Medicaid maximum payment.

Small rural hospitals, as defined in state law, were exempted from this limitation on payment of Medicare Part A claims to the Medicaid maximum payment. As a result of a legislative oversight hearing, the Department has been directed to withdraw this emergency rule. Therefore, the following emergency rule is being adopted to repeal the April 1, 1999 emergency rule that limited the reimbursement for Medicare Part A claims to the Medicaid maximum payment for inpatient hospital services rendered to dually eligible Medicare/Medicaid recipients and Qualified Medicare Beneficiaries.

Emergency Rule

Effective June 8, 1999, the Department of Health and Hospitals, Bureau of Health Services Financing repeals the April 1, 1999 emergency rule that amended the reimbursement methodology for Medicare Part A claims for inpatient hospital services rendered to dually eligible Medicare/Medicaid recipients and Qualified Medicare Beneficiaries by limiting the reimbursement to the Medicaid maximum payment. The April 1, 1999 emergency rule was published in the March 31, 1999 editions of the state's major newspapers.

David Hood
Secretary

9906#043

DECLARATION OF EMERGENCY

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

Targeted Case Management Services

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing adopts the following emergency rule under the Administrative Procedure Act, R.S. 49:950 et seq., and shall be in effect for the maximum period allowed or until adoption of the rule, whichever occurs first.

The Department of Health and Hospitals, Bureau of Health Services Financing adopted a rule in June of 1997 governing the provision of case management services to targeted populations and certain home and community based services waiver groups (*Louisiana Register*, Vol. 23, Number 6). This rule addressed programmatic requirements including general provisions, standards for provider participation, standards for payment, consumer eligibility and reimbursement methodology.

The Department has subsequently determined it is necessary to restructure targeted case management services under the Medicaid Program in order to enhance the quality of services and assure statewide access to services. Section 4118(I) of the "Omnibus Budget Reconciliation Act of 1987" permits the State to limit the case managers available with respect to case management services for eligible individuals with developmental disabilities or chronic mental illness in order to ensure that the case managers are capable of ensuring that such individuals receive needed

services. Therefore, the Department has decided to limit the number of case management agencies that may be enrolled to provide services to recipients in the Mentally Retarded/Developmentally Disabled (MR/DD) Waiver Program by means of a selective contract. The participation of case management agencies providing service to other targeted and waiver populations will also be limited contingent on the approval of a 1915(b)(4) waiver by the Health Care Financing Administration (HCFA). In addition, all case management agencies shall be required to incorporate personal outcome measures in the development of comprehensive plans of care and to implement procedures for self-evaluation of the agency. [An emergency rule was promulgated effective March 1, 1999 establishing the above provisions for case management services (*Louisiana Register*, Volume 25, Number 2.)] This subsequent emergency rule shall continue the provisions for case management services in force.

Emergency Rule

Effective June 28, 1999 the Department of Health and Hospitals, Bureau of Health Services Financing repeals the June 20, 1997 rule and adopts the following rule governing the provision of case management services to targeted population groups and certain home and community based services waiver groups. The number of case management agencies that may be enrolled to provide services to recipients in the Mentally Retarded/Developmentally Disabled (MR/DD) Waiver Program shall be limited to those agencies who have been awarded a contract by the Department. The participation of case management agencies providing service to other targeted and waiver populations will also be limited contingent on the approval of a 1915(b)(4) waiver by the Health Care Financing Administration (HCFA). In addition, all case management agencies shall be required to incorporate personal outcome measures in the development of comprehensive plans of care and to implement procedures for self-evaluation of the agency. All case management agencies must comply with the policies contained in this rule and the Medicaid Case Management Services Provider Manual issued March 1, 1999 and all subsequent changes.

I. General Provisions

A. Case Management Agency Responsibilities. Case Management is defined as services provided to individuals to assist them in gaining access to the full range of needed services including medical, social, educational, and other support services. The Department utilizes a broker model of case management in which recipients are referred to other agencies for the specific services they need. These services are determined by individualized planning with the recipient's family, and other persons/professionals deemed appropriate. Services are provided in accordance with a written comprehensive plan of care which includes measurable person-centered outcomes. All Medicaid enrolled case management agencies are required to perform the following core elements of case management services.

1. Case Management Intake. The purpose of intake is to serve as an entry point for case management services and to gather baseline information to determine the recipient's need, appropriateness, eligibility and desire for case management.

2. Case Management Assessment. Assessment is the process of gathering and integrating formal and informal information regarding a recipient's goals, strengths, and needs to assist in the development of a person centered comprehensive plan of care. The purpose of the assessment is to establish a contract between the case manager and recipient for the provision of service. The assessment shall be performed in the recipient's home.

3. Comprehensive Plan of Care Development. The comprehensive plan of care (CPOC) is a written plan based upon assessment data (which may be multidisciplinary), observations and other sources of information which reflect the recipient's needs, capacities and priorities. The purpose of the CPOC is to identify the services required and the resources available to meet these needs.

a. The CPOC must be developed through a collaborative process involving the recipient, family, case manager, other support systems, appropriate professionals and service providers. It shall be developed in the presence of the recipient; therefore, it cannot be completed prior to a meeting with the recipient. The recipient, family, case manager, support system and appropriate professional personnel must be directly involved and agree to assume specific functions and responsibilities.

b. The CPOC must be completed and submitted for approval within 35 calendar days of the referral for case management services.

4. Case Management Linkage. Linkage is the arranging of services agreed upon with the recipient and identified in the CPOC. Upon the request of the recipient or responsible party, attempts must be made to meet service needs with informal resources as much as possible.

5. Case Management Follow-Up/Monitoring. Follow-up/monitoring is the mechanism used by the case manager to assure the appropriateness of the CPOC. The purpose of follow-up/monitoring contacts is to determine if the services are being delivered as planned; are effective and adequate to meet the recipient's needs; and whether the recipient is satisfied with the services. Through follow-up/monitoring activity, the case manager not only determines the effectiveness of the CPOC in meeting the recipient's needs, but identifies when changes in the recipient's status necessitate a revision in the CPOC.

6. Case Management Reassessment. Reassessment is the process by which the baseline assessment is reviewed and information is gathered for evaluating and revising the overall CPOC. At least every quarter, a complete review of the CPOC must be performed to assure that the goals and services are appropriate to the recipient's needs as identified in the assessment/reassessment process. A reassessment is also required when a major change occurs in the status of the recipient and/or his family.

7. Case Management Transition/Closure. Discharge from a case management agency must occur when the recipient no longer requires services, desires to terminate services, becomes ineligible for services, or chooses to transfer to another case management agency; provided that the recipient has satisfied the requirements of linkage under Section B below. The closure process must ease the transition to other services or care systems. The agency shall not retaliate in any way against the recipient for terminating

services or transferring to another agency for case management services.

8. Maintenance of Records. All agency records must be maintained in an accessible, standardized order and format at the DHH enrolled office site. The agency must have sufficient space, facilities and supplies to ensure effective record keeping.

a. Administrative and recipient records must be maintained in a manner to ensure confidentiality and security against loss, tampering, destruction or unauthorized use.

b. The case management agency must retain its records for the longer of the following time frames:

(1) Five years from the date of the last payment; or

(2) Until the records are audited and all audit questions are answered.

c. Agency records must be available for review by the appropriate state and federal personnel at all reasonable times.

B. Monitoring Provision. The Department of Health and Hospitals and the Department of Health and Human Services have the authority to monitor and audit all case management agencies in order to determine continued compliance with the rules, regulations, policies, and procedures governing case management services.

C. Agency Caseload Limitations. Under the terms of the contractual agreement, case management agencies have a restriction on the total number of recipients it may serve. In a region where there are two agencies providing services, the maximum number of recipients that any one agency may serve is sixty percent (60 percent) of the available recipient population. In a region where there are three agencies providing services, the maximum number of recipients that any one agency may serve is forty percent (40 percent) of the available recipient population.

D. Recipient Freedom of Choice. Selection of Case Management Agency. Recipients have the right to select the provider of their case management services from among those available agencies enrolled to participate in the Program. Recipients are requested to indicate a first and second choice of a provider from among those available providers in the region. If the recipient fails to respond or fails to indicate a second choice of provider and their first choice is full, the Department will automatically assign them to an available provider. Recipients who are auto-assigned may change once, after 30 days but before 45 days of auto assignment, to an available provider.

Recipients must be linked to a case management agency for a six-month period before they can transfer to another agency unless there is good cause for the transfer. Good cause is determined to exist under the following circumstances: 1) the recipient moves to another DHH Region or 2) there are irreconcilable differences between the agency and the recipient. Approval of good cause shall be made by the DHH Case Management Administrator.

Recipients who are being transitioned from a developmental center into the MD/DD Waiver Program shall receive their case management services through the Office for Citizens with Developmental Disabilities (OCDD).

Recipients who are under the age of 21 and require ventilator assisted care may receive case management services through the Children's Hospital Ventilator Assisted Care Program.

II. Standards of Participation

A. In order to participate as a case management services provider in the Medicaid Program, an agency must comply with licensure and certification requirements, provider enrollment requirements, the case management manual, and the specific terms of individual contractual agreements.

B. Provider Enrollment Requirements. A separate PE-50 and Disclosure of Ownership form is required for each targeted or waiver population and DHH designated region that the agency plans to serve, as well as for each office site it plans to operate. The agency shall provide services only in the parishes of the DHH administrative region for which approval has been granted. The following enrollment requirements are applicable to all case management agencies, regardless of the targeted or waiver group served and failure to comply with these requirements may result in sanctions and/or recoupment and disenrollment.

To serve the MR/DD waiver recipients the agency must have a contract with Medicaid and comply with the terms of the contract.

1. demonstrate direct experience in successfully serving the target population and have demonstrated knowledge of available community services and methods for accessing them including the following:

a. maintain a current file of community resources available to the target population and have established linkages with those resources;

b. demonstrate knowledge of the eligibility requirements and application procedures for federal, state, and local government assistance programs which are applicable to the target population served;

c. employ a sufficient number of case manager and supervisory staff to comply with the staff coverage, staffing qualifications and maximum caseload size requirements described in Section III.A, B, and D;

2. demonstrate administrative capacity and financial resources to provide all core elements of case management services and ensure effective service delivery in accordance with DHH licensing and programmatic requirements;

3. submit a yearly audit of case management costs only and have no outstanding or unresolved audit disclaimer(s) with DHH;

4. assure that all agency staff is employed in accordance with Internal Revenue Service (IRS) and Department of Labor regulations. The subcontracting of individual case managers and/or supervisors is prohibited. However, those agencies who have been awarded Medicaid contracts for case management services may subcontract with another licensed case management agency for case manager and/or supervisory staff if prior approval has been obtained from the Department;

5. assure that all new staff satisfactorily completes an orientation and training program in the first 90 days of employment. All case managers must attend all training mandated by the Department. Each case manager and supervisor must satisfactorily complete case management related training annually to meet the minimum training requirements;

6. implement and maintain an ongoing quality assurance plan and a self-evaluation plan evidenced by written documentation approved by the Department to determine program compliance and effectiveness;

7. document and maintain recipient records in accordance with federal and state regulations governing confidentiality and licensing requirements;

8. assure the recipient's right to elect to receive or terminate case management services (except for recipients in the MR/DD or Elderly and Disabled Adult Waiver Programs). Assure that each recipient has freedom of choice in the selection of an available case management agency (every six months), a qualified case manager, or other service providers and the right to change providers or case managers; all the above are subject to the recipient's freedom of choice requirements contained in Section I.B. of this rule;

9. assure that the agency and case managers will not provide case management and Medicaid reimbursed direct services to the same recipient(s) unless by an affiliate agency with a separate board of directors;

10. with the recipient's permission, agree to maintain regular contact, share relevant information and coordinate medical services with the recipient's attending physician;

11. demonstrate the capacity to participate in the department's electronic data gathering system(s). All requirements for data submittal must be followed and participation is required for all enrolled case management agencies. The software is the property of the department;

12. complete management reports as described in the provider manual.

C. Agencies serving certain specific target groups must meet the following additional participation requirements:

1. Case management agencies serving high risk pregnant women must also demonstrate successful experience with the coordination and/or delivery of services for pregnant women; have a working relationship with a local obstetrical provider and acute care hospital that provides deliveries for 24-hour medical consultation; and have a multidisciplinary team which consists, at a minimum, of the following professionals: a physician, primary nurse associate or certified nurse manager, registered nurse, social worker, and nutritionist. The team members must meet the licensure and perinatal experience requirements applicable for services to high-risk pregnant women; and

2. Case managers serving HIV-infected individuals must also satisfactorily complete a one-day training approved by the Department's HIV Program Office.

III. Standards for Payment. In order to be reimbursed by the Medicaid Program, an enrolled provider of targeted or waiver case management service must comply with all of the requirements listed below.

A. Staff Coverage

1. Case management agencies must maintain sufficient staff to serve recipients within the mandated caseload size of 35 with a supervisor to staff ratio of no more than eight case managers per supervisor. All case managers must be employed by the agency at least 40 hours per week and work at least 50 percent of the time during normal business hours (8:00 a.m. to 5:00 p.m., Monday through Friday). Case management supervisors must be full time employees and must be continuously available to case managers by telephone or beeper at all other times when not

on site when case management services are being provided. All exceptions to the maximum caseload size or full time employment of staff requirements must be prior authorized by the Bureau. The agency must have a written policy to ensure service coverage for all recipients during the normal absences of case managers and supervisors or prior to the filling of vacated staff positions.

2. The agency must maintain a toll-free telephone number to ensure that recipients have access to case management services 24 hours a day, seven days a week. Recipients must be able to reach an actual person in case of an emergency, not a recording.

B. Staff Qualifications. Each Medicaid-enrolled agency must ensure that all staff providing case management services meet the following qualifications, skills and training requirements prior to assuming any full caseload responsibilities.

1. Education and Experience for Case Managers. All case managers must meet one of the following minimum education and experience qualifications.

a. a bachelor's degree in a human-service-related field such as psychology, education, rehabilitation counseling, or counseling from an accredited college or university and one year of paid experience in a human-service-related field providing direct services or case management services; or

b. a licensed registered nurse with one year of paid experience as a registered nurse in public health or a human-service-related field providing direct services or case management services; or

c. a bachelor's or master's degree in social work from a social work program accredited by the Council on Social Work Education.

The above-referenced minimum qualifications for case managers are applicable for all targeted and waiver groups. Thirty hours of graduate level course credit in a human-service-related field may be substituted for the one year of required paid experience.

In addition, case managers serving High-Risk Pregnant Women must demonstrate knowledge about perinatal care and meet either one of the qualifications cited above or the following qualification:

d. a registered dietician with one year of paid experience in providing nutrition services to pregnant women.

2. Education and Experience for Case Management Supervisors. All case management supervisors must meet one of the following education and experience requirements. Supervisors of case managers for High-Risk Pregnant Women must demonstrate knowledge about perinatal care in addition to meeting one of these qualifications:

a. a master's degree in social work, psychology, nursing, counseling, rehabilitation counseling, education (with special education certification), occupational therapy, speech therapy or physical therapy from an accredited college or university and two years of paid post-master's degree experience in a human-service related field providing direct services or case management services. One year of this experience must be in providing direct services to the target population served; or

b. a bachelor's degree in social work from a social work program accredited by the Council on Social Work

Education and three years of paid post-bachelor's degree experience in a human-service related field providing direct services or case management services. One year of this experience must be in providing direct services to the target population served; or

c. a licensed registered nurse with three years of paid post-licensure experience as a registered nurse in public health or a human service-related field providing direct services or case management services. Two years of this experience must be in providing direct services to the target population served; or

d. a bachelor's degree in a human-service-related field such as psychology, education, rehabilitation counseling, or counseling from an accredited college or university and four years of paid post-bachelor's degree experience in a human service related field providing direct services or case management services. Two years of this experience must be in providing direct services to the target population served.

The above minimum qualifications for case management supervisors are applicable for all targeted and waiver groups.

Thirty hours of graduate level course credit in a human-service-related field may be substituted for one year of the required paid experience.

3. Training. Training for case managers and supervisors must be provided or arranged for by the case management agency at its own expense. Agencies must send the appropriate staff to all training mandated by DHH.

a. Training for New Staff. A minimum of sixteen (16) hours of orientation must be provided to all staff, volunteers, and students within one week of employment. A minimum of eight hours of the orientation training must address the target population including, but not limited to, specific service needs, available resources and other topics. In addition to the required 16 hours of orientation, all new employees who have no documentation of previous training must receive a minimum of 16 hours of training during the first 90 calendar days of employment related to the target population and the skills and techniques needed to provide case management to that population.

b. Annual Training. Case managers and supervisors must satisfactorily complete a minimum of forty (40) hours of case-management related training annually which may include updates on subjects covered in orientation and initial training. The 16 hours of orientation training required for new employees are not included in the annual training requirement of at least 40 hours.

c. Documentation. All training required in a. and b. above must be evidenced by written documentation and provided to the Department upon request.

C. Supervisory Responsibilities. Each case management supervisor shall be responsible for assessing staff performance, reviewing individual cases, providing feedback, and assisting staff to develop problem solving skills using two or more of the following methods:

1. individual, face-to-face sessions with staff;

2. group face-to-face sessions with all case management staff; or

3. sessions in which the supervisor accompanies a case manager to meet with recipients.

IV. Reimbursement. The reimbursement methodology for optional targeted and waiver case management services is a

fixed monthly rate for the provision of the core elements of case management services as described in Section I. A. and in acceptance with the terms of contract with the Bureau. The primary objective of case management is the attainment of the personal outcomes identified in the recipient's comprehensive plan of care.

In addition to the provision of the core elements, a minimum of one home visit per quarter is required for all recipients of optional targeted and waiver case management services. The agency shall ensure that more frequent home visits are performed if indicated in the recipient's CPOC. The purpose of the home visit is to assess the effectiveness of support strategies and to assist the individual to address problems, maximize opportunities and/or revise support strategies or personal outcomes if it is determined necessary.

The case management agency shall also be responsible for monitoring service providers quarterly through telephone monitoring, on-site observation of service visits and review of the service providers' records. The agency must also ensure that the service provider and recipient are given a copy of the recipient's most current CPOC and any subsequent updates.

A technical amendment (Public Law 100-617) in 1988 specifies that the Medicaid Program is not required to pay for case management services that are furnished to consumers without charge. This is in keeping with Medicaid's longstanding position as the payer of last resort. With the statutory exceptions of case management services included in the Individualized Education Programs (IEP'S) or Individualized Family Service Plans (IFSP's) and services furnished through Title V public health agencies, reimbursement by Medicaid payment for case management services cannot be made when another third party payer is liable, nor may payments be made for services for which no payment liability is incurred.

David W. Hood
Secretary

9906#040

DECLARATION OF EMERGENCY

Department of Natural Resources Office of Conservation

Pollution Control—Statewide 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 Louisiana 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 Louisiana 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.

The fourth Emergency Rule, adopted January 29, 1999, 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 a Fifth Emergency Rule, effective May 29, 1999, 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. This Fifth Emergency Rule requires 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 Conservation - General Operations

Subpart 1. Statewide Order No. 29-B

Chapter 1. General Provisions

§129. Pollution Control

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—a 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—drilling 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	workover and completion 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—exploration and production waste

* * *

M.2. - 5. ...

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

i. ...

ii. 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.l. ...

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 25:

Summary

The Emergency Rule hereinabove 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 29, 1999.

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.

Signed at Baton Rouge, Louisiana, this 1st day of June, 1999.

Philip N. Asprodites
Commissioner

9906#022

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