

# Rules

## RULE

### Department of Agriculture and Forestry Office of Agricultural and Environmental Sciences Seed Commission

Seed Law—Application Deadlines; Fees; Sweet Potato Standards; Greenhouse Requirements  
(LAC 7:XIII.131, 143, and 222)

In accordance with the provisions of the Administrative Procedure Act, La. R.S. 49:950 et seq., the Department of Agriculture and Forestry, Office of the Louisiana Seed Commission, adopts regulations regarding virus-tested sweet potato certification standards and general seed certification requirements.

The Department of Agriculture and Forestry, Louisiana Seed Commission adopts these rules and regulations for the purpose of increasing the availability of virus-tested sweet potato seed for Louisiana producers. These regulations provide a mechanism to maintain the genetic and physical quality of virus-tested sweet potato plants and seed. These rules are enabled by R.S. 3:1433.

#### Title 7

### AGRICULTURE AND ANIMALS

#### Part XIII. Seeds

#### Chapter 1. Louisiana Seed Law

#### Subchapter B. General Seed Certification Requirements

#### §131. Application Deadlines

- A. - D. ...
- E. Watermelon, tissue culture sugarcane - May 1
- F. Sweet potatoes and sweet potato plants
  - 1. Greenhouse plantings (virus-tested) - 45 days prior to planting
  - 2. Field plantings - June 1

\* \* \*

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:1433.

HISTORICAL NOTE: Promulgated by the Department of Agriculture, Seed Commission, LR 8:565 (November 1982), amended LR 9:195 (April 1983), repealed and readopted by the Department of Agriculture and Forestry, Seed Commission, LR 12:825 (December 1986), amended LR 13:155 (March 1987), LR 12:232 (April 1987), LR 14:603 (September 1988), LR 23:1283 (October 1997), LR 25:1616 (September 1999).

#### §143. Fees

- A. - D.6. ...
- E. Fees for Sweet Potatoes
  - 1. The fee for greenhouse inspections of virus-tested sweet potato plants and mini-roots shall be fifty (50) dollars per crop year.
  - 2. A fee of five cents per 1,000 plants will be collected for each 1,000 sweet potato plants inspected for certification purposes.

\* \* \*

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:1433.

HISTORICAL NOTE: Promulgated by the Department of Agriculture, Seed Commission, LR 8:566 (November 1982), amended LR 10:495 (July, 1984); repealed and readopted by the Department of Agriculture and Forestry, Seed Commission LR 12:825 (December 1986), amended LR 14:604 (September 1988), amended LR 16:847 (October 1990), LR 25:1617 (September 1999).

#### Subchapter C. Certification of Specific Crops/Varieties

#### §222. Virus-Tested Sweet Potato Certification

##### Standards

A. Explanation of General Standards as Applied to Sweet Potatoes

1. The general "seed" certification standards as adopted are basic and together with the following specific standards constitute the standards for certification of virus-tested sweet potatoes.

2. Definitions

*Mericlones*—all plants clonally propagated from a single meristem tip. For example, mericlone B-63 includes all plants descended from the sixty-third meristem-tip culture derived from the variety Beauregard.

*Micropropagated*—is the art and science of plant multiplication in vitro. The process includes many steps stock plant care, explant selection and sterilization, media manipulation to obtain proliferation, rooting, acclimation, and growing on. Sweet potato is most commonly micropropagated in tissue culture by aseptic transfer of stem segments containing 1-3 nodes to sterile tissue culture medium.

*Vine Cutting*—sections preferably 8-12 inches in length cut from vines that can be transplanted in the greenhouse or field. All such cuttings will be made at least one inch above the surface of the soil or growing medium, slips that have been pulled are not to be used to avoid the possibility of carrying pathogens or insects that can be present on stems below the soil surface.

*Virus-Tested*—a plant that has been previously tested for the presence of viruses on at least three separate occasions by grafting to the standard indicator plant for sweet potato viruses, the Brazilian morning glory (*Ipomoea setosa*). If the plant is found to be negative (no symptoms developed on the indicator) each time, it is considered *virus-tested* since it is not possible to absolutely prove the absence of any and all viruses.

3. The general standards are further defined as follows to apply specifically to *virus-tested* sweet potatoes. Classes and sources of certified "seed" are defined as follows.

a. *Source Seed*—shall be material entering the Louisiana Agricultural Experiment Station (LAES) seed program obtained by methods acceptable to the Louisiana Department of Agriculture and Forestry (LDAF).

b. *Nuclear Stock Plants*—shall be *source seed* that has been micropropagated, *virus-tested*, apparently free of other pests, and evaluated in field test for trueness to variety. This material shall be maintained under strict isolation in laboratory facilities maintained by LAES and/or any

contracted micropropagation provider and approved by LDAF. The facilities shall be in a clean, dust-free building and be separated from any greenhouse or sweet potato storage operations. This building shall be at least 250 feet from any sweet potato field or greenhouse.

c. *Foundation Plants*—shall be greenhouse plants, produced by the LAES from *nuclear stock plants* that are *virus-tested* and recognized by LDAF. These plants must be grown under strict isolation in screen cages in which only plants that are *virus-tested* are grown.

d. *Certified G0*—shall be greenhouse plants produced by certified greenhouse growers from Foundation Plants. *Certified G0* Plants will be propagated as follows.

i. *Mother Plants*—are the plants obtained from LAES. *Mother plants* will be kept isolated in screen cages. *Mother plants* may be cut repeatedly for up to no more than 5 months to produce *daughter plants*.

ii. *Daughter Plants*—are plants produced by cuttings from *mother plants*. *Daughter plants* may be cut repeatedly for up to no more than 5 months to produce additional *daughter plants*.

(a). All plants produced from these propagations will be designated as *certified G0* and may be used to establish *certified G1* field plantings.

iii. *Mini-Roots*—storage roots produced on plants grown in *certified G0* greenhouses may be used to establish *certified G2* field plantings.

(a). All plants, vine cuttings and roots produced from these mini-roots shall be designated as *certified G2*.

e. *Certified G1* (Field Generation 1)—*certified G1* plantings will be established from *certified G0* plants. Vine cuttings may be taken repeatedly from this original G1 planting, to establish a second G1 planting. Vine cuttings may be taken repeatedly from the second G1 planting to establish a third G1 planting. No additional plantings may be established from this third G1 planting.

(a). All vine cuttings and roots produced during this first year of field production shall be designated as *certified G1*.

f. *Certified G2* (Field Generation 2)—*certified G2* plantings will be established from *certified G1* stocks. Vine cuttings may be taken repeatedly from this original G2 planting, to establish a second G2 planting. Vine cuttings may be taken repeatedly from the second G2 planting, to establish a third G2 planting. No additional plantings may be established from this third G2 planting.

(a). All vine cuttings and roots produced during this second year of field production shall be designated as *certified G2*.

g. *Certified G3* (Field Generation 3)—*certified G3* plantings will be established from *certified G2* stocks. Vine cuttings may be taken repeatedly from this original G3 planting, to establish a second G3 planting. Vine cuttings may be taken repeatedly from the second G3 planting to establish a third G3 planting. No additional plantings may be established from this third G3 planting.

(a). All vine cuttings and roots produced during this third year of field production shall be designated as *certified G3*.

## B. Greenhouse Requirements

### 1. Production

a. *Mother plants* will be kept isolated in screen cages.

b. For Greenhouse production it is required that:

i. entry shall be through double doors;

ii. a system for sanitizing hands and feet shall be in place;

iii. doors shall be kept locked;

iv. yellow sticky traps shall be used to monitor aphids and other insects;

v. screens of such mesh as to prevent entry of aphids shall be placed over all openings (vents, fans, windows, etc.);

vi. greenhouses shall be clearly marked to warn workers that they shall not enter, if they are coming from the field or from other noncertified greenhouses;

vii. aphids, whiteflies or other insects with sucking, mouthparts shall be controlled;

viii. decontaminate cutting tools on a regular basis and always when moving to another group of stock plants or plant lots;

ix. all growing medium (e.g. soil), containers, etc. used in the greenhouse must be sanitized by a method approved by LDAF;

x. all plants shall be removed from the greenhouse and the greenhouse kept free of plants for a minimum of 6 weeks between crop years.

### c. Isolation

i. There shall be no plants growing within 10 feet of the greenhouse (grass for stabilization will be permitted, but weeds must be controlled).

ii. No other plants are allowed in the greenhouse.

iii. Greenhouses should be as far away as possible from sweet potato storage sheds, cull piles or other potential sources of sweet potato viruses.

d. Different varieties or mericlones must be clearly identified and separated.

e. LDAF must approve greenhouses before *mother plants* will be released to the grower.

## 2. Inspections

### a. Grower

i. Producer will inspect vines twice weekly. If symptomatic plants are found, they will be removed and destroyed and parent plants will be inspected for disease symptoms. The grower will keep a log showing that inspections were made and if plants were removed.

ii. There will be a weekly inspection in and around the greenhouse perimeters to ensure isolation standards are being met.

iii. If problems are observed during weekly inspections the producer should notify LDAF.

### b. LDAF

i. LDAF will inspect certified greenhouses several times during the year as needed. If symptomatic plants are found during these inspections they must be rogued and disposed of properly.

ii. Once shipping of plants begins, final certification will not be allowed if symptomatic plants are found.

## 3. Inspection Standards

### a. General Requirements

i. Unit of Certification shall be the entire greenhouse and such unit cannot be divided for the purpose for certification.

ii. Isolation requirements are described in 222.B.1.c.

iii. Increase requirements are described in 222.A.3.

b. Specific Greenhouse Requirements

Presence or Symptoms of:	Maximum Tolerance Allowed	
	Foundation (LAES)	Certified GO
Bacterial Stem Rot ( <i>Erwinia chrysanthemi</i> )*	0	0
Black Rot ( <i>Ceratocystis fimbriata</i> )*	0	0
Scurf ( <i>Monilochaetes infusans</i> )*	0	0
Root-Knot Nematode ( <i>Meloidogyne</i> spp.)	0	0
Feathery Mottle (sweet potato feathery mottle virus [SPFMV])*	0	0
Russet Crack (a strain of SPFMV)*	0	0
Internal Cork (a virus)*	0	0
Wilt ( <i>Fusarium oxysporum</i> f. sp. <i>batatas</i> )*	0	0
Sweet Potato Weevil ( <i>Cylas formicarius</i> var. <i>elegantulus</i> )	0	0
Variety mixture	0	0
Off-types (mutations)	0	0

\*Plants or mini-roots exhibiting symptoms

C. Field Requirements

1. Production

a. All sweet potatoes produced in a field for certification must be grown from virus-tested stock.

b. Virus-tested C1 sweet potato "seed" will not be eligible for certification if produced on land which:

- i. has produced sweet potatoes in the last 2 years;
- ii. has received manure or sweet potato residue in the last 2 years;
- iii. is subject to drainage from fields in which sweet potatoes have been grown in the last 2 years.

c. Isolation

i. Virus-tested sweet potato "seed" production fields shall be 750 feet from other sweet potatoes.

ii. An approved program shall be in place to control perennial plants of morning glories (e.g. *Ipomoea pandurata*, Bigroot Morning Glory, *Ipomoea cordatotriloba* sharp-pod or cotton Morning Glory), and volunteer sweet potato plants.

d. Different varieties or mericlones will be clearly identified and separated from each other by 20 feet.

e. Each unit of sweet potatoes that passed field inspection shall be marked or labeled at harvest to correspond with the field unit.

2. Inspections

a. The grower should inspect fields regularly during the growing season and remove any symptomatic plants that are found. LDAF should be informed if any problems are found.

b. At least two inspections by LDAF will be made during the growing season; others will be made if necessary.

i. At least one seed bed inspection will be made when applicable.

ii. First field inspection shall be made before vines have covered the ground so that symptomatic plants may be easily identified. Roguing will consist of pulling up the symptomatic plants, bagging them, and removing them from the field.

iii. Final inspection shall be made near to harvest.

3. Inspection Standards

a. General requirements

i. Unit of certification for production is a field and such unit cannot be divided for the purpose for certification.

ii. Isolation requirements are described in §222.C.1.c.

iii. If the "seed" of two virus-tested varieties are grown in the same field, they must be clearly identified and separated by at least 20 feet.

iv. Land requirement for certified C1 fields is subject to §222.C.1.b. Land requirement for certified C2 and C3 fields is 2 years.

b. Specific Field Requirements (Vine Inspection)

Presence or symptoms of:	Maximum Tolerance Allowed		
	Certified G1	Certified G2	Certified G3
Bacterial Stem Rot ( <i>Erwinia chrysanthemi</i> )	none	none	none
Wilt ( <i>Fusarium oxysporum</i> f. sp <i>batatas</i> )	none	none	none
Exotic or Hazardous Pests	none	none	none
Variety Mixture	none	none	none
Off-types (mutations) 0.05%	0.05%	0.10%	

D. Storage Requirements

1. Before sweet potatoes grown for certification can be stored, the storage house must be cleaned and disinfected in a manner approved by LDAF.

2. Sweet potatoes grown for certification shall be stored in new containers (crates, pallet boxes, etc.) or used containers that have been disinfected and decontaminated in a manner approved by LDAF.

3. Certified seed roots shall be stored in a separate room from any noncertified roots.

4. Sweet potatoes from different field units shall be separated in storage by an aisle at least two feet wide.

5. A minimum of 20 percent of each lot of sweet potatoes entered for certification shall be inspected by LDAF during the storage inspection.

E. Standards for Plant and Root "Seed"

1. Plants:

a. apparently free of injurious disease, insects, or other pests;

- b. true to variety characteristics;
- c. of good color, fresh, firm, and strong;
- d. of satisfactory size for commercial planting (cuttings approximately 8" - 12" long);
- e. cuttings will be loosely packed and shipped in an upright position in boxes;
- f. cuttings will not be shipped with other non-program plants.

2. Seed Roots

- a. One storage inspection shall be made after harvest.
- b. Sweet potatoes for certification must be well shaped. The minimum size shall be one inch in diameter and four inches in length, 30 ounces maximum weight.
- c. Specific Seed Root Standards

Maximum Tolerance Allowed

Presence or Symptoms of:	Maximum Tolerance Allowed		
	Certified G1	Certified G2	Certified G3
Surface Rots ( <i>Fusarium</i> spp.) & Soft Rots ( <i>Rhizopus</i> spp.)	5%	5%	5%
Bacterial Root Rot ( <i>Erwinia</i> spp.)	none	none	none
Black Rot ( <i>Ceratocystis fimbriata</i> )	none	none	none
Scurf ( <i>Monilochaetes infuscans</i> )	1.0%	1.0%	2.0%
Steptomcyes Soil Rot ( <i>Streptomyces ipomoeae</i> )	2.5%	2.5%	5.0%
Root-Knot Nematode ( <i>Meloidgyne</i> spp.)	5.0%	5.0%	5.0%
Russet Crack (a stain of SPFMV)	none	none	none
Internal Cork (a virus)	none	none	none
Wilt ( <i>Fusarium oxysporum</i> f. sp. <i>batatas</i> )	none	none	none

F. Certificate Reporting System

1. The grower will be furnished numbered certificates of certification by the Louisiana Department of Agriculture and Forestry and shall:

- a. issue a copy of the certificate to the purchaser for each shipment;
- b. send a copy of each issued certificate to the Louisiana Department of Agriculture and Forestry within 10 days after each sale; and
- c. maintain a copy of each issued certificate on file.

G. Sweet Potato Weevil Quarantine Area

1. Sweet potato plants grown in a sweet potato-weevil quarantine area will be approved for seed or plant sources for use only within the quarantined area if:

- a. all requirements for certification are met; and
- b. there are no sweet potato weevils within a two-mile radius of the field or storage house.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:1433.

HISTORICAL NOTE: Promulgated by the Department of Agriculture and Forestry, Seed Commission, LR 25:1617 (September 1999).

Bob Odom  
Commissioner

9909#032

**RULE**

**Department of Agriculture and Forestry  
Structural Pest Control Commission**

**Minimum Specifications for Termite Control Work  
(LAC 7:XXV.141)**

In accordance with provisions of the Administrative Procedure Act, R.S. 49:950 et seq., the Department of Agriculture and Forestry, Structural Pest Control Commission, amends regulations regarding pre-treatments of slabs for termites.

The Department of Agriculture and Forestry deems the implementation of these rules and regulations necessary to increase the distance that wood parts must be above ground level, provide that a waiver of minimum specifications for termite control work be secured by the customer, and that pest control operators must monitor for termites prior to making bait toxicant applications around residential, day care, and nursing home properties, thus providing a safety factor to those individuals at these properties. These rules comply with and are enabled by LSA-R.S. 3:3203.

**Title 7**

**AGRICULTURE AND ANIMALS  
Part XXV. Structural Pest Control**

**Chapter 1. Structural Pest Control Commission  
§141. Minimum Specifications for Termite Control Work**

A. - C.2.c. ...

3. Elimination of Direct Contact of Wood with Ground

a. Piers and stiff legs must have concrete or metal-capped bases extending at least three inches above the ground. Creosote or penta pressure-treated piling foundations are exempt from this requirement but should be drilled and pressure treated to the center of the piling.

b. Wood parts which extend through concrete or masonry (such as posts, door frames or stair carriages) must be cut off and set on metal or concrete bases at least three inches above ground level.

c. - 8.b. ...

9. Dirt Filled Porches

a. Where the sill or other wood extends to, or below, the under side of the concrete slab, the dirt must be excavated so as to leave a horizontal tunnel at the junction of slab and foundation wall. The tunnel shall extend the full length of the fill and be at least 12 inches deep (or down to grade) and 12 inches wide. Soil in the tunnel shall be treated with chemical at all points of contact with wall and slab. Supports for the slab shall be erected in the tunnel if

necessary. Tunnel shall be well ventilated, but care shall be taken to assure that water does not run into those tunnels.

(See Figure 1 [in appendix])

Exception: If, due to construction, it is impractical to break into and excavate dirt-filled areas, a method of drilling, rodding and flooding as outlined in §141.C.9.b.ii below, may be employed.

b. - H.2. ...

I. Waiver of Requirements of Minimum Specifications for Termite Control Work. Whenever it is impossible or impractical to treat any structure in accordance with these minimum specifications, the pest control operator may request a waiver of these requirements. A waiver must be secured from the customer prior to any treatment in any instance where all requirements of these minimum specifications cannot be complied with.

1. - 8.c. ...

d. monitoring shall be used to detect the presence of subterranean termites in the soil. All delivery systems shall be inspected at regular intervals, not less than once monthly and data shall be recorded;

e. baits and baiting systems may be used as a stand-alone termite treatment only with written approval by LDAF;

f. baits and baiting systems may be used as a supplement to traditional ground termiticide treatments;

g. monitoring stations shall be placed, where soil is available, a minimum of twenty (20) feet apart around the perimeter of the structure;

h. toxicant delivery following label and labeling shall be placed in or in close proximity to each monitoring station that is infested with live termites.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:3302 and R.S. 3:3306.

HISTORICAL NOTE: Promulgated by the Department of Agriculture, Structural Pest Control Commission, LR 11:330 (April 1985), amended by the Department of Agriculture and Forestry, Structural Pest Control Commission, LR 15:958 (November 1989), LR 20:644 (June 1994), LR 21:931 (September 1995), LR 23:1285 (October 1997), LR 25:1620 (September 1999).

Bob Odom  
Commissioner

9909#031

**RULE**

**Board of Elementary and Secondary Education**

**Bulletin 1868—Personnel Manual (LAC 28:I.922)**

In accordance with R.S. 49:950 et seq., the Administrative Procedure Act, the State Board of Elementary and Secondary Education adopted an amendment to Bulletin 1868, BESE Personnel Manual, Chapter E: Employee Benefits. Bulletin 1868 is referenced in LAC 28:I.922. The revision addresses the issue of payment of accrued annual leave (up to 300 hours) for SSD #1 and BESE Special Schools, upon separation from employment.

**Title 28  
EDUCATION**

**Part I. Board of Elementary and Secondary Education  
Chapter 9. Bulletins, Regulations, and State Plans  
Subchapter A. Bulletins and Regulations  
§922. Personnel Policies**

**A. Bulletin 1868**

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AUTHORITY NOTE: Promulgated in accordance with R.S. 17:6(a)(10); R.S. 17:6(B); R.S. 17:7(5); R.S. 17:7(10); R.S.17:81.4; R.S. 17:1941-1956; R.S. 17:1993; H. B. 239 of 1994.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 16:297 (April 1990), amended LR 21:163 (February 1995), LR 22:3 (January 1996), LR 24:434 (March 1998), LR 25:1621 (September 1999).

**Chapter E: Employee Benefits**

**153: Leave**

**A. Board Special Schools and Special School District #1  
Part I: Certificated Staff/Paraeducator Leave Plan**

**C. Annual Leave**

1. - 4.d. ...

e. Employees who must be absent, without prior approval, for non-illness reasons will be charged with personal leave if they possess such leave. Lacking personal leave, annual leave will be used.

5. When an employee changes employment from a Board Special School, Special School District #1 school, or a Louisiana public school system to a Board Special School, Special School District #1, or Louisiana Technical College System, the accumulated annual leave balance shall be carried forward to the new school and shall be credited to the employee.

6. Upon resignation, death, removal or other termination of employment of an unclassified employee, annual leave amounting to the same maximum as is provided in the Civil Service Rules for classified employees, and accrued to the employee's credit shall be computed and the value thereof shall be paid to him/her or the heirs, provided that the annual leave has been accrued under established leave regulations and an attendance record has been maintained for the employee by the supervisor. Such pay shall be computed on the employee's base rate of pay at the time of termination.

7. When an employee terminates employment and has used annual leave hours in excess of what was earned by the time of separation, the applicable school shall deduct the amount of money due from the last pay check and/or the employee shall pay in cash to the school the amount due, according to the following formula:

Hourly rate of pay X (times) number of annual leave hours used but not earned.

Weegie Peabody  
Executive Director

9909#049

**RULE**

**Department of Environmental Quality  
Office of Environmental Assessment  
Environmental Planning Division**

**Emission Reduction Credits Banking  
(LAC 33:III.603, 605, 607, 613, 615, and 621)(AQ190)**

Editor's Note: Due to reengineering at the Department of Environmental Quality effective July 1, 1999, the Office and Division names have been changed in the Rule heading and the Historical Note for each section in this rule. The contents of the notice and the rule have not changed, with the exception of technical amendments to the proposed rule.

Under the authority of the Environmental Quality Act, R.S. 30:2001 et seq., and in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., the secretary has amended the Air Quality regulations, LAC 33:III.603, 605, 607, 613, 615, and 621 (AQ190).

The EPA promulgated the new ozone national ambient air quality standards (NAAQS) on July 18, 1998, which became effective on July 18, 1999. This rule accommodates ozone nonattainment classifications resulting from the new NAAQS. It also corrects a typographical error for the date on which emission credits begin their 10-year life and clarifies the use for emission credits having a 10-year life. The basis and rationale for this proposed rule are to assist the department in meeting air quality management goals through flexible approaches that benefit both the environment and the regulated entities, allow for less costly control strategies, and provide stronger incentives for the development and implementation of pollution prevention measures and innovative emission reduction technology.

This rule meets the exceptions listed in R.S. 30:2019(D)(3) and R.S. 49:953(G)(3); therefore, no report regarding environmental/health benefits and social/economic costs is required.

**Title 33  
ENVIRONMENTAL QUALITY  
Part III. Air**

**Chapter 6. Regulations on Control of Emissions  
Through the Use of Emission Reduction  
Credits Banking**

**§603. Applicability**

Sources in EPA-designated ozone nonattainment areas must participate in the emissions banking program in order to utilize emission reductions for netting or as offsets. Sources in EPA-designated ozone attainment areas may participate in the emissions banking program. If a source in an attainment area participates in the emissions banking program, the source must submit the annual submission required by LAC 33:III.613.D. The following sources in ozone nonattainment parishes are eligible to participate in the emissions banking program: any stationary point source, any area source, and any registered mobile source. The following sources in ozone attainment parishes are eligible to participate in the emissions banking program: any stationary point source and any area source. The rule shall apply to the following pollutants: NO<sub>x</sub> and VOC.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:2054.

HISTORICAL NOTE: Promulgated by the Department of Environmental Quality, Office of Air Quality and Radiation Protection, Air Quality Division, LR 20:874 (August 1994), amended LR 24:2239 (December 1998), amended by the Office of Environmental Assessment, Environmental Planning Division, LR 25:1622 (September 1999).

**§605. Definitions**

The terms used in this Chapter are defined in LAC 33:III.111 of these regulations except as defined within the separate subchapters or as follows:

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[See Prior Text]

*Area Source*—any small residential, governmental, institutional, commercial, or industrial fuel combustion operation; on-site solid waste disposal facilities; aircraft vessels, or other transportation facilities, or other miscellaneous sources identified through inventory techniques similar to those described in the Aerometric Emissions Reporting System (AEROS) Manual (see 40 CFR 51.100).

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[See Prior Text]

*Registered Mobile Source*—any vehicle registered and insured by the owner (without change of ownership) at an address within the nonattainment area continuously for at least 12 months prior to the date the vehicle is purchased.

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[See Prior Text]

*Stationary Point Source*—any building, structure, facility, or installation that emits or may emit any air pollutant subject to regulation under the Clean Air Act.

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[See Prior Text]

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:2054.

HISTORICAL NOTE: Promulgated by the Department of Environmental Quality, Office of Air Quality and Radiation Protection, Air Quality Division, LR 20:874 (August 1994), amended by the Office of Environmental Assessment, Environmental Planning Division, LR 25:1622 (September 1999).

**§607. Stationary Point Source Emission Reductions**

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[See Prior Text in A-A.1]

- a. volatile organic compounds (VOCs); and
- b. nitrogen oxides (NO<sub>x</sub>).

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[See Prior Text in A.2-D]

E. Geographic Areas. Emissions are banked by geographic areas, usually individual parishes. Separate accounts shall be maintained (either by parish or by EPA-designated geographic area) for ozone nonattainment areas and ozone attainment areas. Each area, shall maintain separate accounts for NO<sub>x</sub> and for VOCs.

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[See Prior Text in F-G4]

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:2054.

HISTORICAL NOTE: Promulgated by the Department of Environmental Quality, Office of Air Quality and Radiation Protection, Air Quality Division, LR 20:877 (August 1994), amended by the Office of Environmental Assessment, Environmental Planning Division, LR 25:1522 (September 1999).

**§613. ERC Bank Balance Sheet**

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[See Prior Text in A-C]

D. Schedule. All applications for banking ERCs in the parishes of Ascension, East Baton Rouge, Iberville, Livingston, and West Baton Rouge where the emission reductions occurred before August 20, 1994, must have been submitted prior to January 20, 1995. First-time applications for banking ERCs for attainment parishes may be submitted at any time. If a parish is redesignated as ozone nonattainment by the EPA, applications for banking ERCs for those parishes must be submitted within six months after the effective date of the EPA designation. All applications for banking ERCs where the emission reductions occurred after the date this banking rule was adopted for an area shall be submitted by March 1 following the year in which the reduction occurred. The balances (i.e., the balance available for netting and the balance available for offsets) from the ERC bank balance sheets of Subsection A of this Section shall be submitted to the department by March 1 of each year together with the certification specified in Subsection E of this Section. All emission reductions must meet the timing restrictions set forth in LAC 33:III.607.D in order to be eligible for banking as ERCs.

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[See Prior Text in E-F]

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:2054.

HISTORICAL NOTE: Promulgated by the Department of Environmental Quality, Office of Air Quality and Radiation Protection, Air Quality Division, LR 20:877 (August 1994), amended by the Office of Environmental Assessment, Environmental Planning Division, LR 25:1622 (September 1999).

#### **§615. Schedule for Submitting Applications**

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[See Prior Text in A]

B. All applications for banking ERCs in the parishes of Ascension, East Baton Rouge, Iberville, Livingston, and West Baton Rouge where the emission reductions occurred before August 20, 1994, must have been submitted prior to January 20, 1995. First-time applications for banking ERCs for attainment parishes may be submitted at any time. If a parish is redesignated as ozone nonattainment by the EPA, application for banking ERCs for those parishes must be submitted within six months after the effective date of the EPA designation. Once a banking application has been filed, the bank balance and the applicant's certification should be submitted annually on March 1.

C. Owner(s) or operator(s) of major sources in nonattainment areas with VOC or NO<sub>x</sub> emission reductions not identified through the process described in Subsection B of this Section will be confiscated. A notification of confiscation will be sent by the department at such time that a permit modification or renewal is submitted using "unbanked" VOC or NO<sub>x</sub> emission reductions described in Subsection B of this Section as offsets or for netting purposes.

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[See Prior Text in D]

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:2054.

HISTORICAL NOTE: Promulgated by the Department of Environmental Quality, Office of Air Quality and Radiation Protection, Air Quality Division, LR 20:878 (August 1994), amended LR 21:681 (July 1995), amended by the Office of Environmental Assessment, Environmental Planning Division, LR 25:1623 (September 1999).

#### **§621. Protection of Banked ERCs**

A. Only ERCs used as offsets are valid for 10 years from the date of their actual emission reduction to the atmosphere. ERCs can also be used for netting, but only during the contemporaneous period as specified in LAC 33:III.504.

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[See Prior Text in B-B.3]

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:2054.

HISTORICAL NOTE: Promulgated by the Department of Environmental Quality, Office of Air Quality and Radiation Protection, Air Quality Division, LR 20:879 (August 1994), amended by the Office of Environmental Assessment, Environmental Planning Division, LR 25:1623 (September 1999).

Gus Von Bodungen, P.E.  
Assistant Secretary

9909#051

### **RULE**

#### **Office of the Governor Division of Administration Office of Telecommunications Management**

Telecommunications  
(LAC 4:IX.Chapters 1-21)

The Division of Administration, Office of Telecommunications Management hereby adopts in accordance with R.S. 49:950 et seq., and R.S. 39:140-143 that it intends to amend LAC 4:IX relative to telecommunications.

### **Title 4**

#### **ADMINISTRATION**

#### **Part IX. Telecommunications**

#### **Chapter 1. General Provisions**

#### **§101. Title**

These rules shall be known as the administrative rules and regulations of the Office of Telecommunications Management.

AUTHORITY NOTE: Promulgated in accordance with R.S. 39:140, R.S. 39:141, R.S. 39:143, R.S. 39:1751, R.S. 39:1752, R.S. 39:1753, R.S. 39:1754, and R.S. 39:1755.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Telecommunications Management, LR 6:722 (December 1980), repromulgated LR 10:80 (February 1984), LR 17:267 (March 1991), LR 25:1623 (September 1999).

#### **§103. Authority**

These rules are adopted pursuant to R.S. 39:140-143 and R.S. 39:1751-1755.

AUTHORITY NOTE: Promulgated in accordance with R.S. 39:140, R.S. 39:141, R.S. 39:143, R.S. 39:1751, R.S. 39:1752, R.S. 39:1753, R.S. 39:1754, and R.S. 39:1755.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Telecommunications Management, LR 6:722 (December 1980), repromulgated LR 10:80 (February 1984), LR 17:267 (March 1991), LR 25:1623 (September 1999).

#### **§105. Purpose**

The purpose is to establish overall policy and define areas of responsibility for the provision and management of

coordinated telecommunications services to support the programs of the Executive Branch of State government.

AUTHORITY NOTE: Promulgated in accordance with R.S. 39:140, R.S. 39:141, R.S. 39:143, R.S. 39:1751, R.S. 39:1752, R.S. 39:1753, R.S. 39:1754, and R.S. 39:1755.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Telecommunications Management, LR 6:722 (December 1980), repromulgated LR 10:80 (February 1984), LR 17:267 (March 1991), LR 25:1623 (September 1999).

### **§107. Scope**

These rules apply to the Executive Branch of State government as defined in R.S. 36:3(1) and any and all entities, state or non-state, approved to utilize state telecommunications systems and telecommunications services. All groups may be referred to collectively hereafter as agency or agencies.

AUTHORITY NOTE: Promulgated in accordance with R.S. 39:140, R.S. 39:141, R.S. 39:143, R.S. 39:1751, R.S. 39:1752, R.S. 39:1753, R.S. 39:1754, and R.S. 39:1755.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Telecommunications Management, LR 6:722 (December 1980), repromulgated LR 10:80 (February 1984), LR 17:267 (March 1991), LR 25:1624 (September 1999).

## **Chapter 3. State Agencies' Responsibilities**

### **§301. General**

All agencies must comply with the requirements and standards stated in these rules and regulations.

AUTHORITY NOTE: Promulgated in accordance with R.S. 39:140, R.S. 39:141, R.S. 39:143, R.S. 39:1751, R.S. 39:1752, R.S. 39:1753, R.S. 39:1754, and R.S. 39:1755.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Telecommunications Management, LR 6:722 (December 1980), repromulgated LR 10:80 (February 1984), LR 17:267 (March 1991), LR 25:1624 (September 1999).

### **§303. Telecommunications Coordinator**

All agencies shall appoint one or more representatives to be designated as the agency Telecommunications Coordinator(s). The Telecommunications Coordinator shall be recognized by the Office of Telecommunications Management as the agency's authorized representative for approving and coordinating telecommunications activity. Communications concerning policy and operating procedures will be directed to agencies through their respective Telecommunications Coordinator(s).

Training designed to instruct the Telecommunications Coordinator on the procedural aspects of interfacing with the Office of Telecommunications Management and the design and operation of various telecommunications systems will be furnished by the Office of Telecommunications Management upon request by agencies.

AUTHORITY NOTE: Promulgated in accordance with R.S. 39:140, R.S. 39:141, R.S. 39:143, R.S. 39:1751, R.S. 39:1752, R.S. 39:1753, R.S. 39:1754, and R.S. 39:1755.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Telecommunications Management, LR 6:722 (December 1980), repromulgated LR 10:80 (February 1984), LR 17:267 (March 1991), LR 25:1624 (September 1999).

### **§305. Telecommunications Problem Reporting**

It is the agency's responsibility to report all repair problems to the Office of Telecommunications Management.

AUTHORITY NOTE: Promulgated in accordance with R.S. 39:140, R.S. 39:141, R.S. 39:143, R.S. 39:1751, R.S. 39:1752, R.S. 39:1753, R.S. 39:1754, and R.S. 39:1755.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Telecommunications Management, LR 6:722 (December 1980), repromulgated LR 10:80 (February 1984), LR 17:267 (March 1991), LR 25:1624 (September 1999).

## **Chapter 5. Approval of Non-State Entity Use of State Telecommunications Services**

### **§501. General**

Non-state entities may be allowed to use state telecommunications services under particular circumstances.

AUTHORITY NOTE: Promulgated in accordance with R.S. 39:140, R.S. 39:141, R.S. 39:143, R.S. 39:1751, R.S. 39:1752, R.S. 39:1753, R.S. 39:1754, and R.S. 39:1755.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Telecommunications Management, LR 6:722 (December 1980), repromulgated LR 10:80 (February 1984), LR 17:267 (March 1991), LR 25:1624 (September 1999).

### **§503. Approval Criteria**

A. When one of the following criteria is met and upon approval of the Office of Telecommunications Management, non-state entities may use state telecommunications services. The non-state entities shall be either:

1. political subdivisions created by statute;
2. state credit unions;
3. Blind Services approved operators in state buildings;
4. the working press with offices in the State Capitol;
5. private educational institutions in the State of Louisiana with classes from kindergarten through 12th grade, and colleges and universities, when requesting access to the LaNet Wide Area Network for educational and/or research purposes; or
6. any non-state entity working in cooperation with the Louisiana Department of Labor's efforts to comply with the federal Workforce Investment Act of 1998 (Public Law 105-220).

B. A non-state entity may be required to supply documentation or evidence of its creation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 39:140, R.S. 39:141, R.S. 39:143, R.S. 39:1751, R.S. 39:1752, R.S. 39:1753, R.S. 39:1754, and R.S. 39:1755.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Telecommunications Management, LR 6:722 (December 1980), repromulgated LR 10:80 (February 1984), LR 17:267 (March 1991), LR 25:1624 (September 1999).

### **§505. Charges**

The non-state entities being allowed to use the state provided services will be charged the same rates as state agencies and must pay for the service within thirty days of receipt of the Office of Telecommunications Management invoice.

AUTHORITY NOTE: Promulgated in accordance with R.S. 39:140, R.S. 39:141, R.S. 39:143, R.S. 39:1751, R.S. 39:1752, R.S. 39:1753, R.S. 39:1754, and R.S. 39:1755.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Telecommunications Management, LR 6:722 (December 1980), repromulgated LR 10:80 (February 1984), LR 17:267 (March 1991), LR 25:1624 (September 1999).

## **§507. Availability and Usage Constraints**

The use of the state services by the non-state entities shall not preclude any state agency from use of those services. The non-state entity's use of these services should not result in any additional unreimbursed cost to the state.

AUTHORITY NOTE: Promulgated in accordance with R.S. 39:140, R.S. 39:141, R.S. 39:143, R.S. 39:1751, R.S. 39:1752, R.S. 39:1753, R.S. 39:1754, and R.S. 39:1755.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Telecommunications Management, LR 6:722 (December 1980), repromulgated LR 10:80 (February 1984), LR 17:267 (March 1991), LR 25:1624 (September 1999).

## **Chapter 7. Telecommunications Service Standards**

### **§701. General**

The State of Louisiana will utilize a statewide, consolidated concept of providing telecommunications services which are most cost effective and best meet the overall needs of the state.

AUTHORITY NOTE: Promulgated in accordance with R.S. 39:140, R.S. 39:141, R.S. 39:143, R.S. 39:1751, R.S. 39:1752, R.S. 39:1753, R.S. 39:1754, and R.S. 39:1755.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Telecommunications Management, LR 6:722 (December 1980), repromulgated LR 10:80 (February 1984), LR 17:267 (March 1991), LR 25:1625 (September 1999).

### **§703. Local Service Standards**

The Office of Telecommunications Management will determine the means of providing telecommunications services to be used within a given metropolitan area. The selection of the service will be based on the best overall service alternative for that area. Agencies will be provided service through this metropolitan service vehicle.

AUTHORITY NOTE: Promulgated in accordance with R.S. 39:140, R.S. 39:141, R.S. 39:143, R.S. 39:1751, R.S. 39:1752, R.S. 39:1753, R.S. 39:1754, and R.S. 39:1755.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Telecommunications Management, LR 6:722 (December 1980), repromulgated LR 10:80 (February 1984), LR 17:267 (March 1991), LR 25:1625 (September 1999).

### **§705. Long Distance Network Service Standards**

The Office of Telecommunications Management will determine the means for providing long distance telephone service for each individual metropolitan area. State agencies will be provided service through this metropolitan service vehicle.

AUTHORITY NOTE: Promulgated in accordance with R.S. 39:140, R.S. 39:141, R.S. 39:143, R.S. 39:1751, R.S. 39:1752, R.S. 39:1753, R.S. 39:1754, and R.S. 39:1755.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Telecommunications Management, LR 6:722 (December 1980), repromulgated LR 10:80 (February 1984), LR 17:267 (March 1991), LR 25:1625 (September 1999).

## **Chapter 9. Telecommunications Use**

### **§901. General**

All agencies are responsible for devising, implementing, and enforcing cost controls related to telephone usage and informing employees of such policies to preclude unnecessary and unauthorized charges.

AUTHORITY NOTE: Promulgated in accordance with R.S. 39:140, R.S. 39:141, R.S. 39:143, R.S. 39:1751, R.S. 39:1752, R.S. 39:1753, R.S. 39:1754, and R.S. 39:1755.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Telecommunications Management, LR 6:722 (December 1980), repromulgated LR 10:80 (February 1984), LR 17:267 (March 1991), LR 25:1625 (September 1999).

### **§903. Authorized Use**

State telecommunications systems and telecommunications services are provided for the conduct of state business.

AUTHORITY NOTE: Promulgated in accordance with R.S. 39:140, R.S. 39:141, R.S. 39:143, R.S. 39:1751, R.S. 39:1752, R.S. 39:1753, R.S. 39:1754, and R.S. 39:1755.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Telecommunications Management, LR 6:722 (December 1980), repromulgated LR 10:80 (February 1984), LR 17:267 (March 1991), LR 25:1625 (September 1999).

### **§ 905. Receiving Collect Telephone Calls**

Collect calls shall not be accepted on state telephones.

AUTHORITY NOTE: Promulgated in accordance with R.S. 39:140, R.S. 39:141, R.S. 39:143, R.S. 39:1751, R.S. 39:1752, R.S. 39:1753, R.S. 39:1754, and R.S. 39:1755.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Telecommunications Management, LR 6:722 (December 1980), repromulgated LR 10:80 (February 1984), LR 17:267 (March 1991), LR 25:1625 (September 1999).

### **§907. Calls Billed As a Third Number Call to State Telephone Numbers**

Third number calls billed to state telephones are prohibited.

AUTHORITY NOTE: Promulgated in accordance with R.S. 39:140, R.S. 39:141, R.S. 39:143, R.S. 39:1751, R.S. 39:1752, R.S. 39:1753, R.S. 39:1754, and R.S. 39:1755.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Telecommunications Management, LR 6:722 (December 1980), repromulgated LR 10:80 (February 1984), LR 17:267 (March 1991), LR 25:1625 (September 1999).

### **§909. LINC Management Reporting**

LINC management reporting shall be provided by the Office of Telecommunications Management to agency management when available to assist in monitoring and controlling the usage of long distance service.

AUTHORITY NOTE: Promulgated in accordance with R.S. 39:140, R.S. 39:141, R.S. 39:143, R.S. 39:1751, R.S. 39:1752, R.S. 39:1753, R.S. 39:1754, and R.S. 39:1755.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Telecommunications Management, LR 6:722 (December 1980), repromulgated LR 10:80 (February 1984), LR 17:267 (March 1991), LR 25:1625 (September 1999).

### **§911. Agency Usage Policy**

Agency policy concerning telephone usage must be consistent with this Chapter and should be appropriate for the particular needs of each agency.

AUTHORITY NOTE: Promulgated in accordance with R.S. 39:140, R.S. 39:141, R.S. 39:143, R.S. 39:1751, R.S. 39:1752, R.S. 39:1753, R.S. 39:1754, and R.S. 39:1755.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of

Telecommunications Management, LR 6:722 (December 1980), repromulgated LR 10:80 (February 1984), LR 17:267 (March 1991), LR 25:1625 (September 1999).

## **Chapter 11. Telecommunications Service Requests**

### **§1101. Submission**

All agency requests for telecommunications systems and/or telecommunications services must be submitted on the appropriate forms to the Office of Telecommunications Management.

**AUTHORITY NOTE:** Promulgated in accordance with R.S. 39:140, R.S. 39:141, R.S. 39:143, R.S. 39:1751, R.S. 39:1752, R.S. 39:1753, R.S. 39:1754, and R.S. 39:1755.

**HISTORICAL NOTE:** Promulgated by the Office of the Governor, Division of Administration, Office of Telecommunications Management, LR 6:722 (December 1980), repromulgated LR 10:80 (February 1984), LR 17:267 (March 1991), LR 25:1625 (September 1999).

## **Chapter 13. Telecommunications Charges**

### **§1301. Charges for Services**

The specific charges for each line of service provided will be published in the Office of Telecommunications Management's Catalog of Services.

**AUTHORITY NOTE:** Promulgated in accordance with R.S. 39:140, R.S. 39:141, R.S. 39:143, R.S. 39:1751, R.S. 39:1752, R.S. 39:1753, R.S. 39:1754, and R.S. 39:1755.

**HISTORICAL NOTE:** Promulgated by the Office of the Governor, Division of Administration, Office of Telecommunications Management, LR 6:722 (December 1980), repromulgated LR 10:80 (February 1984), LR 17:267 (March 1991), LR 25:1626 (September 1999).

## **Chapter 15. Directory Requirements**

### **§1501. Responsibilities**

The Office of Telecommunications Management will be responsible for the coordination and publication of all directory information for state telephone users. Respective agency Telecommunications Coordinators will be responsible for initiating directory listing changes and for verifying accuracy prior to publication.

**AUTHORITY NOTE:** Promulgated in accordance with R.S. 39:140, R.S. 39:141, R.S. 39:143, R.S. 39:1751, R.S. 39:1752, R.S. 39:1753, R.S. 39:1754, and R.S. 39:1755.

**HISTORICAL NOTE:** Promulgated by the Office of the Governor, Division of Administration, Office of Telecommunications Management, LR 6:722 (December 1980), repromulgated LR 10:80 (February 1984), LR 17:267 (March 1991), LR 25:1626 (September 1999).

## **Chapter 17. Telecommunications Procurement**

### **§1701. Tariffs**

When determined by the Office of Telecommunications Management to be in the best interest of the state and when available, general subscriber tariffs and related special billing assemblies may be used.

**AUTHORITY NOTE:** Promulgated in accordance with R.S. 39:140, R.S. 39:141, R.S. 39:143, R.S. 39:1751, R.S. 39:1752, R.S. 39:1753, R.S. 39:1754, and R.S. 39:1755.

**HISTORICAL NOTE:** Promulgated by the Office of the Governor, Division of Administration, Office of Telecommunications Management, LR 6:722 (December 1980), repromulgated LR 10:80 (February 1984), LR 17:267 (March 1991), LR 25:1626 (September 1999).

### **§1703. Contract Contents**

The request for proposals, or the invitation to bid, and its addenda with the vendor's response shall be incorporated into the final contract consummated with that vendor. In the event of ambiguity, the order of precedence will be the

contract, the request for proposals or the invitation to bid, and the vendor's response.

**AUTHORITY NOTE:** Promulgated in accordance with R.S. 39:140, R.S. 39:141, R.S. 39:143, R.S. 39:1751, R.S. 39:1752, R.S. 39:1753, R.S. 39:1754, and R.S. 39:1755.

**HISTORICAL NOTE:** Promulgated by the Office of the Governor, Division of Administration, Office of Telecommunications Management, LR 6:722 (December 1980), repromulgated LR 10:80 (February 1984), LR 17:267 (March 1991), LR 25:1626 (September 1999).

### **§1705. Multi-Year Contract Use**

Multi-year contract use must be justified and approved in writing. Such justification shall identify and consider all cost factors relevant to that contract. The multi-year method of contracting may be used in, but shall not be limited to, the following situations:

A. utility-type contracts; or

B. when it has been determined that vendors could provide lower unit prices over a longer period of time due to increased volume or lower production costs; or

C. when the cost and burden of contract solicitation, award, and administration of the procurement may be reduced; or

D. when the cost and burden of contract conversion or service implementation are excessive; or

E. when the Commissioner of Administration deems the use of a multi-year contract to be in the best interest of the state.

**AUTHORITY NOTE:** Promulgated in accordance with R.S. 39:140, R.S. 39:141, R.S. 39:143, R.S. 39:1751, R.S. 39:1752, R.S. 39:1753, R.S. 39:1754, and R.S. 39:1755.

**HISTORICAL NOTE:** Promulgated by the Office of the Governor, Division of Administration, Office of Telecommunications Management, LR 6:722 (December 1980), repromulgated LR 10:80 (February 1984), LR 17:267 (March 1991), LR 25:1626 (September 1999).

## **Chapter 19. Vendor Responsibilities**

### **§1901. General**

All vendor contact for sales and service of telecommunications systems and telecommunications services shall be with the Office of Telecommunications Management and not directly with agencies.

**AUTHORITY NOTE:** Promulgated in accordance with R.S. 39:140, R.S. 39:141, R.S. 39:143, R.S. 39:1751, R.S. 39:1752, R.S. 39:1753, R.S. 39:1754, and R.S. 39:1755.

**HISTORICAL NOTE:** Promulgated by the Office of the Governor, Division of Administration, Office of Telecommunications Management, LR 6:722 (December 1980), repromulgated LR 10:80 (February 1984), LR 17:267 (March 1991), LR 25:1626 (September 1999).

### **§1903. Bid Notification**

It is each vendor's responsibility to notify the State Purchasing Office of its desire to receive notification of state telecommunications bids.

**AUTHORITY NOTE:** Promulgated in accordance with R.S. 39:140, R.S. 39:141, R.S. 39:143, R.S. 39:1751, R.S. 39:1752, R.S. 39:1753, R.S. 39:1754, and R.S. 39:1755.

**HISTORICAL NOTE:** Promulgated by the Office of the Governor, Division of Administration, Office of Telecommunications Management, LR 6:722 (December 1980), repromulgated LR 10:80 (February 1984), LR 17:267 (March 1991), LR 25:1626 (September 1999).

### **§1905. Telecommunications Contracts**

Vendors shall not enter into any contract with any state agency for telecommunications systems or

telecommunications services without prior written approval from the Office of Telecommunications Management.

AUTHORITY NOTE: Promulgated in accordance with R.S. 39:140, R.S. 39:141, R.S. 39:143, R.S. 39:1751, R.S. 39:1752, R.S. 39:1753, R.S. 39:1754, and R.S. 39:1755.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Telecommunications Management, LR 6:722 (December 1980), repromulgated LR 10:80 (February 1984), LR 17:267 (March 1991), LR 25:1626 (September 1999).

### **Chapter 21. Waiver of Regulations**

#### **§2101. Commissioner's Authority to Waive Regulations**

The Commissioner of Administration may waive in writing, upon the recommendation of the Office of Telecommunications Management, any provision in these rules when the best interest of the state will be served.

AUTHORITY NOTE: Promulgated in accordance with R.S. 39:140, R.S. 39:141, R.S. 39:143, R.S. 39:1751, R.S. 39:1752, R.S. 39:1753, R.S. 39:1754, and R.S. 39:1755.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Telecommunications Management, LR 6:722 (December 1980), repromulgated LR 10:80 (February 1984), LR 17:267 (March 1991), LR 25:1627 (September 1999).

Joseph A. Lanier  
Director

9909#029

### **RULE**

#### **Department of Health and Hospitals Board of Nursing**

Registration of Licenses and Certificates  
(LAC 46:XLIX.1103)

In accordance with the emergency provisions of the Administrative Procedure Act, R.S. 49:950 et seq., the Department of Health and Hospitals, Board of Examiners of Nursing Facility Administrators has amended the rules pertaining to annual registration and registration fees. The board finds it necessary to amend this rule to provide for annual registration periods and new registration fees in order to ensure continued protection of public health and continued compliance with Federal rules and regulations regarding Medicaid/Medicare.

#### **Title 46**

### **PROFESSIONAL AND OCCUPATIONAL STANDARDS**

#### **Part XLIX. Board of Examiners of Nursing Facility Administrators**

#### **Chapter 11. Licenses**

#### **§1103. Registration of Licenses and Certificates**

A.1. Every person who holds a valid license as a nursing home administrator issued by the board shall immediately upon issuance thereof be deemed registered with the board and issued a certificate of registration. Thereafter, such individual shall annually apply to the board for a new certificate of registration and report any facts required by the board on forms provided for such purpose.

A.2. - 3. ...

B.1. Upon making an application for a new certificate of registration such licensee shall pay an annual registration fee

of \$245 and, at the same time, shall submit evidence satisfactory to the board that, during the annual period immediately preceding such application for registration, they have attended a continuing education program or course of study as provided in Chapter 9 of these rules and regulations. A copy of the certificate(s) of attendance for 15 hours of approved continuing education shall be attached to the annual re-registration application.

2. A licensed nursing home administrator no longer practicing in Louisiana may place his license in an inactive status. He shall continue to register his license annually but is exempt from continuing education requirements. Should a licensee wish to reactivate their license they shall undergo 60 days of on-site re-orientation under supervision of a board-approved preceptor, unless such person has been actively practicing in another state and meets Louisiana continuing education requirements.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:2504.

HISTORICAL NOTE: Adopted by the Department of Health and Human Resources, Board of Examiners of Nursing Home Administrators, April 1970, amended and promulgated LR 9:461 (July 1983), repealed and repromulgated by the Department of Health and Hospitals, Board of Examiners of Nursing Home Administrators LR 18:181 (February 1992), amended LR 25:1627 (September 1999).

Kemp Wright  
Executive Director

9909#038

### **RULE**

#### **Department of Health and Hospitals Board of Veterinary Medicine**

Expired Drugs (LAC 46:LXXXV.705)

The Board of Veterinary Medicine hereby amends LAC 46:LXXXV.705 in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., and the Veterinary Practice Act, La. R.S. 37:1518 et seq.

#### **Title 46**

### **PROFESSIONAL AND OCCUPATIONAL STANDARDS**

#### **Part LXXXV. Veterinarians**

#### **Chapter 7. Veterinary Practice**

#### **§705. Prescribing and Dispensing Drugs**

A. - G. ...

H. It shall be a violation of the rules of professional conduct under R.S. 37:1526(14) for a veterinarian in the course of his veterinary practice to use or dispense any products, including drugs, which are expired.

I. It shall be a violation of the rules of professional conduct under R.S. 37:1526(14) for a veterinarian to be in possession of drugs or other medical products which are over six months past their expiration date unless the materials are obviously removed from use and it can be documented that said drugs are in the process of being returned or otherwise disposed of.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1518 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Veterinary Medicine, LR 6:71

(February 1980), amended LR 16:226 (March 1990), LR 19:1329 (October 1993), LR 20:1381 (December 1994), LR 23:1686 (December 1997), LR 24:1932 (October 1998), LR 25:1627 (September 1999).

Kimberly B. Barbier  
Administrative Director

9909#012

#### **RULE**

### **Department of Health and Hospitals Board of Veterinary Medicine**

Partnerships, Corporations, and Limited Liability Companies  
(LAC 46:LXXXV.1015)

The Board of Veterinary Medicine hereby amends LAC 46:LXXXV.1015 in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., and the Veterinary Practice Act, La. R.S. 37:1518 et seq.

#### **Title 46**

### **PROFESSIONAL AND OCCUPATIONAL STANDARDS**

#### **Part LXXXV. Veterinarians**

#### **Chapter 10. Rules of Professional Conduct**

#### **§1015. Partnerships, Corporations, and Limited Liability Companies**

In the formation of partnerships, corporations, or limited liability companies for the practice of veterinary medicine, no person shall be admitted as a partner or owner who is not a member of the veterinary profession, duly licensed to practice in this state, and amenable to professional discipline. No person shall be held out as a practitioner of veterinary medicine or a member of the firm who is not so admitted. In the selection and use of a firm name, no false or misleading name shall be used. Partnerships between veterinarians and members of other professions or nonprofessional persons shall not be formed or permitted if a part of the partnership employment consists of the practice of veterinary medicine. Corporations or limited liability companies created or owned by licensed veterinarians in conjunction with non-veterinarians shall not be permitted if a part of the company's function consists of the practice of veterinary medicine

**AUTHORITY NOTE:** Promulgated in accordance with R.S. 37:1518 et seq.

**HISTORICAL NOTE:** Promulgated by the Department of Health and Hospitals, Board of Veterinary Medicine, LR 16:229 (March 1990), amended LR 25:1628 (September 1999).

Kimberly B. Barbier  
Administrative Director

9909#013

#### **RULE**

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

Eligibility—Louisiana Children's Health  
Insurance Program (LaCHIP)

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, adopts the following rule as authorized by LA. R.S. 46:153. This rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

#### **Rule**

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing implements the second phase of the Louisiana Children's Health Insurance Program (LaCHIP) effective October 1, 1999 by expanding coverage under the Medicaid Program to uninsured children, birth through age nineteen, whose family income is between 133 percent and 150 percent of the federal poverty level (FPL). This expansion is in compliance with section 4901 of the Balanced Budget Act of 1997 which enacted Title XXI of the Social Security Act, Act 128 of the First Extraordinary Session of the 1998 Louisiana Legislature which enacted the LaCHIP Program, and Senate Bill No. 256 and the General Appropriation Act of the 1999 Regular Session of the Louisiana Legislature which authorizes the funding for the expansion. All other requirements for LaCHIP eligibility will remain the same.

David W. Hood  
Secretary

9909#045

#### **RULE**

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

Eligibility—Presumptive Eligibility Certification Period

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

#### **Rule**

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing amends the length of the presumptive eligibility period when the pregnant woman does not file a standard Medicaid

application after being determined presumptively eligible. If a presumptively eligible pregnant woman does not file an application for Medicaid by the last day of the month following the month in which she is determined presumptively eligible, her presumptive eligibility ends on that last day. If she files an application timely, her presumptive eligibility certification stays open until a decision is made.

David W. Hood  
Secretary

9909#046

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

Home and Community Based Services Waiver  
Program—Mentally Retarded/Developmentally Disabled

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

**Rule**

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing amends the provisions governing programmatic allocation of waiver slots for the Mentally Retarded/Developmentally Disabled Waiver contained in the March 20, 1998 rule as follows:

**Programmatic Allocation of Waiver Slots.** The waiting list shall be used to protect the individual's right to be evaluated for waiver eligibility. The Regional Office for Citizens with Developmental Disabilities (OCDD) shall notify the next individual on the waiting list in writing that a slot is available and that he/she is next in line to be evaluated for possible waiver slot assignment. The OCDD staff shall follow the procedures established by the Division of Home and Community-Based Waivers (DHCBW) as part of the application process. The individual then chooses a case manager who will assist in the gathering of the documents needed for both the financial eligibility and medical certification process. If the individual is determined to be ineligible either financially or medically, that individual is notified in writing and a copy of the notice is forwarded to the regional OCDD office. The next person on the waiting list is notified as stated above and the process continues until an eligible person is identified. A waiver slot is assigned to an individual when eligibility is established and the individual is certified. Utilizing these procedures, waiver slots shall be allocated to the targeted groups cited below as follows:

1. A minimum of 80 slots shall be available for allocation to foster children in the custody of the Office of Community Services (OCS) who successfully complete the financial and medical certification eligibility process and are certified for the waiver. OCS is the guardian for those

children who have been placed in their custody by court order. OCS shall be responsible for assisting the individual to gather the documents needed in the eligibility determination process; preparing the comprehensive plan of care; and submitting the plan of care document to DHCBW.

2. A minimum of 160 slots shall be available for residents of the Pinecrest and Hammond Developmental Centers, or their alternates, who successfully complete the financial and medical certification eligibility process and are certified for the waiver. Alternate shall be defined as those residents of ICF-MR facilities who choose to apply for waiver participation, are determined eligible for the waiver, and vacate a bed in the ICF-MR facility which will be used for a resident being discharged from a public developmental center. The Pinecrest or Hammond Developmental Center resident must be given freedom of choice in the selection of a private ICF-MR facility placement in the area of the resident's choice in order to designate the resident being discharged from the ICF-MR facility as an alternate. The bed being vacated in the ICF-MR facility is reserved for placement of a public developmental center resident for 120 days.

3. Any slots vacated during the waiver year shall be available to residents leaving any publicly operated ICF-MR facility.

4. At minimum of 36 slots shall be available for the conversion of whole ICF-MR facilities to waiver services. In order to qualify, all residents of the ICF-MR facility must choose to participate in the waiver, must meet the financial and medical eligibility requirements for the waiver, and the ICF-MR facility must be closed and its licensure and certificate of need forfeited.

5. Funded slots, not addressed in this section, shall be available for allocation to the next applicants on the MR/DD Waiver waiting list, in order of application, who successfully complete the financial eligibility and medical certification process and are certified for the waiver.

Waiver slots shall not be reserved for use as emergency slots nor shall emergency slots be assigned.

The Bureau of Health Services Financing, Division of Home and Community-Based Waivers has the authority to monitor the utilization of waiver slots. Specially allocated slots may be reallocated to better meet the needs of Medicaid recipients with developmental disabilities.

David W. Hood  
Secretary

9909#043

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

Medicaid—Gifts to Children with Life-Threatening  
Conditions

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

Social Security Act. This rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

### Rule

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing amends section I of the Medicaid Eligibility Manual governing countable income and resources by adopting the provisions of P.L. 105-306 which exclude from consideration as countable income and resources, any gifts made to, or for the benefit of, children who are under age 18 and have a life-threatening condition, if the gifts are from an organization described in section 501(c)(3) of the Internal Revenue Code of 1986 as exempt from taxation. This amendment is applicable to gifts made on or after October 28, 1996.

A. Income Determinations. Gifts are excluded from the income determination of Medicaid eligibility under the following circumstances:

1. in the case of an in-kind gift, it is not considered income if the gift is not converted to cash;
2. if an in-kind gift is converted to cash, the cash is counted as income in the month it is converted;
3. in the case of a cash gift, it is excluded as income only to the extent that the total amount excluded from the income under this provision does not exceed \$2,000 in any calendar year;
4. cash in excess of \$2,000 received in a calendar year is subject to regular income determination policy.

B. Resource Determination. Gifts will be excluded from the resource determination of Medicaid eligibility under the following circumstances:

1. in the case of an in-kind gift, it is not considered as income if the gift is not converted to cash;
2. if an in-kind gift is converted to cash, any cash remaining in the month following the month that it is converted is a resource;
3. in the case of a cash gift, it is considered as a resource only to the extent that the cash excluded does not exceed \$2,000 in any calendar year;
4. retained cash in excess of \$2,000 received in a calendar year is subject to regular resource determination policy.

C. A gift to a parent whose income and resources are subject to deeming is excluded (subject to the aforementioned limits) if the gift is for the benefit of a child under age 18 with a life-threatening condition.

David W. Hood  
Secretary

9909#044

### RULE

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

Surveillance and Utilization Review Systems (SURS)  
(LAC 50:II.Chapter 41)

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

following rule as authorized by LA. R.S. 46:153 and pursuant to Title XIX of the Social Security Act. This proposed rule is in accordance with the Administrative Procedure Act R.S. 49:950 et seq.

### Title 50

### PUBLIC HEALTH MEDICAL ASSISTANCE

### Part II. Medical Assistance Program

### Subpart 1. General /Program Integrity

### Chapter 41. Surveillance and Utilization Review Systems (SURS)

### Subchapter A. General Provisions

### §4101. Foreword

A. The Medical Assistance Program is a four party arrangement: the taxpayer, the government, the beneficiaries and the providers. The Secretary of the Department of Health and Hospitals, through this regulation, recognizes:

1. the obligation to the taxpayers to assure the fiscal and programmatic integrity of the Medical Assistance Program. The Secretary has zero tolerance for fraudulent, willful, abusive or other ill practices perpetrated upon the Medical Assistance Program by providers, providers-in-fact and others, including beneficiaries. Such practices will be vigorously pursued to the fullest extent allowed under the applicable laws and regulations;

2. the responsibility to assure that actions brought in pursuit of providers, providers-in-fact and others, including beneficiaries, under this regulation are not frivolous, vexatious or brought primarily for the purpose of harassment. Providers, providers-in-fact and others, including beneficiaries, must recognize that they have an obligation to obey and follow all applicable laws, regulations, policies, criteria and procedures; and

3. that when determining whether a fraudulent pattern of incorrect submissions exists under this regulation, the department has an obligation to demonstrate that the pattern of incorrect submissions are material, as defined under this regulation, prior to imposing a fine or other monetary sanction which is greater than the amount of the identified overpayment resulting from the pattern of incorrect submissions. In the case of an action brought for a pattern of incorrect submissions, providers and providers-in-fact must recognize that if they frivolously or unreasonably deny the existence or amount of an overpayment resulting from a pattern of incorrect submissions, the department may impose judicial interest on any outstanding recovery or recoupment or reasonable cost and expenses incurred as the direct result of the investigation or review, including but not limited to the time and expenses incurred by departmental employees or agents and the fiscal intermediary's employees or agents.

B. The Department of Health and Hospitals, Bureau of Health Services Financing (BHSF) has adopted this regulation in order to:

1. establish procedures for conducting surveillance and utilization review of providers and others;
2. define conduct in which providers and other cannot be engaged;
3. establish grounds for sanctioning providers and others who engage in prohibited conduct; and
4. establish the procedures to be used when sanctioning or otherwise restricting a provider and others under the Louisiana Medicaid Program.

C. The purpose of this regulation is to assure the quality, quantity, and need for such goods, services, and supplies and to provide for the sanctioning of those who do not provide adequate goods, services, or supplies or request payment or reimbursement for goods, services, or supplies which do not comply with the requirements of federal laws, federal regulations, state laws, state regulations or the rules, procedures, criteria or policies governing providers and others under the Louisiana Medicaid Program.

D. A further purpose of this regulation is to assure the integrity of the Louisiana Medicaid Program by providing methods and procedures to:

1. prevent, detect, investigate, review, hear, refer, and report fraudulent or abusive practices, errors, over-utilization, or under-utilization by providers and others;
2. impose any and all administrative sanctions and remedial measures authorized by law or regulation, which are appropriate under the circumstances;
3. pursue recoupment or recovery arising out of prohibited conduct or overpayments;
4. allow for informal resolution of disputes between the Louisiana Medicaid Program and providers and others;
5. establish rules, policies, criteria and procedures; and
6. other functions as may be deemed appropriate.

E. In order to further the purpose of this regulation the Secretary may establish peer review groups for the purpose of advising the Secretary on any matters covered in this regulation.

F. Nothing in this regulation is intended, nor shall it be construed, to grant any person any right to participate in the Louisiana Medicaid Program which is not specifically granted by federal law or the laws of this state or to confer upon any person's rights or privileges which are not contained within this regulation.

**AUTHORITY NOTE:** Promulgated in accordance with R.S. 36:254, 46:437.4 and 46:437.1-46:440.3 (Medical Assistance Program Integrity Law).

**HISTORICAL NOTE:** Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:1630 (September 1999).

### **§4103. Definitions**

A. The following specific terms shall apply to all those participating in the Louisiana Medicaid Program, either directly or indirectly, and shall be applied when making any and all determinations related to this and other departmental regulations, rules, policies, criteria, and procedures applicable to the Louisiana Medicaid program and its programs.

*Affiliates*—any person who has a direct or indirect relationship or association with a provider such that the provider is directly or indirectly influenced or controlled by the affiliate or has the power to do so. Any person with a direct or indirect ownership interest in a provider is presumed to be an affiliate of that provider. Any person who shares in the proceeds or has the right to share in the proceeds of a provider is presumed to be an affiliate of that provider unless that person is a spouse or a minor child of the provider and has no other affiliation with the provider other than that of being a family member of the provider.

*Agent*—a person who is employed by or has a contractual relationship with a provider or who acts on behalf of the provider.

*Agreement to Repay*—a formal written and enforceable arrangement to repay an identified overpayment, interest, monetary penalties or costs and expenses.

*Billing Agent*—any agent who performs any or all of the provider's billing functions. Billing agents are presumed to be an agent of the provider.

*Billing or Bill*—submitting, or attempting to submit, a claim for goods, supplies, or services.

*Claim*—any request or demand, including any and all documents or information required by federal or state law or by rule made against Medical Assistance Program funds for payment. A claim may be based on costs or projected costs and includes any entry or omission in a cost report or similar document, book of account, or any other document which supports, or attempts to support, the claim. In the case of a claim based on a cost report, any entry or omission in a cost report, book of account or other documents used or intended to be used to support a cost report shall constitute a claim. Each claim may be treated as a separate claim, or several claims may be combined to form one claim.

*Claims or Payment Review*—the process of reviewing documents or other information or sources required or related to the payment or reimbursement to a provider by the department, BHSF, SURS or the fiscal intermediary in order to determine if the bill or claim should be or should have been paid or reimbursed. Payment and claim reviews are the same process.

*Contractor*—any person with whom the provider has a contract to perform a service or function on behalf of the provider. A contractor is presumed to be an agent of the provider.

*Corrective Action Plan*—a written plan, short of an administrative sanction, agreed to by a provider, provider-in-fact or other person with the department, BHSF or, Program Integrity designed to remedy any inefficient, aberrant or prohibited practices by a provider, provider-in-fact or other person. A corrective action plan is not a sanction.

*Department*—the Louisiana Department of Health and Hospitals.

*Deputy Secretary*—the Deputy Secretary of the department or authorized designee.

*Director of Program Integrity or Assistant Director of Program Integrity*—the individual whom the Secretary has designated as the director, program manager or section chief of the Program Integrity Division or the designated assistant to the Director of Program Integrity Division respectively or their authorized designee.

*Director of the Bureau of Health Finance Services*—the director of BHSF or authorized designee.

*Exclusion from Participation*—a sanction that terminates a provider, provider-in-fact or other person from participation in the Louisiana Medicaid program, or one or more of its programs and cancels the provider's provider agreement.

a. A provider who is excluded may, at the end of the period of exclusion, reapply for enrollment.

b. A provider, provider-in-fact or other person who is excluded may not be a provider or provider-in-fact, agent of a provider, or affiliate of a provider or have a direct or indirect ownership in any provider during their period of exclusion.

*False or Fraudulent*—a claim which the provider or his billing agent submits knowing the claim to be false, fictitious, untrue, or misleading in regard to any material information. "False or fraudulent claim" shall include a claim which is part of a pattern of incorrect submissions in regard to material information or which is otherwise part of a pattern in violation of applicable federal or state law or rule.

*Federal Regulations*—the provisions contained in the *Code of Federal Regulations* (CFR) or the *Federal Register* (FR).

*Finalized Sanction or Final Administrative Adjudication or Order*—a final order imposed pursuant to an administrative adjudication that has been signed by the Secretary or the Secretary's authorized designee.

*Fiscal Agent or Fiscal Intermediary*—an organization or legal entity whom the department contracts with to provide for the processing, review of or payment of provider bills and claims.

*Good, Service or Supply*—any good, item, device, supply, or service for which a claim is made, or is attempted to be made, in whole or in part.

*Health Care Provider*—any person furnishing or claiming to furnish a good, service, or supply under the Medical Assistance Programs as defined in R.S. 46:437.3 and any other person defined as a health care provider by federal or state law or by rule. For the purpose of this regulation, health care provider and provider are interchangeable terms.

*Identified Overpayment*—the amount of overpayment made to or requested by a provider that has been identified in a final administrative adjudication or order.

*Indirect Ownership*—an ownership interest in an entity that has an ownership interest in a provider. This term includes an ownership interest in any entity that has an indirect ownership interest in a provider.

*Ineligible Recipient*—an individual who is not eligible to receive health care through the medical assistance programs.

*Informal Hearing*—an informal conference between the provider, provider-in-fact or other persons and the Director of Program Integrity or the SURS manager related to a notice of corrective action, notice of withholding of payments or notice of sanction.

*Investigator or Analyst*—any person authorized to conduct investigations on behalf of the department, BHSF, Program Integrity Division, SURS or the fiscal intermediary, either through employment or contract for the purposes of payment or programmatic review.

*Investigatory Process*—the examination of the provider, provider-in-fact, agent-of-the-provider, or affiliate, and any other person or entity, and any and all records held by or pertaining to them pursuant to a written request from BHSF. No adjudication is made during this process.

*Knew or Should Have Known*—the person knew or should have known that the activity engaged in or not engaged in was prohibited conduct under this regulation or federal or

state laws and regulations. The standard to be used in determining knew or should have known is that of a reasonable person engaged in the activity or practice related to the Medical Assistance Program at issue.

*Knowing or Knowingly*—the person has actual knowledge of the information, or acts in deliberate ignorance or reckless disregard of the truth or falsity of the information. The standard to be used in determining knowing or knowingly is that of a reasonable person engaged in the activity or practice related to the Medical Assistance Program at issue.

*Law*—the constitutions, statutory or code provisions of the federal government and the government of the state of Louisiana.

*Louisiana Administrative Code (LAC)*—the *Louisiana Administrative Code* or the *Louisiana Register*.

*Managing Employee*—a person who exercises operational or managerial control over, or who directly or indirectly conducts, the day-to-day operations of a provider. Managing employee shall include, but is not limited to, a chief executive officer, president, general manager, business manager, administrator, or director.

*Medical Assistance Program or Medicaid*—the Medical Assistance Program (Title XIX of the Social Security Act), commonly referred to as "Medicaid", and other programs operated by and funded in the department which provide payment to providers.

*Misrepresentation*—the knowing failure to truthfully or fully disclose any and all information required, or the concealment of any and all information required on a claim or a provider agreement or the making of a false or misleading statement to the department relative to the Medical Assistance Program.

*Notice*—actual or constructive notice.

*Notice of an Action*—a written notification of an action taken or to be taken by the department, BHSF or SURS. A notice must be signed by or on behalf of the Secretary, Director of BHSF, or Director of Program Integrity.

*Ownership Interest*—the possession, directly or indirectly, of equity in the capital or the stock, or right to share in the profits of a provider.

*Payment or Reimbursement*—the payment or reimbursement to a provider from Medical Assistance Programs' funds pursuant to a claim, or the attempt to seek payment for a claim.

*Person*—any natural person, company, corporation, partnership, firm, association, group, or other legal entity or as otherwise provided for by law.

*Policies, Criteria or Procedure*—those things established or provided for through departmental manuals, provider updates, remittance advice or bulletins issued by the Medical Assistance Program or on behalf of the Medical Assistance Program.

*Program*—any program authorized under the Medical Assistance Program.

*Program Integrity Division (PID)*—the Program Integrity Unit under BHSF within the department, its predecessor and successor.

*Provider Agreement*—the document(s) signed by or on behalf of the provider and those things established or provided for in R.S. 46:437.11 - 437.14 or by rule, which

enrolls the provider in the Medical Assistance Program or one or more of its programs and grants to the provider a provider number and the privilege to participate in Medicaid of Louisiana or one or more of its programs.

*Provider Enrollment*—the process through which a person becomes enrolled in the Medical Assistance Program or one of its programs for the purpose of providing goods, services, or supplies to one or more Medicaid recipients or submissions of claims.

*Provider-in-Fact*—person who directly or indirectly participates in management decisions, has an ownership interest in the provider, or other persons defined as a provider-in-fact by federal or state law or by rule. A person is presumed to be a provider-in-fact if the person is:

- a. a partner;
- b. a board of Directors member;
- c. an office holder; or
- d. a person who performs a significant management or administrative function for the provider, including any person or entity who has a contract with the provider to perform one or more significant management or administrative functions on behalf of the provider;
- e. a person who signs the provider enrollment paper work on behalf of the provider;
- f. a managing employee;
- g. an agent of the provider, or a billing agent may

also be a provider-in-fact for the purpose of determining a violation and the imposing of a sanction under this regulation.

*Provider Number*—a provider's billing or claim reimbursement number issued by the department through BHSF under the Medical Assistance Program.

*Recipient*—an individual who is eligible to receive health care through the medical assistance programs.

*Recoupment*—recovery through the reduction, in whole or in part, of payments or reimbursements to a provider.

*Recovery*—the recovery of overpayments, damages, fines, penalties, costs, expenses, restitution, attorney's fees, or interest or settlement amounts.

*Referring Provider*—any provider, provider-in-fact or anyone operating on behalf of the provider who refers a recipient to another person for the purpose of providing goods, services, or supplies.

*Rule or Regulation*—any rule or regulation promulgated by the department in accordance with the Administrative Procedure Act and any federal rule or regulation promulgated by the federal government in accordance with federal law.

*Secretary*—the secretary of the Department of Health and Hospitals, or his authorized designee.

*Statistical Sample*—a statistical formula and sampling technique used to produce a statistical extrapolation of the amount of overpayment made to a provider or a volume of the violations.

*SURS Manager*—the individual designated by the Secretary as the manager of SURS or authorized designee.

*Surveillance and Utilization Review Section (SURS)*—the section within BHSF assigned to identify providers for review, conduct payment reviews, and sanction providers

resulting from payments to and claims from providers, and any other functions or duties assigned by the Secretary.

*Suspension from Participation*—occurs between the issuing of the notice of the results of the informal hearing and the issuing of the final administrative adjudication or order.

*Terms of the Provider Agreement*—the terms contained in the provider agreement or related documents and established or provided for in R.S. 46:437.11 - 437.14 or established by law or rule.

*Undersecretary*—the Undersecretary of the department or authorized designee.

*Violations*—any practice or activity by a provider, provider-in-fact, agent-of-the-provider, affiliate, or other persons which is prohibited by law or this rule.

*Withhold Payment*—to reduce or adjust the amount, in whole or in part, to be paid to a provider for pending or future claims during the time of a criminal, civil, or departmental investigation or proceeding or claims review of the provider.

*Working Days*—Monday through Friday, except for legal holidays and other situations when the department is closed.

B. General Terms. Definitions contained in applicable federal laws and regulations shall also apply to this and all department regulations. In the case of a conflict between federal definitions and departmental definitions, the department's definition shall apply unless the federal definition, as a matter of law, supersedes a departmental definition. Definitions contained in applicable state laws shall also apply to this and all departmental definitions. In the case of a conflict between a state statutory definition and a departmental definition, the departmental definition shall apply unless the state statutory definition, as a matter of state law, supersedes the departmental definition.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, 46:437.4 and 46:437.1-46:440.3 (Medical Assistance Program Integrity Law).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:1631 (September 1999).

#### **§4105. Material**

A. The Secretary of the Department of Health and Hospitals establishes the following definitions of Material:

1. For the purpose of the R.S. 48:438.3 as required under R.S. 48:438.8D, in determining whether a pattern of incorrect submissions exists in regards to an alleged false or fraudulent claim the incorrect submissions must be five (5) percent or more of the total claims submitted or to be submitted by the provider during the period covered in the civil action filed or to be filed. The total amount of claims for the purpose of this provision is the total number of claims submitted or to be submitted by the provider during the period of time and type or kind of claim which is the subject of the civil action under R.S. 48:438.3.

2. For the purpose of this regulation, in determining whether a pattern of incorrect submissions exist in regards to an alleged fraudulent or willful violation the incorrect submissions must be five (5) percent or more of the total claims being subjected to claims review under the provisions of this regulation. The total amount of claims for the purpose of this provision is the total number of claims submitted or

to be submitted by the provider during the period of time and type or kind of claim which is the subject of claims review.

3. Statistically valid sampling techniques may be used by either party to prove or disprove whether the pattern was material.

B. This provision is enacted under the authority provided in R.S. 46:438.8(D).

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, 46:437.4 and 46:437.1-46:440.3 (Medical Assistance Program Integrity Law).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:1633 (September 1999).

#### **§4107. Statistical Sampling**

A. Statistical Sampling techniques may be used by any party to the proceedings.

B. A valid sampling technique may be used to produce an extrapolation of the amount of overpayment made to a provider or the volume or number of violations committed by a provider or to disprove same.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, 46:437.4 and 46:437.1-46:440.3 (Medical Assistance Program Integrity Law).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:1634 (September 1999).

#### **Subchapter B. Claims Review Prepayment or Post-Payment Review**

##### **§4109. Departmental and Provider Obligations**

A. The department, through the Secretary, has an obligation, imposed by federal and state laws and regulations, to:

1. review bills and claims submitted by providers before payment is made or after;

a. Payments made by the Louisiana Medicaid Program are subject to review by the Department of Health and Hospitals, Bureau of Health Services Financing, Program Integrity Division or the fiscal intermediary at anytime to ensure the quality, quantity, and need for goods, services, or supplies provided to or for a recipient by a provider, and to protect the fiscal and programmatic integrity of the Louisiana Medicaid Program and its programs.

b. It is the function of the Program Integrity Division (PID) and the Surveillance and Utilization Review Section (SURS) to provide for and administer the utilization review process within the department.

2. assure that claims review brought under this regulation are not frivolous, vexatious or brought primarily for the purpose of harassment;

3. recognize that when determining whether a fraudulent pattern of incorrect submissions exists under this regulation, the department has an obligation to demonstrate that the pattern of incorrect submissions are material as defined under this regulation prior to imposing a fine or other monetary sanction which is greater than the amount of the identified or projected overpayment resulting from the pattern of incorrect submissions;

4. recognize the need to obtain advice from applicable professions and individuals concerning the standards to be applied under this regulation. At the discretion of the Secretary may seek advice from peer review groups which the Secretary has established for the purpose of seeking such advice;

5. recognize the right of each individual to exercise all rights and privileges afforded to that individual under the law including, but not limited to the right to counsel as provided under the applicable laws.

B. Providers have no right to receive payment for bills or claims submitted to BHSF or its fiscal intermediary. Providers only have a right to receive payment for valid claims. Payment of a bill or claim does not constitute acceptance by the department or its fiscal intermediary that the bill or claim is a valid claim. The provider is responsible for maintaining all records necessary to demonstrate that a bill or claim is in fact a valid claim. It is the provider's obligation to demonstrate that the bill or claim submitted was for goods, services, or supplies:

1. provided to a recipient who was entitled to receive the goods, services, or supplies;

2. were medically necessary or otherwise properly authorized;

3. were provided by or authorized by an individual with the necessary qualifications to make that determination; and

4. were actually provided to the appropriate recipient in the appropriate quality and quantity by an individual qualified to provide the good, service or supply; or

5. in the case of a claim based on a cost report, that each entry is complete, accurate and supported by the necessary documentation.

C. The provider must maintain and make available for inspection all documents required to demonstrate that a bill or claim is a valid claim. Failure on the part of the provider to adequately document means that the goods, services, or supplies will not be paid for or reimbursed by the Louisiana Medicaid program.

D. A person has no property interest in any payments or reimbursements from Medicaid which are determined to be an overpayment or are subject to payment review.

E. Providers, providers-in-fact and others, including beneficiaries must recognize that they have an obligation to obey and follow all applicable laws, regulations, policies, criteria and procedures. In the case of an action brought for a pattern of incorrect submissions, providers and providers in fact recognize that if they frivolously or unreasonably deny the existence or amount of an overpayment resulting from a pattern of incorrect submissions the department may impose judicial interest on any outstanding recovery or recoupment, or reasonable cost and expenses incurred as the direct result of the investigation or review including, but not limited to, the time and expenses incurred by departmental employees or agents and the fiscal intermediary's employees or agents.

F. In determining the amount to be paid or reimbursed to a provider any and all overpayments, recoupment or recovery must be taken into consideration prior to determining the actual amount owed to the provider.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, 46:437.4 and 46:437.1-46:440.3 (Medical Assistance Program Integrity Law).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:1634 (September 1999).

##### **§4111. Claims Review**

BHSF establishes the following procedures for review of bills and claims submitted to it or its fiscal intermediary:

#### A. Prepayment Review

1. Upon concurrence of the Director of BHSF and the Director of Program Integrity, bills or claims submitted by a provider may be reviewed by the SURS or the SURS unit of the Fiscal Intermediary for fifteen (15) days from date the payment or reimbursement is ordinarily sent to a provider by BHSF or its fiscal intermediary prior to the issuing of or denial of payment or reimbursement.

2. If, during the prepayment review process, it is determined that the provider may be overpaid, BHSF or its fiscal intermediary must conduct an investigation to determine the reasons for and estimates of the amount of the potential overpayments.

a. If it is determined that evidence exists which would lead the Director of BHSF and the Director of Program Integrity to believe that the provider, provider-in-fact, agent of the provider, or affiliate of the provider has engaged in fraudulent, false, or fictitious billing practices or willful misrepresentation, current and future payments shall be withheld.

b. If it is determined that evidence exists which would lead the Director of BHSF and the Director of Program Integrity to believe that overpayments may have occurred through reasons other than fraudulent, false or fictitious billing or willful misrepresentation, current and future payments may be withheld.

3. Prepayment review is not a sanction and cannot be appealed nor is it subject to an informal hearing. If prepayment review results in withholding of payments, the provider or provider-in-fact will be notified within five (5) working days of the determination to withhold payments. In the case of an ongoing criminal or outside governmental investigation, information related to the investigation shall not be disclosed to the provider, provider-in-fact or other person unless release of such information is otherwise authorized or required under law. The issuing of a notice of withholding triggers the right to an informal hearing. Denials or refusals to pay individual bills that are the result of the edit and audit system are not withholdings of payments.

4. Prepayment review is conducted at the absolute discretion of the Director of BHSF and the Director of Program Integrity.

#### B. Post-payment Review

1. Providers have a right to receive payment only for those bills that are valid claims. A person has no property interest in any payments or reimbursements from Medicaid, which are determined to be an overpayment or are subject to payment review. After payment to a provider, BHSF or its fiscal intermediary may review any or all payments made to a provider for the purpose of determining if the amounts paid were for valid claims.

2. If, during the post-payment review process, it is determined that the provider may have been overpaid, BHSF or its fiscal intermediary must conduct an investigation to determine the reasons for and estimated amounts of the alleged overpayments.

a. If it is determined that evidence exists that would lead the Director of BHSF and the Director of Program Integrity to believe that the provider, provider-in-fact, agent of the provider, or affiliate of the provider may have engaged in fraudulent, false, or fictitious billing practices or willful

misrepresentation, current and future payments shall be withheld.

b. If it is determined that evidence exists that overpayments may have occurred through reasons other than fraud or willful misrepresentation, current and future payments may be withheld.

3. Post-payment review is not a sanction and is not appealable nor subject to an informal hearing. If post-payment review results in withholding of payments, the provider or provider-in-fact will be notified within five working days of the determination to withhold payments. In the case of an ongoing criminal or outside government investigation, information related to the investigation shall not be disclosed to the provider, provider-in-fact or other person. The issuing of a notice of withholding triggers the right to an informal hearing. Denials or refusals to pay individual bills that are the result of the edit and audit system are not withholdings of payments.

4. Post-payment review is conducted is at the absolute discretion of the Director of BHSF and Director of Program Integrity.

**AUTHORITY NOTE:** Promulgated in accordance with R.S. 36:254, 46:437.4 and 46:437.1-46:440.3 (Medical Assistance Program Integrity Law).

**HISTORICAL NOTE:** Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:1634 (September 1999).

#### **§4113. Claims Review Scope and Extent**

A. Prepayment and post-payment review may be limited to specific items or procedures or include all billings or claims by a provider.

B. The length of time a provider is on post-payment review shall be at the sole discretion of the Director of BHSF and the Director of Program Integrity.

**AUTHORITY NOTE:** Promulgated in accordance with R.S. 36:254, 46:437.4 and 46:437.1-46:440.3 (Medical Assistance Program Integrity Law).

**HISTORICAL NOTE:** Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:1635 (September 1999).

#### **Subchapter C. Investigations**

##### **§4115. Formal or Informal Investigations**

Prepayment and post-payment review may be conducted through either a formal or informal process.

**AUTHORITY NOTE:** Promulgated in accordance with R.S. 36:254, 46:153 and 46:442.1, 46:437.4 and 46:437.1-46:440.3 (Medical Assistance Program Integrity Law).

**HISTORICAL NOTE:** Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:1635 (September 1999).

##### **§4117. Informal Investigatory Process**

An informal investigation may be initiated without cause and requires no justification. The provider and provider-in-fact of the provider have an affirmative duty to cooperate fully with the investigation. The provider and provider-in-fact, if they have the ability to do so, shall make all records requested as part of the investigation available for review or copying. The provider and provider-in-fact, if they have the ability to do so, shall make available all agents and affiliates of the provider for the purpose of being interviewed during the course of the informal investigation at the provider's ordinary place of business or any other mutually agreeable location.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, 46:153 and 46:442.1, 46:437.4 and 46:437.1-46:440.3 (Medical Assistance Program Integrity Law).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:1635 (September 1999).

#### **§4119. Formal Investigatory Process**

A. The formal investigatory process must be initiated in writing by the Director of BHSF and Director of Program Integrity. The written notice of investigation shall be directed to a provider, specifically naming an investigating officer and be given to the provider, provider-in-fact or their agent. The investigating officer shall provide written notice of the investigation to the provider or a provider-in-fact of the provider at the time of the on-site investigation.

B. The written notice need not contain any reasons or justifications for the investigation, only that such an investigation has been authorized and the individual in charge of the investigation.

C. The investigating officer and the agents of the investigating officer shall have the authority to review and copy records of the provider including, but not limited to, any financial or other business records of the provider or any or all records related to the recipients, and take statements from the provider, provider-in-fact, agents of the provider and any affiliates of the provider, as well as any recipients who have received goods, services, or supplies from the provider or whom the provider has claimed to have provided goods, services, or supplies.

D. The provider and provider-in-fact of the provider have an affirmative duty to cooperate fully with the investigating officer and agents of the investigating officer, including full and truthful disclosure of all information requested and questions asked. The provider and provider-in-fact, if they have the ability to do so, shall make all records requested by the investigating officer available for review and copying. The provider and provider-in-fact, if they have the ability to do so, shall make available all agents and affiliates of the provider for the purpose of being interviewed by the investigating officer or agent of the investigating officer at the provider's ordinary place of business or any other mutually agreeable location.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, 46:153 and 46:442.1, 46:437.4 and 46:437.1-46:440.3 (Medical Assistance Program Integrity Law).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:1636 (September 1999).

#### **§4121. Investigatory Discussion**

A. During the investigatory process the provider, provider-in-fact, agent of the provider, or affiliate of the provider shall be notified in writing of the time and place of an investigatory discussion. The notice shall contain the names of the individuals who are requested to be present at the discussion and any documents that the provider, provider-in-fact, agent of the provider or affiliate of the provider must bring to the discussion.

B. The provider and provider-in-fact, if they have the ability to do so, shall be responsible for assuring the attendance of individuals who are currently employed by, contracted by, or affiliated with the provider.

C. This notice may contain a request to bring records to the investigatory discussion. If such a request for records is

made, the provider and provider-in-fact are responsible for having those records produced at the investigatory discussion. The provider or provider-in-fact shall be given at least five working days to comply with the request.

D. At the investigatory discussion, the authorized investigating officer can ask any of the individuals present at the discussion questions related to the provider's billing practices or other aspects directly or indirectly related to the providing of goods, supplies, and services to Medicaid recipients or nonrecipients, or any other aspect related to the provider's participation in the Louisiana Medicaid program. Any provider, provider-in-fact, agent of the provider, affiliate of the provider, or recipient brought to an investigatory discussion has an affirmative duty to fully and truthfully answer any questions asked and provide any and all information requested.

E. Any person present at an Investigatory Discussion may be represented by counsel. The exercising of a constitutional or statutory right during an Investigatory Discussion shall not be construed as a failure to cooperate.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, 46:437.4 and 46:437.1-46:440.3 (Medical Assistance Program Integrity Law).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:1636 (September 1999).

#### **§4123. Written Investigatory Reports**

The investigating officer or analyst, at the discretion of the Director of Program Integrity or the SURS manager, may draft a written investigative report concerning the results of the informal or formal investigation. The Director of BHSF and Director of Program Integrity at their discretion, may release the report to outside law enforcement agencies, authorized federal representatives, the legislative auditor or any individuals within the department whom the Secretary has authorized to review such reports. No other entities or persons shall have a right to review the contents of an investigative report.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, 46:437.4 and 46:437.1-46:440.3 (Medical Assistance Program Integrity Law).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:1636 (September 1999).

### **Subchapter D. Conduct**

#### **§4125. Introduction**

This Subchapter pertains to the kinds of conduct which are violations, the scope of a violation, types of violations and elements of violations.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, 46:437.4 and 46:437.1-46:440.3 (Medical Assistance Program Integrity Law).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:1636 (September 1999).

#### **§4127. Prohibited Conduct**

Violations are kinds of conduct that are prohibited and constitute a violation under this regulation. No provider, provider-in-fact, agent of the provider, billing agent, affiliate of a provider or other person may engage in any conduct prohibited by this regulation. If they do, the provider or provider-in-fact, agent of the provider, billing agent, affiliate of the provider or other person may be subject to corrective

action, withholding of payment, recoupment, recovery, suspension, exclusion, posting bond or other security, monetary penalties or any other sanction listed in this regulation.

**AUTHORITY NOTE:** Promulgated in accordance with R.S. 36:254, 46:437.4 and 46:437.1-46:440.3 (Medical Assistance Program Integrity Law).

**HISTORICAL NOTE:** Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:1636 (September 1999).

#### **§4129. Violations**

A. The following is a list of violations.

1. Failure to comply with any or all federal or state laws applicable to the Medical Assistance Program or a program of the Medical Assistance Program in which the provider, provider-in-fact, agent of the provider, billing agent, affiliate or other person is participating is a violation of this provision.

a. Neither the Secretary, Director of BHSF, or any other person can waive or alter a requirement or condition established by statute.

b. Requirements or conditions imposed by a statute can only be waived, modified or changed through legislation.

c. Providers and providers-in-fact are required and have an affirmative duty to fully inform all their agents and affiliates, who are performing any function connected to the provider's activities related to the Medicaid program, of the applicable laws.

d. Providers, providers-in-fact, agents of providers, billing agents, and affiliates of providers are presumed to know the law. Ignorance of the applicable laws is not a defense to any administrative action.

2. Failure to comply with any or all federal or state regulations or rule applicable to the Medical Assistance Program or a program of the Medical Assistance Program in which the provider, provider-in-fact, agent of the provider, billing agent, or affiliate of the provider is participating is a violation of this provision.

a. Neither the Secretary, Director BHSF or any other person can waive or alter a requirement or condition established by regulation.

b. Requirements or conditions imposed by a regulation can only be waived, modified, or changed through formal promulgation of a new or amended regulation, unless authority to do so is specifically provided for in the regulation.

c. Providers and providers-in-fact are required and have an affirmative duty to fully inform all their agents and affiliates, who are performing any function connected to the provider's activities related to the Medicaid program, of the applicable regulations.

d. Providers, providers-in-fact, agents of providers, and affiliates of the provider are presumed to know the regulations and rules applicable to participation in the Medical Assistance Program or one or more of its programs in which they are participating. Ignorance of the applicable regulations is not a defense to any administrative action.

3. Failure to comply with any or all policies, criteria or procedures of the Medical Assistance Program or the applicable program of the Medical Assistance Program in which the provider, provider-in-fact, agent of the provider,

billing agent or affiliate of the provider is participating is a violation of this provision.

a. Policies, criteria and procedures are contained in program manuals, training manuals, remittance advice, provider updates or bulletins issued by or on behalf of the Secretary or Director of BHSF.

b. Policies, criteria and procedures can be waived, amended, clarified, repealed or otherwise changed, either generally or in specific cases, only by the Secretary, Undersecretary, Deputy Secretary or the Director of BHSF.

c. Such waivers, amendments, clarifications, repeals, or other changes must be in writing and state that it is a waiver, amendment, clarification, or change in order to be effective.

d. Notice of the policies, criteria and procedures of the Medical Assistance Program and its programs are provided to providers upon enrollment and receipt of a provider number. It is the duty of the provider at the time of enrollment or re-enrollment to obtain the policies, criteria, and procedures, which are in effect at the time of enrollment or re-enrollment.

e. Waivers, amendments, clarifications, repeals, or other changes to the policies, criteria, or procedures must be in writing and are generally contained in a new or reissued program manual, new manual pages, remittance advice, provider updates, or specifically designated bulletins from the Secretary, Undersecretary, Deputy Secretary or Director of BHSF.

f. Waivers, amendments, clarifications, repeals or other changes are mailed to the provider at the address given to BHSF or the fiscal intermediary by the provider for the express purpose of receiving such notifications.

i. It is the duty of the provider to provide the above address and make arrangements to receive these mailings through that address. This includes the duty to inform BHSF or the fiscal intermediary of any changes in the above address prior to actual change of address.

ii. Mailing of a manual, new manual pages, provider update, bulletins, or remittance advice to the provider's latest listed address creates a reputable presumption that the provider received it. The burden of proving lack of notice of policy, criteria, or procedure or waivers, amendments, clarifications, repeals, or other changes in same is on the party asserting it.

iii. Providers and providers-in-fact are presumed to know the applicable policies, criteria and procedures and any or all waivers, amendments, clarifications, repeals, or other changes to the applicable rules, policies, criteria and procedures which have been mailed to the address provided by the provider for the purpose of receiving notice of same.

iv. Ignorance of an applicable policy, criteria, or procedure or any and all waivers, amendments, clarifications, repeals, or other changes to applicable policies, criteria and procedures is not a defense to an administrative action brought against a provider or provider-in-fact. Lack of notice of a policy, criteria, or procedure or waiver, amendment, clarification, repeal, or other change of the same is a defense to a violation based on abusive, fraudulent, false, or fictitious billing practice or willful practices or the imposition of any sanction except issuing a warning, education and training, prior authorization, posting bond or other security, recovery of overpayment or

recoupment of overpayment. Lack of notice of a policy, criteria, or procedure, or waivers, amendments, clarifications, repeals, or other changes to applicable policies, criteria, or procedures is not a defense to a violation, which is aberrant.

g. Providers and providers-in-fact are required and have an affirmative duty to fully inform all their agents and affiliates, who are performing any function connected to the provider's activities related to the Medicaid program, of the applicable policies, criteria, and procedures and any waivers, amendments, clarifications, repeals, or other changes in applicable policies, criteria, or procedures.

4. Failure to comply with one or more of the terms or conditions contained in the provider's provider agreement or any and all forms signed by or on behalf of the provider setting forth the terms and conditions applicable to participation in the Medical Assistance Program or one or more of its programs is a violation of this provision.

a. The terms or conditions of a provider agreement or those contained in the signed forms, unless specifically provided for by law or regulation or rule, can only be waived, changed or amended through mutual written agreement between the provider and the Secretary, Undersecretary, Deputy Secretary or the Director of BHSF. Those conditions or terms that are established by law or regulation or rule may not be waived, altered, amended, or otherwise changed except through legislation or rule making.

b. A waiver, change, or amendment to a term or condition of a provider agreement and any signed forms must be reduced to writing and be signed by the provider and the Secretary, Undersecretary, Deputy Secretary or the Director of BHSF in order to be effective.

c. Such mutual agreements cannot waive, change or amend the law, regulations, rules, policies, criteria or procedures.

d. The provider and provider-in-fact are presumed to know the terms and conditions in their provider agreement and any signed forms related thereto and any changes to their provider agreement or the signed forms related thereto.

e. The provider and provider-in-fact are required and have an affirmative duty to fully inform all their agents or affiliates, who are performing any function connected to the provider's activities related to the Medicaid program, of the terms and conditions contained in the provider agreement and the signed forms related thereto and any change made to them. Ignorance of the terms and conditions in the provider agreement or signed forms or any changes to them is not a defense.

Note: The Department, BHSF or the fiscal intermediary may, from time to time, provide training sessions and consultation on the law, regulations, rules, policies, criteria, and procedures applicable to the Medical Assistance Program and its programs. These training sessions and consultations are intended to assist the provider, provider-in-fact, agents of providers, billing agents, and affiliates. Information presented during these training sessions and consultations do not necessarily constitute the official stands of the department and BHSF in regard to the law, regulations and rules, policies, or procedures unless reduced to writing in compliance with this Subpart.

5. Making a false, fictitious, untrue, misleading statement or concealment of information during the application process or not fully disclosing all information

required or requested on the application forms for the Medicaid Assistance Program, provider number, enrollment paperwork, or any other forms required by the department, BHSF or its fiscal intermediary that is related to enrollment in the Medical Assistance Program or one of its programs or failing to disclose any other information which is required under this regulation, or other departmental regulations, rules, policies, criteria, or procedures is a violation of this provision. This includes the information required under R.S. 46:437.11 - 437.14. Failure to pay any fees or post security related to enrollment is also a violation of this Section.

a. The provider and provider-in-fact have an affirmative duty to inform BHSF in writing through provider enrollment of any and all changes in ownership, control, or managing employee of a provider and fully and completely disclose any and all administrative sanctions, withholding of payments, criminal charges, or convictions, guilty pleas, or no contest pleas, civil judgments, civil fines, or penalties imposed on the provider, provider-in-fact, agent of the provider, billing agent, or affiliates of the provider which are related to Medicare or Medicaid in this or any other state or territory of the United States.

i. Failure to do so within ten (10) working days of when the provider or provider-in-fact knew or should have known of such a change or information is a violation of this provision.

ii. If it is determined that a failure to disclose was willful or fraudulent, the provider's enrollment can be voided back to the date of the willful misrepresentation or concealment or fraudulent disclosure.

6. Not being properly licensed, certified, or otherwise qualified to provide for the particular goods, services, or supplies provided or billed for or such license, certificate, or other qualification required or necessary in order to provide a good, service, or supply has not been renewed or has been revoked, suspended or otherwise terminated is a violation of this provision. This includes, but is not limited to, professional licenses, business licenses, paraprofessional certificates, and licenses or other similar licenses or certificates required by federal, state, or local governmental agencies, as well as, professional or paraprofessional organizations or governing bodies which are required by the Medical Assistance Program. Failure to pay required fees related to licensure or certification is also a violation of this provision.

7. Having engaged in conduct or performing an act in violation of official sanction which has been applied by a licensing authority, professional peer group, or peer review board or organization, or continuing such conduct following notification by the licensing or reviewing body that said conduct should cease is a violation of this provision.

8. Having been excluded or suspended from participation in Medicare is a violation of this provision. It is also a violation of this provision for a provider to employ, contract with, or otherwise affiliate with any person who has been excluded or suspended from Medicare during the period of exclusion or suspension.

a. The provider and provider-in-fact after they knew or should have known of same have an affirmative duty to:

i. inform BHSF in writing of any such exclusions or suspensions on the part of the provider, provider-in-fact, their agents or their affiliates;

ii. not hire, contract with or affiliate with any person or entity who has been excluded or suspended from Medicare; and

iii. terminate any and all ownership, employment and contractual relationships with any person or entity that has been excluded or suspended from Medicare.

b. Failure to do so on the part of the provider or provider-in-fact within ten (10) working days of when the provider or provider-in-fact knew or should have known of any violation of this provision by the provider, provider-in-fact, their agents, or affiliates is a violation of Paragraph 5 of this Subsection.

c. If the terms of the exclusion or suspension have been completed, no violation of this provision has occurred.

9. Having been excluded, suspended, or otherwise terminated from participation in Medicaid or other publicly funded health care or insurance programs of this state or any other state or territory of the United States is a violation of this provision. It is also a violation of this Section for a provider to employ, contract with, or otherwise affiliate with any person who has been excluded, suspended or otherwise terminated from participation in Medicaid or other publicly funded health care or health insurance programs of this state or another state or territory of the United States. It is also a violation of this provision for a provider to employ, contract with, or otherwise affiliate with any person who has been excluded from Medicaid or other publicly funded health care or health insurance programs of this state or any other state or territory of the United States during the period of exclusion or suspension.

a. The provider and provider-in-fact after they knew or should have known have an affirmative duty to:

i. inform BHSF in writing of any such exclusions or suspensions on the part of the provider, provider-in-fact, their agents or their affiliates;

ii. not hire, contract with, or affiliate with any person or entity who has been excluded or suspended from any Medicaid or other publicly funded health care or health insurance programs; and

iii. terminate any and all ownership, employment and contractual relationships with any person or entity that has been excluded or suspended from any Medicaid or other publicly funded health care or health insurance programs.

b. Failure to do so on the part of the provider or provider-in-fact within ten (10) working days of when the provider or provider-in-fact knew or should have known of any violation of this provisions by the provider, provider-in-fact, their agents or affiliates is a violation of Paragraph 5 of this Subsection.

c. If the terms of the exclusion or suspension have been completed, no violation of this provision has occurred.

10. Having been convicted of, pled guilty, or pled no contest to a crime, including attempts or conspiracy to commit a crime, in federal court, any state court, or court in any United States territory related to providing goods, services, or supplies or billing for goods, services, or supplies under Medicare, Medicaid, or any other program involving the expenditure of public funds is a violation of this provision. It is also a violation for a provider to employ, contract with, or otherwise affiliate with any person who has been convicted of, pled guilty, or pled no contest to a crime, including attempts to or conspiracy to commit a crime, in

federal court, any state court, or court in any United States territory related to providing goods, services, or supplies or billing for goods, services, or supplies under Medicare, Medicaid, or any other program involving the expenditure of public funds.

a. The provider and provider-in-fact after they knew or should have known of same have an affirmative duty to:

i. inform BHSF in writing of any such convictions, guilt pled, or no contest plea to the above felony criminal conduct on the part of the provider, provider-in-fact, their agents or affiliates;

ii. not hire, contract with, or affiliate with any person or entity who has been convicted, pled guilty to, or pled no contest to the above felony criminal conduct; and

iii. terminate any and all ownership, employment and contractual relationships with any person or entity that has been convicted, pled guilty to, or pled no contest to the above felony criminal conduct.

b. Failure to do so on the part of the provider or provider-in-fact within ten (10) working days of when the provider or provider-in-fact knew or should have known of any violation of this provision by the provider, provider-in-fact, their agents or affiliates is a violation of Paragraph 5 of this Subsection.

c. If three (3) years have passed since the completion of the sentence and no other criminal misconduct by that person has occurred during that three (3) year period, this provision is not violated. Criminal conduct, which has been pardoned, does not violate this provision.

11. Having been convicted of, pled guilty to, or pled no contest to Medicaid Fraud in a Louisiana court or any other criminal offense, including attempts to or conspiracy to commit a crime, relating to the performance of a provider agreement with the Medical Assistance Program is a violation of this provision. It is also a violation of this provision for a provider to employ, contract with, or otherwise affiliate with any person who has been convicted of, pled guilty, or pled no contest to Medicaid Fraud in a Louisiana court or any other criminal offense, including attempts to or conspiracy to commit a crime, relating to the performance of a provider agreement with the Louisiana Medicaid program.

a. The provider and provider-in-fact after they knew or should have known of same have an affirmative duty to:

i. inform BHSF in writing of any such convictions, guilty plea, or no contest plea to the above criminal conduct on the part of the provider, provider-in-fact, their agents or affiliates;

ii. not hire, contract with, or affiliate with any person or entity who has been convicted, plead guilty to, or plead no contest to the above criminal conduct; and

iii. terminate any and all ownership, employment and contractual relationships with any person or entity that has been convicted, plead guilty to, or plead no contest to the above criminal conduct.

b. Failure to do so on the part of the provider or provider-in-fact within ten (10) working days of when the provider or provider-in-fact knew or should have known of any violation of this provision by the provider, provider-in-fact, their agents or affiliates is a violation of Paragraph 5 of this Subsection.

c. If three (3) years have passed since the completion of the sentence and no other criminal misconduct by that person has occurred during that three (3) year period, this provision is not violated. Criminal conduct, which has been pardoned, does not violate this provision.

12. Having been convicted of, pled guilty, or pled no contest in federal court, any state court, or court of any United States territory to criminal conduct involving the negligent practice of medicine or any other activity or skill related to an activity or skill performed by or billed by that person or entity under the Medical Assistance Program or one of its programs or which caused death or serious bodily, emotional, or mental injury to an individual under their care is a violation of this provision. It is also a violation of this provision for a provider to employ, contract with, or otherwise affiliate with any person who has been convicted of, pled guilty, or pled no contest in federal court, any state court, or court of any United States territory to criminal conduct involving the negligent practice of medicine or any other activity or skill related to an activity or skill performed by or billed by that person or entity under the Medical Assistance Program or one of its programs or which caused death or serious bodily, emotional, or mental injury to an individual under their care.

a. The provider and provider-in-fact after they knew or should have known have an affirmative duty to:

i. inform BHSF in writing of any such convictions, guilty plea, or no contest plea to the above criminal conduct on the part of the provider, provider-in-fact, or their agents or affiliates;

ii. not hire, contract with, or affiliate with any person or entity who has been convicted, plead guilty to, or plead no contest to the above criminal conduct; and

iii. terminate any and all ownership, employment or contractual relationships with any person or entity that has been convicted, pled guilty to, or pled no contest to the above criminal conduct.

b. Failure to do so on the part of the provider or provider-in-fact within ten (10) working days of when the provider or provider-in-fact knew or should have known of any violation of this provision by the provider, provider-in-fact, their agents or affiliates is a violation of Paragraph 5 of this Subsection.

c. If three (3) years have passed since the completion of the sentence and no other criminal misconduct by that person has occurred during that three (3) year period, this provision is not violated. Criminal conduct, which has been pardoned, does not violate this provision.

13. Having been convicted of, pled guilty, or pled no contest to Medicaid, Medicare or health care fraud, including attempts to or conspiracy to commit Medicaid, Medicare or health care fraud or any other criminal offense related to the performance of or providing any goods, services, or supplies to Medicaid or Medicare recipients or billings to any Medicaid, Medicare, publicly funded health care or publicly funded health insurance programs in any state court, federal court or a court in any territory of the United States is a violation of this provision. It is also a violation of this provision for a provider to employ, contract with, or otherwise affiliate with any person who has been convicted of, plead guilty, or plead no contest to Medicaid, Medicare, or health care fraud, including attempts to or

conspiracy to commit Medicaid, Medicare or health care fraud, or any other criminal offense related to the performance of or providing any goods, services, or supplies to Medicaid or Medicare recipients or billings to any Medicaid, Medicare, publicly funded health care or publicly funded health insurance programs in any state court, federal court or a court in any territory of the United States.

a. The provider and provider-in-fact after they knew or should have known of same have an affirmative duty to:

i. inform BHSF in writing of any such convictions, guilty plea, or no contest plea to the above criminal conduct on the part of the provider, provider-in-fact, or their agents or affiliates;

ii. not hire, contract with, or affiliate with any person or entity who has been convicted, pled guilty to, or pled no contest to the above criminal conduct; and

iii. terminate any and all ownership, employment and contractual relationships with any person or entity that has been convicted, pled guilty to, or pled no contest to the above criminal conduct.

b. Failure to do so on the part of the provider or provider-in-fact within ten (10) working days of when the provider or provider-in-fact knew or should have known of any violation of this provision by the provider, provider-in-fact, their agents or affiliates is a violation of Paragraph 5 of this Subsection.

c. If three (3) years have passed since the completion of the sentence and no other criminal misconduct by that person has occurred during that three (3) year period, this provision is not violated. Criminal conduct that has been pardoned does not violate this provision.

14. Having been convicted of, pled guilty to, or pled no contest to in any federal court, state court, or court in any territory of the United States to any of the following criminal conduct, attempt to commit or conspiracy to commit any of the following crimes are violations of this provision:

a. bribery or extortion;

b. sale, distribution, or importation of a substance or item that is prohibited by law;

c. tax evasion or fraud;

d. money laundering;

e. securities or exchange fraud;

f. wire or mail fraud;

g. violence against a person;

h. act against the aged, juveniles or infirmed;

i. any crime involving public funds; or

j. other similar felony criminal conduct.

i. The provider and provider-in-fact after they knew or should have known of same have an affirmative duty to:

(a). inform BHSF in writing of any such criminal charges, convictions, or pleas on the part of the provider, provider-in-fact, their agents, or their affiliates;

(b). not hire, contract with, or affiliate with any person or entity who has engaged in any such criminal misconduct; and

(c). terminate any and all ownership, employment and contractual relationships with any person or entity that has engaged in any such criminal misconduct.

ii. Failure to do so on the part of the provider or provider-in-fact within ten (10) working days of when the provider or provider-in-fact knew or should have known of

any violation of this provision by the provider, provider-in-fact, their agents or their affiliates is a violation of Paragraph 5 of this Subsection.

iii. If three (3) years have passed since the completion of the sentence and no other criminal misconduct by that person has occurred during that three (3) -year period, this provision is not violated. Criminal conduct that has been pardoned does not violate this provision.

15. Being found in violation of or entering into a settlement agreement under this state's Medical Assistance Program Integrity Law, the Federal False Claims Act, Federal Civil Monetary Penalties Act, or any other similar civil statutes in this state, in any other state, United States or United States territory is a violation of this provision.

a. Relating to violations of this provision, the provider and provider-in-fact after they knew or should have known have an affirmative duty to:

i. inform BHSF in writing of any violations of this provision on the part of the provider, provider-in-fact, their agents or their affiliates;

ii. not hire, contract with or affiliate with any person or entity who has violated this provision; and

iii. terminate any and all ownership, employment and contractual relationships with any person or entity that has violated this provision.

b. Failure to do so on the part of the provider or provider-in-fact within ten (10) working days of when the provider or provider-in-fact knew or should have known of any violation of this provision by the provider, provider-in-fact, their agents or their affiliates is a violation of Paragraph 5 of this Subsection.

c. If a False Claims Act action or other similar civil action is brought by a Qui-Tam plaintiff or under a little attorney general or other similar provision, no violation of this provision has occurred until the defendant has been found liable in the action.

d. If three (3) years have passed from the time a person is found liable or entered a settlement agreement under the False Claims Act or other similar civil statute and the conditions of the judgement or settlement have been satisfactorily fulfilled, no violation has occurred under this provision.

16. Failure to correct the deficiencies or problem areas listed in a notice of corrective action or failure to meet the provisions of a corrective action plan or failure to correct deficiencies in delivery of goods, services, or supplies or deficiencies in billing practices or record keeping after receiving written notice to do so from the Secretary, Director of BHSF or Director of Program Integrity is a violation of this provision.

17. Having presented, causing to be presented, attempting to present, or conspiring to present false, fraudulent, fictitious, or misleading claims or billings for payment or reimbursement to the Medical Assistance Program through BHSF or its authorized fiscal intermediary for goods, services, or supplies, or in documents related to a cost report or other similar submission is a violation of this provision.

18. Engaging in the practice of charging or accepting payments, in whole or in part, from one or more recipients for goods, services, or supplies for which the provider has made or will make a claim for payment to the Louisiana

Medicaid program is a violation of this provision, unless this prohibition has been specifically excluded within the program under which the claim was submitted or will be made or the payment by the recipient is an authorized copayment or is otherwise specifically authorized by law or regulation. Having engaged in practices prohibited by R.S. 46:438.2 or the federal anti-kickback or anti-referral statutes is also a violation of this provision.

19. Having rebated or accepted a fee or a portion of a fee or anything of value for a Medicaid recipient referral is a violation of this provision, unless this prohibition has been specifically excluded within the program or is otherwise authorized by statute or regulation, rule, policy, criteria or procedure of the department through BHSF. Having engaged in practices prohibited by R.S. 46:438.2 or the federal anti-kickback or anti-referral statutes is also a violation of this provision.

20. Paying to another a fee in cash or kind for the purpose of obtaining recipient lists or recipients names is a violation of this provision, unless this prohibition has been specifically excluded within the program or is otherwise authorized by statute or regulation, rule, policy, criteria or procedure of the department through BHSF. Using or possessing any recipient list or information, which was obtained through unauthorized means, or using such in an unauthorized manner is also a violation of this provision. Having engaged in practices prohibited by R.S. 46:438.2 or R.S. 46:438.4 or the federal anti-kickback or anti-referral statutes is also a violation of this provision.

21. Failure to repay or make arrangements to repay an identified overpayment or otherwise erroneous payment within ten (10) working days after the provider or provider-in-fact receives written notice of same is a violation of this provision. Failure to pay any and all administrative or court ordered restitution, civil money damages, criminal or civil fines, monetary penalties or costs or expenses is also a violation of this provision. Failure to pay any assessed provider fee or payment is also a violation of this provision.

22. Failure to keep or make available for inspection, audit, or copying records related to the Louisiana Medicaid program or one or more of its programs for which the provider has been enrolled or issued a provider number or has failed to allow BHSF or its fiscal intermediary or any other duly authorized governmental entity an opportunity to inspect, audit, or copy those records is a violation of this provision. Failure to keep records required by Medicaid or one of its programs until payment review has been conducted is also a violation of this provision;

23. Failure to furnish or arrange to furnish information or documents to BHSF within five (5) working days after receiving a written request to provide that information to BHSF or its fiscal intermediary is a violation of this provision.

24. Failure to cooperate with BHSF, its fiscal intermediary or the investigating officer during the post-payment or prepayment process, investigative process, an investigatory discussion, informal hearing or the administrative appeal process or any other legal process or making, or caused to be made, a false or misleading statement of a material fact in connection with the post-payment or prepayment process, corrective action, investigation process, investigatory discussion, informal

hearing or the administrative appeals process or any other legal process is a violation of this provision. The exercising of a constitutional or statutory right is not a failure to cooperate. Requests to for scheduling changes or asking questions are not grounds for failure to cooperate.

25. Making, or causing to be made, a false, fictitious or misleading statement or making, or caused to be made, a false, fictitious or misleading statement of a fact in connection with the administration of the Medical Assistance Program which the person knew or should have known was false, fictitious or misleading is a violation of this provision. This includes, but is not limited to, the following:

- a. claiming costs for noncovered or nonchargeable services, supplies, or goods disguised as covered items;
- b. billing for services, supplies, or goods which are not rendered to person(s) who are eligible to receive the services, supplies, or goods;
- c. misrepresenting dates and descriptions and the identity of the person(s) who rendered the services, supplies, or goods;
- d. duplicate billing that are abusive, willful or fraudulent;
- e. upcoding of services, supplies, or goods provided;
- f. misrepresenting a recipient's need or eligibility to receive services, goods, or supplies or the recipients eligibility for a program;
- g. improperly unbundling goods, services, or supplies for billing purposes;
- h. misrepresenting the quality or quantity of services, goods, or supplies;
- i. submitting claims for payment for goods, services, and supplies provided to nonrecipients if the provider knew or should have known that the individual was not eligible to receive the good, supply, or service at the time the good, service, or supply was provided or billed.
- j. Furnishing or causing to be furnished goods, services, or supplies to a recipient which;
  - i. are in excess of the recipient's needs;
  - ii. were or could be harmful to the recipient;
  - iii. serve no real medical purpose;
  - iv. are of grossly inadequate or inferior quality;
  - v. were furnished by an individual who was not qualified under the applicable Louisiana Medicaid program to provide the good, service, or supply;
  - vi. the good, service, or supply was not furnished under the required programmatic authorization; or
  - vii. the goods, services or supplies provided were not provided in compliance with the appropriate licensing or certification board's regulations, rules, policies or procedures governing the conduct of the person who provided the goods, services or supplies.
- k. providing goods, services, or supplies in a manner or form that is not within the normal scope and range of the standards used within the applicable profession.

l. billing for goods, services, or supplies in a manner inconsistent with the standards established in relevant billing codes or practices.

26. In the case of a managed care provider or provider operating under a voucher, notwithstanding any contractual agreements to the contrary, failure to provide all medically

necessary goods, services, or supplies of which the recipient is in need of and entitled to is a violation of this provision.

27. Submitting bills or claims for payment or reimbursement to the Louisiana Medicaid program through BHSF or its fiscal intermediary on behalf of a person or entity which is serving out a period of suspension or exclusion from participation in the Medical Assistance Program or one of its programs, Medicare, Medicaid, publicly funded health care or publicly funded health insurance program in any other state or territory of the United States or the United States is a violation of this provision except for bona fide emergency services provided during a bona fide medical emergency.

28. Engaging in a systematic billing practice which is abusive or fraudulent and which maximizes the costs to the Louisiana Medicaid program after written notice to cease such billing practice(s) is a violation of this provision.

29. Failure to meet the terms of an agreement to repay or settlement agreement entered into under this state's Medical Assistance Program Integrity Law or this regulation is a violation of this provision.

30. If the provider, a person with management responsibility for a provider, an officer or person owning, either directly or indirectly, any shares of stock or other evidence of ownership in a corporate provider, an owner of a sole proprietorship which is a provider, or a partner in a partnership which is a provider, is found to fall into one or more of the following categories:

a. the provider was previously terminated from participation in the Louisiana Medicaid program or one or more of its programs; and

i. was a person with management responsibility for a previously terminated provider during the time of the conduct which was the basis for that provider's termination from participation in the Louisiana Medicaid program or one or more of its programs; or

ii. was an officer or person owning, directly or indirectly, any shares of stock or other evidence of ownership in a previously terminated provider during the time of the conduct which was the basis for that provider's termination from participation in the Louisiana Medicaid program or one or more of its programs; or

iii. was an owner of a sole proprietorship or a partner of a partnership in a previously terminated provider during the time of the conduct which was the basis for that provider's termination from participation in the Louisiana Medicaid program or one or more of its programs.

b. the provider has been found to have engaged in practices prohibited by federal or state law or regulation; and

i. was a person with management responsibility for a provider during the time the provider engaged in practices prohibited by federal or state law or regulation; or

ii. was an officer or person owning, directly or indirectly, any shares of stock or other evidence of ownership in a provider during the time the provider engaged in practices prohibited by federal or state law or regulation; or

iii. was an owner of a sole proprietorship or a partner of a partnership which was a provider during the time the provider engaged in practices prohibited by federal or state law or regulation.

c. the provider was convicted of Medicaid or Medicare fraud or other criminal misconduct related to Medicaid or Medicare under federal or state law;

i. was a person with management responsibility for a provider during the time the provider engaged in practices for which the provider was convicted of Medicaid or Medicare fraud or other criminal misconduct related to Medicaid or Medicare under federal or state law;

ii. was an officer or person owning, directly or indirectly, any of the shares of stock or other evidence of ownership in a provider during the time the provider engaged in practices the provider was convicted of Medicaid or Medicare fraud or other criminal misconduct related to Medicaid or Medicare under federal or state law;

iii. was an owner of a sole proprietorship or a partner of a partnership which was a provider during the time the provider engaged in practices the provider was convicted of Medicaid or Medicare fraud or other criminal misconduct related to Medicaid or Medicare under federal or state law.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, 46:437.4 and 46:437.1-46:440.3 (Medical Assistance Program Integrity Law).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:1642 (September 1999).

#### **§4131. Scope of a Violation**

A. Violations may be imputed in the following manner.

1. The conduct of a provider-in-fact is always attributable to the provider. The conduct of a managing employee is always attributable to the provider and provider-in-fact.

2. The conduct of an agent of the provider, billing agent, or affiliate of the provider may be imputed to the provider or provider-in-fact if the conduct was performed within the course of his duties for the provider or was effectuated by him with the knowledge or approval of the provider or provider-in-fact.

3. The conduct of any person or entity operating on behalf of a provider may be imputed to the provider or provider-in-fact.

4. The provider and provider-in-fact are responsible for the conduct of any and all officers, employees or agents of the provider including any with whom the provider has a contract to provide managerial or administrative functions for the provider or to provide goods, services, or supplies on behalf of the provider. The conduct of these persons or entities may be imputed to the provider or provider-in-fact.

5. A violation under one Medicaid number may be extended to any and all Medicaid Numbers held by the provider or provider-in-fact or which may be obtained by the provider or provider-in-fact.

6. Recoupments or recoveries may be made from any payments or reimbursement made under any and all provider numbers held by or obtained by the provider or provider-in-fact.

7. Any sanctions, including recovery or recoupment, imposed on a provider or provider-in-fact shall remain in effect until its terms have been satisfied. Any person or entity who purchases, merges or otherwise consolidates with a provider or employs or affiliates a provider-in-fact, agent of the provider or affiliate of a provider who has had sanctions imposed on it under this regulation assumes

liability for those sanctions, if the person or entity knew or should have known about the existence of the sanctions, and may be subject to additional sanctions based on the purchase, merger, consolidation, affiliation or employment of the sanctioned provider or provider-in-fact.

8. A provider or provider-in-fact who refers a recipient to another for the purpose of providing a good, service, or supply to a recipient may be held responsible for any or all over-billing by the person to whom the recipient was referred provided the referring provider or person knew or should have known that such over-billing was likely to occur.

9. Providers which are legal entities, i.e. clinics, corporations, HMO's, PPO's, etc., may be held jointly liable for the repayment or recoupment of any person within that legal entity if it can be shown that the entity received any economic benefit related to the overpayment.

10. Withholdings of payments imposed on a provider may be extended to any or all provider numbers held or obtained by that provider or any provider-in-fact of that provider.

B. Attributing, imputing, extension or imposing under this provision shall be done on a case-by-case basis with written reasons for same. The written reasons must demonstrate that the imputing was based on knowledge of the violation and that the person to which it was imputed received an economic benefit as a result of the violation. The person to whom the violation has been imputed may only be sanctioned up to the amount of the economic benefit received by that individual.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, 46:437.4 and 46:437.1-46:440.3 (Medical Assistance Program Integrity Law).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:1637 (September 1999).

#### **§4133. Types of Violation**

A. Violations can be of four different types: aberrant; abusive; willful; or fraudulent. This Subsection defines these four different types of violations.

1. *Aberrant Practice*—any practice that is inconsistent with the laws, regulations, rules, policies, criteria or practices or the terms in the provider agreement or signed forms related to the provider agreement and are applicable to the Louisiana Medicaid program or one or more of its programs in which the provider is enrolled or was enrolled at the time of the alleged occurrence.

2. *Abusive Practice*—any practice of which the provider has been informed in writing by the Secretary, Director of BHSF, or Director of Program is aberrant, and the provider, provider-in-fact, agent of the provider, or an affiliate of the provider continues to engage in that practice after the written notice to discontinue such a practice has been provided to the provider or provider-in-fact.

3. *Willful Practice*—a deception or misrepresentation made by a person who knew, or should have known, that the deception or misrepresentation was false, untrue, misleading, or wrong or an aberrant or abusive practice which is so pervasive as to indicate that the practice was willful. A willful practice also includes conduct that would be in violation of this state's Medical Assistance Program Integrity Law.

4. *Fraudulent Practice*—a deception or misrepresentation made by a person who had knowledge that the deception or misrepresentation was false, untrue or wrong or deliberately failed to take reasonable steps to determine the truthfulness or correctness of information, and the deception or misrepresentation did or could have resulted in payment of one or more claims for which payment should not have been made or payment on one or more claims which would or could be greater than the amount entitled to. This includes any act or attempted act that could constitute fraud under either criminal or civil standards under applicable federal or Louisiana law.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, 46:437.4 and 46:437.1-46:440.3 (Medical Assistance Program Integrity Law).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:1643 (September 1999).

#### **§4135. Elements**

A. Each type of violation contains different elements, which must be established.

1. An aberrant practice is a technical or inadvertent violation where the person did not knowingly engage in prohibited conduct. A finding of an aberrant practice does not require proof of knowledge, intent, or overpayment or attempted overpayment.

2. An abusive practice occurs where the person has been informed in writing that the person has engaged in an aberrant practice and the person continues to engage in the practice after such notice but the person has not obtained or attempted to obtain an overpayment. A finding of an abusive practice requires notice of the aberrant practice and its continued existence following that notice, but does not require proof of intent or overpayment or attempted overpayment.

3. A willful practice occurs when the person knew or should have known of the prohibited conduct and the person has obtained or attempted to obtain overpayment. A finding of willful practice requires that the person knew or should have known of the deception or misrepresentation, but does not require proof of intent or overpayment or attempted overpayment.

4. A fraudulent practice occurs when the person had actual knowledge of the prohibited conduct and knowingly obtained or attempted to obtain overpayment. A finding of fraudulent practice requires knowledge, intent and overpayment or attempted overpayment.

B. Providers, providers-in-fact, agents of the provider, affiliates of the provider and other persons may be found to have engaged in the same prohibited conduct but committed different types of violations.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, 46:437.4 and 46:437.1-46:440.3 (Medical Assistance Program Integrity Law).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:1644 (September 1999).

#### **Subchapter E. Administrative Sanctions, Procedures and Processes**

##### **§4137. Sanctions for Prohibited Conduct**

A. Any or all of the following sanctions may be imposed for any one or more of the above listed kinds of prohibited conduct, except as provided for in this regulation:

1. issue a warning to a provider or provider-in-fact or other person through written notice or consultation;

2. require that the provider or provider-in-fact, their affiliates, and agents receive education and training in laws, regulations, rules, policies, criteria and procedures, including billing, at the provider's expense;

3. require that the provider or provider-in-fact receive prior authorization for any or all goods, services or supplies under the Louisiana Medicaid program or one or more of its programs;

4. require that some or all of the provider's claims be subject to manual review.

5. require a provider or provider-in-fact to post a bond or other security or increase the bond or other security already posted as a condition of continued enrollment in the Louisiana Medicaid program or one or more of its programs;

6. require that a provider terminate its association with a provider-in-fact, agent of the provider, or affiliate as a condition of continued enrollment in the Louisiana Medicaid program or one or more of its programs;

7. prohibit a provider from associating, employing or contracting with a specific person or entity as a condition of continued participation in the Louisiana Medicaid program or one or more of its programs;

8. prohibit a provider, provider-in-fact, agent of the provider, billing agent or affiliate of the provider from performing specified tasks or providing goods, services, or supplies at designated locations or to designated recipients or classes or types of recipients;

9. prohibit a provider, provider-in-fact, or agent from referring recipients to another designated person or purchasing goods, services, or supplies from designated persons;

10. recoupment;

11. recovery;

12. impose judicial interest on any outstanding recovery or recoupment;

13. impose reasonable costs or expenses incurred as the direct result of the investigation or review, including but not limited to the time and expenses incurred by departmental employees or agents and the fiscal intermediary's employee or agent;

14. exclusion from the Louisiana Medicaid program or one or more of its programs;

15. suspension from the Louisiana Medicaid program or one or more of its programs pending the resolution of the departments administrative appeals process;

16. impose a bond or other form of security as a condition of continued participation in the Medical Assistance Program;

17. require the forfeiture of a bond or other security;

18. impose an arrangement to repay;

19. impose monetary penalties not to exceed \$10,000 per violation;

20. impose withholding of payments.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, 46:437.4 and 46:437.1-46:440.3 (Medical Assistance Program Integrity Law).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:1644 (September 1999).

### **§4139. Scope of Sanctions**

A. Sanction(s) imposed can be extended to other persons or entities and to other provider numbers held or obtained by the provider in the following manner:

1. sanction(s) imposed on a provider or provider-in-fact may be extended to a provider or provider-in-fact;

2. sanction(s) imposed on an agent of the provider or affiliate of the provider may be imposed on the provider or provider-in-fact if it can be shown that the provider or provider-in-fact knew or should have known about the violation(s) and failed to report the violation(s) to BHSF in writing in a timely manner;

3. sanction(s) imposed on a provider or provider-in-fact arising out of goods, services, or supplies to a referred recipient may also be imposed on the referring provider if it can be shown that the provider or provider-in-fact knew or should have known about the violation(s) and failed to report the violation(s) to BHSF in writing in a timely manner;

4. sanction(s) imposed under one provider number may be extended to all provider numbers held by or which may be obtained in the future by the sanctioned provider or provider-in-fact, unless and until the terms and conditions of the sanction(s) has been fully satisfied.

5. sanction(s) imposed on a person remains in effect unless and until its terms and conditions are fully satisfied. The terms and conditions of the sanction(s) remain in effect in the event of the sale or transfer of ownership of the sanctioned provider;

a. the entity or person who obtains ownership interest in a sanctioned provider assumes liability and responsibility for the sanctions imposed on the purchased provider including, but not limited to, all recoupments or recovery of funds or arrangements to repay that the entity or person knew or should have known about;

b. an entity or person who employs or otherwise affiliates itself with a provider-in-fact who has been sanctioned assumes the liability and responsibility for the sanctions imposed on the provider-in-fact that the entity or person knew or should have known about;

c. any entity or person who purchases an interest in, merges with or otherwise consolidates with a provider which has been sanctioned assumes the liability and responsibility for the sanction(s) imposed on the provider that the entity or person knew or should have known about.

B. Exclusion from participation in the Louisiana Medicaid program precludes any such person from submitting claims for payment, either personally or through claims submitted by any other person or entity, for any goods, services, or supplies provided by an excluded person or entity, except bona fide emergency services provided during a bona fide medical emergency. Any payments made to a person or entity, which are prohibited by this provision, shall be immediately repaid to the Medical Assistance Program through BHSF by the person or entity which received the payments.

C. No provider shall submit claims for payment to the department or its fiscal intermediary for any goods, services, or supplies provided by a person or entity within that provider who has been excluded from the Medical Assistance Program or one or more of its programs for goods, services, or supplies provided by the excluded person

or entity under the programs which it has been excluded from except for goods, services, or supplies provided prior to the exclusion and for bona fide emergency services provided during a bona fide medical emergency. Any payments made to a person or entity, which are prohibited by this provision, shall be immediately repaid to the Medical Assistance Program through BHSF by the person or entity which received the payments.

D. When the provisions of §4133 B-C are violated, the person or entity which committed the violations may be sanctioned using any and all of the sanctions provided for in this rule.

E. Extending of sanctions must be done on a case-by-case basis.

F. The provisions in R.S. 46:437.10 shall apply to all sanctions and withholding of payments imposed pursuant to this regulation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, 46:437.4 and 46:437.1-46:440.3 (Medical Assistance Program Integrity Law).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:1645 (September 1999).

### **§4141. Imposition of Sanction(s)**

A. The decision as to the sanction(s) to be imposed shall be at the discretion of the Director of BHSF and Director of Program Integrity except as provide for in this provision, unless the sanction is mandatory. In order to impose a sanction the Director of BHSF and the Director of Program Integrity must concur. One or more sanctions may be imposed for a single violation. The imposition of one sanction does not preclude the imposition of another sanction for the same or different violations.

B. At the discretion of the Director of BHSF and the Director of Program Integrity each occurrence of misconduct may be considered a violation or multiple occurrences of misconduct may be considered a single violation or any combination thereof.

C. The following factors may be considered in determining the sanction(s) to be imposed:

1. seriousness of the violation(s);
2. extent of the violation(s);
3. history of prior violation(s);
4. prior imposition of sanction(s);
5. prior provision of education;
6. willingness to obey program rules;
7. whether a lesser sanction will be sufficient to remedy the problem;
8. actions taken or recommended by peer review groups or licensing boards;
9. cooperation related to reviews or investigations by the department or cooperation with other investigatory agencies; and
10. willingness and ability to repay identified overpayments.

D. Notwithstanding §4141.A, sanctions of judicial interest, costs and expenses may only be imposed upon a finding willful or fraudulent practice or upon a finding that the persons' denial of prohibited conduct was frivolous.

E. Notwithstanding §4141.A, a monetary penalty may be imposed only after a finding that the violation involved a willful or fraudulent practice.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, 46:437.4 and 46:437.1-46:440.3 (Medical Assistance Program Integrity Law)

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:1645 (September 1999).

#### **§4143. Mandatory Sanctions**

A. Mandatory Exclusion from the Medical Assistance Program. Notwithstanding any other provision to the contrary, Director of BHSF and Director of Program Integrity have no discretion and must exclude the provider, provider-in-fact or other person from the Medical Assistance Program if the violation involves one or more of the following:

1. a conviction, guilty plea, or no contest plea to a criminal offense(s) in federal or Louisiana state court related, either directly or indirectly, to participation in either Medicaid or Medicare;

2. has been excluded from Louisiana Medicaid or Medicare; or

3. has failed to meet the terms and conditions of a Repayment Agreement, settlement or judgment entered into under this state's Medical Assistance Program Integrity Law.

4. In these situations the exclusion from the Medical Assistance Program is automatic and can be longer than, but not shorter in time than, the sentence imposed in criminal court, the exclusion from Medicaid or Medicare or time provided to make payment;

a. The exclusion is retroactive to the time of the conviction, plea, exclusion, the date the repayment agreement was entered by the department or the settlement or judgment was entered under this state's Medical Assistance Program Integrity Law;

b. proof of the conviction, plea, exclusion, failure to meet the terms and conditions of a repayment agreement, or settlement or judgment entered under this state's Medical Assistance Program Integrity Law can be made through certified or true copies of the conviction, plea, exclusion, agreement to repay, settlement, or judgment or via affidavit.

i. if the conviction is overturned, plea set aside, or exclusion or judgment are reversed on appeal, the mandatory exclusion from the Medical Assistance Program shall be removed;

ii. the person or entity that is excluded from the Medical Assistance Program under this Subsection is entitled to an administrative appeal of a mandatory exclusion;

iii. the facts and law surrounding the criminal matter, exclusion, repayment agreement or judgment which serves as the basis for the mandatory exclusion from the Medical Assistance Program cannot be collaterally attacked at the administrative appeal.

B. Mandatory Arrangements to Pay, Recoupment or Recovery. If the violation(s) was fraudulent or willful and resulted in an identified overpayment, the Secretary, Director of BHSF, and Director of Program Integrity has no discretion. The person or entity must have imposed on them an arrangement to repay, recoupment or recovery of the identified overpayment.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, 46:437.4 and 46:437.1-46:440.3 (Medical Assistance Program Integrity Law).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:1646 (September 1999).

#### **§4145. Effective Date of a Sanction**

All sanctions, except exclusion, are effective upon the issuing of the notice of the results of the informal hearing. The filing of a timely and adequate notice of administrative appeal does not suspend the imposition of a sanction(s), except that of exclusion. In the case of the imposition of exclusion from the Louisiana Medicaid Program or one or more of its programs, the filing of a timely and adequate notice of appeal suspends the exclusion. In the case of an exclusion, the Director of BHSF and Director of Program Integrity may impose a suspension from the Medical Assistance Program or one or more of its programs during the pendency of an administrative appeal. A sanction becomes a final administrative adjudication if no administrative appeal has been filed, and the time for filing an administrative appeal has run. Or in the case of a timely filed notice of administrative appeal, a sanction(s) becomes a final administrative adjudication when the order on appeal has been entered by the Secretary. In order for an appeal to be filed timely it must be sent to the Department's Bureau of Appeals within thirty (30) days from the date on the letter informing the person of the results of that person's informal discussion.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, 46:437.4 and 46:437.1-46:440.3 (Medical Assistance Program Integrity Law).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:1646 (September 1999).

#### **Subchapter F. Withholding**

##### **§4147. Withholding of Payments**

A. If, during the course of claims review, the Director of BHSF and the Director of Program Integrity has a reasonable expectation that an overpayment to a provider may have occurred or may occur, that a provider or provider-in-fact has failed to cooperate or attempted to delay or obstruct an investigation, or has information that fraudulent, willful or abusive practices may have been used, or that willful misrepresentations may have occurred, the Director of BHSF and the Director of Program Integrity may initiate the withholding of payments to a provider for the purpose of protecting the interest and fiscal integrity of the Louisiana Medicaid program.

B. Basis for Withholding. The Director of BHSF and the Director of Program Integrity may withhold a portion of or all payments or reimbursements to be made to a provider upon receipt of information that overpayments have been made to a provider, that the provider or provider-in-fact has failed to cooperate or attempted to delay or obstruct an investigation (a request for a delay in a hearing shall not constitute a failure to cooperate or delay or obstruction of an investigation), that fraudulent, willful or abusive practices may have occurred or that willful misrepresentation has occurred. If the Director of BHSF and the Director of Program Integrity has been informed in writing by a prosecuting authority that a provider or provider-in-fact has been formally charged or indicted for crimes or is being investigated for potential criminal activities which relate to the Louisiana Medicaid Program or one or more of its

programs or Medicare, payments to that provider may be withheld. If the Director of BHSF and the Director of Program Integrity has been informed in writing by any governmental agency or authorized agent of a governmental agency that a provider or a provider-in-fact is being investigated by that governmental agency or its authorized agent for billing practices related to any government funded health care program, payment may be withheld. Withholding of payments may occur without first notifying the provider.

#### C. Notice of Withholding

1. The provider shall be sent written notice of the withholding of payments within five (5) working days of the actual withholding of the first check that is the subject of the withholding. The notice shall set forth in general terms the reason(s) for the action, but need not disclose any specific information concerning any ongoing investigations nor the source of the allegations. The notice must:

- a. state that payments are being withheld;
- b. state that the withholding is for a temporary period and cite the circumstances under which the withholding will be terminated;
- c. specify to which type of Medicaid claims withholding is effective;
- d. inform the provider of its right to submit written documentation for consideration and to whom to submit that documentation.

2. Failure to provide timely notice of the withholding to the provider or provider-in-fact may be grounds for dismissing or overturning the withholding, except in cases involving written notification from outside governmental authorities, abusive practice, willful practices or fraudulent practices.

#### D. Duration of Withholding

1. All withholding of payment actions under this Subpart will be temporary and will not continue after:

- a. the Director of BHSF and the Director of Program Integrity has determined that insufficient information exists to warrant the withholding of payments;
- b. recoupment or recovery of overpayments has been imposed on the provider;
- c. the provider or provider-in-fact has posted a bond or other security deemed adequate to cover all past and future projected overpayments by the Director of BHSF and the Director of Program Integrity ;
- d. the notice of the results of the informal hearing.

2. In no case shall withholding remain in effect past the issuance of the notice of the results of the informal hearing, unless the withholding is based on written notification by an outside agency that an active and ongoing criminal investigation is being conducted or that formal criminal charges have been brought. In that case, the withholding may continue for as long as the criminal investigation is active and ongoing or the criminal charges are still pending, unless adequate bond or other security has been posted with BHSF.

#### E. Amount of the Withholding

1. If the withholding of payment results from projected overpayments which the Director of BHSF and the Director of Program Integrity determines not to be related to fraudulent, willful or abusive practices, obstruction or delay in investigation or based on written notification from an outside agency, then when determining the amount to be

withheld, the ability of the provider to continue operations and the needs of the recipient serviced by the provider shall be taken into consideration by the Director of BHSF and the Director of Program Integrity. In the event that a recipient cannot receive needed goods, services or supplies from another source arrangements shall be made to assure that the recipient can receive goods, supplies, and services. The burden is on the provider to demonstrate that absent that providers ability to provide goods, supplies, or services to that recipient, the recipient could not receive needed goods, supplies, or services. Such showing must be made at the Informal Hearing.

2. The amount of the withholding shall be determined by the Director of BHSF and the Director of Program Integrity. The provider should be notified of the amount withheld every 60 days from the date of the issuing of the Notice of Withholding until the withholding is terminated or the Results of the Informal Hearing is issued, which ever comes first.

**AUTHORITY NOTE:** Promulgated in accordance with R.S. 36:254, 46:437.4 and 46:437.1-46:440.3 (Medical Assistance Program Integrity Law).

**HISTORICAL NOTE:** Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:1646 (September 1999).

### **§4149. Effect of Withholding on the Status of a Provider or Provider-in-Fact with the Medical Assistance Program**

Withholding of payments does not, in and of its self, affect the status of a provider or provider-in-fact. During the period of withholding, the provider may continue to provide goods, services, or supplies and continue to submit claims for them, unless the provider has been suspended or excluded from participation. Any and all amounts withheld or bonds or other security posted may be used for recovery, recoupment or arrangements to pay.

**AUTHORITY NOTE:** Promulgated in accordance with R.S. 36:254, 46:437.4 and 46:437.1-46:440.3 (Medical Assistance Program Integrity Law).

**HISTORICAL NOTE:** Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:1647 (September 1999).

### **Subchapter H. Arrangements to Repay**

#### **§4151. Arrangement to Repay**

A. Arrangements to repay may be mutually agreed to or imposed as a sanction on a provider, provider-in-fact or other person. Arrangements to repay identified overpayments, interest, monetary penalties or costs and expenses should be made through a lump sum single payment within 60 days of reaching or imposing the arrangement to repay. However, an agreement to repay may contain installment terms and conditions. In such cases, the repayment period cannot extend two years from the date the agreement is reached or imposed, except that a longer period may be established by the Secretary or Director of BHSF. In such a case the agreement to repay must be signed by the Secretary or Director of BHSF.

B. All agreements to repay must contain at least:

1. the amount to be repaid;
2. the person(s) responsible for making the repayments;
3. a specific time table for making the repayment;

4. if installment payments are involved, the date upon which each installment payment is to be made; and

5. the security posted to assure that the repayments will be made, and if not made, the method through which the security can be seized and converted by Medicaid.

**AUTHORITY NOTE:** Promulgated in accordance with R.S. 36:254, 46:437.4 and 46:437.1-46:440.3 (Medical Assistance Program Integrity Law).

**HISTORICAL NOTE:** Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR. 25:1647 (September 1999).

## **Subchapter I. Corrective Actions**

### **§4153. Corrective Actions Plans**

A. The following procedures are established for the purpose of attempting to resolve problems prior to the issuing of a notice of sanction or for resolution during the informal hearing or administrative hearing.

#### 1. Corrective Action Plan-Notification

a. The Director of BHSF and the Director of Program Integrity may at anytime issue a notice of corrective action to a provider or provider-in-fact, agent of the provider, or affiliate of the provider. The provider, provider-in-fact, agent of the provider, or affiliate of the provider shall either comply with the corrective action plan within ten (10) working days of receipt of the corrective action plan or request an informal hearing within that time. The purpose of a Corrective Action Plan is to identify potential problem areas and correct them before they become significant discrepancies, deviations or violations. This is an informal process.

i. The request for an informal hearing must be made in writing.

ii. If the provider, provider-in-fact, agent of the provider, or affiliate of the provider opts to comply, it must do so in writing, signed by the provider, provider-in-fact, agent of the provider, or affiliate of the provider.

b. Corrective action plans are also used to resolve matters at or before the informal hearing or administrative appeal process. When so used they serve the same function as a settlement agreement.

2. Corrective Action Plan-Inclusive Criteria. The corrective action plan must be in writing and contain at least the following:

a. the nature of the discrepancies or violations;

b. the corrective action(s) that must be taken;

c. notification of any action required of the provider, provider-in-fact, agent of the provider, billing agent or affiliate of the provider;

d. notification of the right to an informal hearing on any or all of the corrective actions which the provider, provider-in-fact, agent of the provider, or affiliate of the provider is not willing to comply with within ten (10) working days of the date of receipt of the notice; and

e. the name, address, telephone and facsimile number of the individual to contact in regards to compliance or requesting an informal hearing.

3. Corrective Action Plans-Restrictions. Corrective actions, which may be included in a corrective action plan, are the following:

a. issuing a warning through written notice or consultation;

b. require that the provider, provider-in-fact, agent of the provider, or affiliate receive education and training in

the law, regulations, rules, policies, criteria and procedures related to the Medical Assistance Program, including billing practices or programmatic requirements and practices. Such education or training may be at the provider or provider-in-fact's expense.

c. require that the provider receive prior authorization for any or all goods, services, or supplies to be rendered;

d. place the provider's claims on manual review status before payment is made;

e. restrict or remove the provider's privilege to submit bills or claims electronically;

f. impose any restrictions deemed appropriate by the Director of BHSF and the Director of Program Integrity; or

g. any other items mutually agreed to by the provider, provider-in-fact, agent of the provider, billing agent, affiliate of the provider or other person and the Director of BHSF or the Director of Program Integrity, including, but not limited to, one or more of the sanctions listed in this regulation and an agreement to repay.

4. Only restrictions in §4153.A.3.a-f above can be imposed on a provider, provider-in-fact, agent of the provider, billing agent, or affiliate of the provider without their agreement. Any other items included in a corrective action plan must be mutually agreed to among the parties to the corrective action plan.

5. A corrective action plan is effective ten (10) days after receipt of the Corrective Action Plan by the provider, provider-in-fact, agent of the provider, or affiliate of the provider.

6. No right to an informal hearing or administrative appeal can arise from a corrective action plan, unless the corrective action plan violates the provisions of this chapter.

**AUTHORITY NOTE:** Promulgated in accordance with R.S. 36:254, 46:437.4 and 46:437.1-46:440.3 (Medical Assistance Program Integrity Law).

**HISTORICAL NOTE:** Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:1648 (September 1999).

## **Subchapter J. Informal Hearing Procedures and Processes**

### **§4155. The Informal Hearing**

A. A provider, provider-in-fact, agent of the provider, billing agent, affiliate of the provider or other person who has received notice of a corrective action(s), notice of sanction or notice of withholding of payment shall be provided with an Informal Hearing if that person makes a written request for an Informal Hearing within fifteen (15) days of receipt of the corrective action plan or notice. The request for an Informal Hearing must be made in writing and sent in accordance with the instruction in the corrective action plan or notice. The time and place for the informal hearing will be set out in the notice of setting of the informal hearing.

B. The informal hearing is designed to provide the opportunity:

1. to provide the provider, provider-in-fact, agent of the provider, billing agent, the affiliate of the provider or other person an opportunity to informally review the situation;

2. for BHSF to offer alternatives based on information presented by the provider, provider-in-fact, agent of the

provider, billing agent, affiliate of the provider, or other person, if any; and

3. for the provider, provider-in-fact, agent of the provider, billing agent, affiliate of the provider or other person to evaluate the necessity for seeking an administrative appeal. During the informal hearing, the provider, provider-in-fact, agent of the provider, billing agent, affiliate of the provider or other person may be afforded the opportunity to talk with the department's personnel involved in the situation, to review pertinent documents on which the alleged violations are based, to ask questions, to seek clarification, to provide additional information and be represented by counsel or other person. Upon agreement of all parties an informal discussion may be recorded or transcribed.

C. Notice of the Results of the Informal Hearing. Following the informal hearing, BHSF shall inform the provider, provider-in-fact, agent of the provider, billing agent, affiliate of the provider or other person in writing of the results which could range from canceling, modifying, or upholding any or all of the violations, sanctions or other actions contained in a corrective action plan, notice of sanction or notice of withholding of payments and the provider, provider-in-fact, agent of the provider, billing agent, affiliate of the provider or other person's right to an administrative appeal. The notice of the results of the informal hearing must be signed by the Director of BHSF and the Director of Program Integrity.

1. The provider, provider-in-fact, agent of the provider, billing agent, affiliate of the provider or other person has the right to request an administrative appeal within thirty (30) days of the mailing of the notice of the results of the informal hearing. At any time prior to the issuance of the written results of the informal hearing, the notice of corrective action or notice of administrative sanction or withholding of payment may be modified.

i. If a finding or reason is dropped from the notice, no additional time will be granted to the provider, provider-in-fact, agent of the provider, billing agent, affiliate of the provider or other person to prepare for the informal hearing.

ii. If additional reasons or sanctions are added to the notice prior to, during or after the informal hearing, the provider, provider-in-fact, agent of the provider, billing agent, affiliate of the provider or other person shall be granted an additional ten (10) working days to prepare responses to the new reasons or sanctions, unless the ten (10) day period is waived by the provider, provider-in-fact, agent of the provider, billing agent, affiliate of the provider or other person.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, 46:437.4 and 46:437.1-46:440.3 (Medical Assistance Program Integrity Law).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:1648 (September 1999).

## **Subchapter K. Administrative Appeals**

### **§4157. Administrative Appeal**

A. The provider, provider-in-fact, agent of the provider, billing agent, or affiliate of the provider may seek an administrative appeal from the notice of the results of an informal hearing if the provider, provider-in-fact, agent of the provider, billing agent, or affiliate of the provider has

had one or more appealable sanctions imposed upon him or an appealable issue exist related to a corrective action plan imposed in a notice of the results of the informal hearing.

B. The notice of administrative appeal must be adequate as to form and lodged with the Bureau of Appeals within thirty (30) days of the receipt of the notice of the results of the informal hearing. The lodging of a timely and adequate request for an administrative appeal does not effect the imposition of a corrective action plan or a sanction, unless the sanction imposed is exclusion. All sanctions imposed through the notice of the results of the informal hearing are effective upon mailing or faxing of the notice of the results of the informal hearing to the provider, provider-in-fact, agent of the provider, billing agent, affiliate of the provider or other person, except exclusion from participation in the Medical Assistance Program or one or more of its programs.

C. In the case of an exclusion from participation, if the Director of BHSF and the Director of Program Integrity determines that allowing that person to participate in the Medicaid Program during the pendency of the administrative appeal process poses a threat to the programmatic or fiscal integrity of the Medicaid Program or poses a potential threat to health, welfare or safety of any recipients, then that person may be suspended from participation in the Medicaid Program during the pendency of the administrative appeal. If the exclusion is mandatory a threat to Medicaid Program or recipients is presumed. This determination shall be made following the Informal Hearing.

D. Failure to lodge a timely and adequate request for an administrative appeal will result in the imposition of any and all sanctions in the notice of the results of the informal hearing or the corrective action plan.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, 46:437.4 and 46:437.1-46:440.3 (Medical Assistance Program Integrity Law).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:1649 (September 1999).

### **§4159. Right to Administrative Appeal and Review**

A. Only the imposing of one or more sanctions can be appealed to the department's Bureau of Appeals.

1. The adversely effected party has the right to challenge the basis for the violation and the sanction imposed.

2. The adversely effected party must specifically state the basis for the appeal is and what actions are being challenged on appeal.

B. The following actions are not sanctions, even if listed as such in the notice of sanction or notice of the results of the informal hearing, and are not subject to appeal or review by the department's Bureau of Appeals:

1. referral to a state, federal or professional licensing authority;

2. referral to the Louisiana Attorney General's Medicaid Fraud Control Unit or any other authorized law enforcement or prosecutorial authority;

3. referral to governing boards, peer review groups or similar entities;

4. issuing a warning to a provider or provider-in-fact or other person through written notice or consultation;

5. require that the provider, or provider-in-fact, their affiliates and agents receive education and training in laws,

regulations, rules, policies, and procedures, including billing;

6. conducting prepayment or post-payment review;
7. place the provider's claims on manual review status before payment is made;
8. require that the provider or provider-in-fact receive prior authorization for any or all goods, services, or supplies under the Louisiana Medicaid program or one or more of its programs;
9. remove or restrict the provider's use of electronic billing;
10. any restrictions imposed as the result of a corrective action plan;
11. any restrictions agreed to by a provider, provider-in-fact, agent of the provider, or affiliate of the provider;
12. any terms or conditions contained in an arrangement to repay which has been agreed to by a provider, provider-in-fact, agent of the provider, or affiliate of the provider.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, 46:437.4 and 46:437.1-46:440.3 (Medical Assistance Program Integrity Law).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:1649 (September 1999).

#### **Subchapter L. Rewards for Fraud and Abuse Information**

##### **§4160. Tip Rewards**

A. The Secretary may approve a reward of ten (10) percent of the actual monies recover from a person, with a maximum reward of two thousand (2,000.00) Dollars, to a person who submits information to the Secretary which results in a recovery under this regulation or the provisions of the Medical Assistance Program Integrity Law.

B. The Secretary shall grant rewards only to the extent monies are appropriated for that purpose from the Medical Assistance Programs Fraud Detection Fund. The approval of a reward is solely at the discretion of the Secretary. In making a determination of a reward, the Secretary shall consider the extent to which the tip information contributed to the investigation and recovery of monies. The person providing the information need not have requested a reward in order to be considered for an award by the Secretary.

C. No reward shall be made to any person if:

1. the information was previously known to the department or criminal investigators;
2. a person planned or participated in the action resulting in the investigation.
3. a person who is, or was at the time of the tip, excluded from participation in the Medical Assistance Program or subject to recovery under this regulation or the Medical Assistance Program Integrity Law.
4. a person who is or was a public employee or public official or person who was or is acting on behalf of the state if the person has or had a duty or obligation to report, investigate, or pursue allegations of wrongdoing or misconduct by health care providers or Medicaid recipients unless that individual has not been employed or had such duties and obligation for a period of two years prior to providing the information.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, 46:437.4, R.S. 46:440.2 and 46:437.1-46:440.3 (Medical Assistance Program Integrity Law).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:1650 (September 1999).

#### **Subchapter M. Miscellaneous**

##### **§4161. Mailing**

Mailing refers to the sending of a hard copy via U.S. mail or commercial carrier. Sending via facsimile is also acceptable, so long as a hard copy is mailed. Delivery via hand is also acceptable.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, 46:437.4 and 46:437.1-46:440.3 (Medical Assistance Program Integrity Law).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:1650 (September 1999).

##### **§4163. Confidentiality**

All contents of claim reviews and investigations conducted under this regulation shall remain confidential until a final administrative adjudication is entered. Prior to that, only the parties or their authorized agents and representatives may review the contents of the payment review and investigatory files, unless by law others are specifically authorized to have access to those files. These files may be released to law enforcement agencies, other governmental investigatory agencies, or specific individuals within the department who are authorized by the Director of BHSF and the Director of Program Integrity to have access to such information.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, 46:437.4 and 46:437.1-46:440.3 (Medical Assistance Program Integrity Law).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:1650 (September 1999).

##### **§4165. Severability Clause**

If any provision of this regulation is declared invalid or unenforceable for any reason by any court of this state or federal court of proper venue and jurisdiction, that provision shall not affect the validity of the entire regulation or other provisions thereof.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, 46:437.4 and 46:437.1-46:440.3 (Medical Assistance Program Integrity Law).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:1650 (September 1999).

##### **§4167. Effect of Promulgation**

This regulation, when promulgated, shall supersede any and all other departmental regulations that conflict with the provisions of this regulation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, 46:437.4 and 46:437.1-46:440.3 (Medical Assistance Program Integrity Law).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:1650 (September 1999).

David W. Hood  
Secretary

9909#057

## RULE

### Department of Health and Hospitals Office of the Secretary Medical Disclosure Panel

#### Cardiology Procedures (LAC 48:I.2349)

As authorized by R.S. 40:1299.40.E, as enacted by Act 1093 of 1990 and later amended by Act 962 of 1992 and Act 633 of 1993, the Department of Health and Hospitals, Office of the Secretary, in consultation with the Louisiana Medical Disclosure Panel, is amending rules which require which risks must be disclosed under the Doctrine of Informed Consent to patients undergoing medical treatments or procedures and the Consent Form to be signed by the patient and physician before undergoing any such treatment or procedure.

#### Title 48

#### PUBLIC HEALTH GENERAL

#### Part I. General Administration

#### Chapter 23. Informed Consent

#### §2349. Cardiology Procedures

- A. Arterial Line Insertion
  1. Swelling, pain, tenderness or bleeding at blood vessel entrance by catheter or needle
  2. Injury to artery or vein entered or studied
  3. Decrease in blood flow to area supplied by the artery
  4. Nerve damage
  5. Loss or loss of function of an arm or leg supplied by the artery
  6. Possible need for surgery due to complications
- B. Cardiac Catheterization
  1. Death
  2. Myocardial infarction (cardiac arrest/heart attack)
  3. Cerebrovascular complication (stroke)
  4. Injury to artery or vein entered or studied
  5. Local, vascular complication (groin or arm)
  6. Bleeding, thrombosis, distal embolization, pseudoaneurysm, arteriovenous (AV) fistula (abnormal communication between an artery and a vein), hematomas, nerve damage, injury to the artery, delayed hemorrhage
    7. Loss or loss of function of an arm or leg
    8. Perforation of heart or great vessels
    9. Vasovagal reaction (hypotension, slow heart rate)
    10. Arrhythmias and conduction disturbances (irregular heart beat)
    11. Kidney failure (partial or complete; may necessitate hemodialysis)
    12. Contrast related anaphylactoid reactions (allergies)
    13. Congestive heart failure
    14. Pulmonary embolism
    15. Bleeding requiring blood transfusion or surgery
    16. Possible need for surgery due to complications
    17. Scar formation at the site of entrance into the artery
- C. General Angiography
  1. Contrast related anaphylactoid reactions (allergies)
  2. Injury to artery or vein entered or studied
  3. Loss or loss of function of an arm or leg

4. Kidney failure (partial or complete; may necessitate hemodialysis)
- D. Percutaneous Coronary Angioplasty / Stent Placement
  1. Death
  2. Brain Damage (stroke)
  3. Quadriplegia
  4. Paraplegia
  5. Injury to artery or vein entered or studied
  6. Loss or loss of function of an arm or leg
  7. Disfigurement (Including scars)
  8. Kidney failure (partial or complete; may necessitate hemodialysis)
  9. Loss of bowel and/or bladder function
  10. Myocardial infarction (cardiac arrest/heart attack)
  11. Restenosis (subsequent recurrence of narrowing of blood vessel)
    12. Possible need for surgery due to complications
    13. Contrast related anaphylactoid reactions (allergies)
    14. Hypotension (abnormally low blood pressure)
    15. Arrhythmias and conduction disturbances (irregular heart beat)
    16. Bleeding requiring blood transfusion or surgery
    17. Pericardial tamponade (compression of the heart due to accumulation of blood or fluid in the sac around the heart)
    18. Stent thrombosis
    19. Displacement of stent or instrument requiring retrieval
- E. Thrombolysis—Regional or Systemic
  1. Death
  2. Brain damage (stroke)
  3. Injury to artery or vein entered or studied
  4. Loss or loss of function of an arm or leg
  5. Bleeding requiring blood transfusion or surgery
  6. Hematoma
  7. Arrhythmias and conduction disturbances (irregular heart beat)
    8. Hypotension (abnormally low blood pressure)
    9. Contrast related anaphylactoid reactions (allergies)
- F. Coronary Intervention (Stents and Atherectomy)/Directional Coronary Arthrectomy (DCA), Transluminal Extraction Catheter Arthrectomy (TEC) and Rotational Atherectomy
  1. Death
  2. Brain Damage (stroke)
  3. Quadriplegia
  4. Paraplegia
  5. Injury to artery or vein entered or studied
  6. Loss or loss of function of an arm or leg
  7. Disfigurement (including scars)
  8. Kidney failure (partial or complete; may necessitate hemodialysis)
  9. Loss of bowel and/or bladder function
  10. Myocardial infarction (cardiac arrest/heart attack)
  11. Restenosis (subsequent recurrence of narrowing of blood vessel)
    12. Possible need for surgery due to complications
    13. Contrast related anaphylactoid reactions (allergies)
    14. Hypotension (abnormally low blood pressure)
    15. Arrhythmias and conduction disturbances (irregular heart beat)

16. Bleeding requiring blood transfusion or surgery
  17. Pericardial tamponade (compression of the heart due to accumulation of blood or fluid in the sac around the heart)
  18. Side branch occlusion
  19. Severe bradycardia (severe slowing of the heart)
  20. Stent thrombosis
  21. Displacement of stent or instrument requiring retrieval
  22. Perforation of heart or great vessels
  23. Coronary vasospasm related to the instrument used
- G. Electrophysiologic Study Including Programmed Electrical Stimulation (EPS) (Stimulating the heart to search for abnormal heart beat)
1. Perforation of heart or great vessels
  2. Pericardial tamponade (compression of the heart due to accumulation of blood or fluid in the sac around the heart)
  3. Bleeding requiring blood transfusion or surgery
  4. Injury to artery or vein entered or studied
  5. Arrhythmia and conduction disturbances (irregular heart beat)
  6. Pneumothorax (collapse of lung)
  7. Death
  8. Myocardial infarction (cardiac arrest/heart attack)
  9. Bleeding, thrombosis, distal embolization, pseudoaneurysm, arteriovenous (AV) fistula (abnormal communication between an artery and a vein), hematomas, nerve damage, injury to the artery, delayed hemorrhage
  10. Thrombophlebitis (inflammation of the vein)
  11. Pulmonary embolism (blood clot from pelvis or legs that moves to lungs)
  12. Brain damage (stroke)
  13. Loss or loss of function of a leg or arm
  14. Electrical burns to the chest
- H. Radiofrequency Catheter Ablation
1. Perforation of heart or great vessels
  2. Injury to artery or vein entered or studied
  3. Pericardial tamponade (compression of the heart due to accumulation of blood or fluid in the sac around the heart)
  4. Bleeding requiring blood transfusion or surgery
  5. Pneumothorax (collapse of lung)
  6. Death
  7. Myocardial infarction (cardiac arrest/heart attack)
  8. Arrhythmia and conduction disturbances (irregular heartbeat)
  9. Bleeding, thrombosis, distal embolization, pseudoaneurysm, arteriovenous (AV) fistula (abnormal communication between an artery and a vein), hematomas, nerve damage, injury to the artery, delayed hemorrhage
  10. Thrombophlebitis (inflammation of the vein)
  11. Pulmonary embolism (blood clot from pelvis or legs that moves to lungs)
  12. Brain damage (stroke)
  13. Loss or loss of function of a leg or arm
  14. Electrical burns to the chest
  15. Possible need for surgery due to complications
  16. Damage to heart valve
  17. Interruption of the normal electrical conduction system of the heart, requiring permanent pacemaker placement
18. Recurrence of arrhythmia after initially successful ablation
    - I. Transesophageal Echocardiography
      1. Arrhythmias and conduction disturbances (irregular heartbeat)
      2. Myocardial infarction (cardiac arrest/heart attack)
      3. Aspiration pneumonia
      4. Respiratory failure which may require ventilation
      5. Trauma to vocal cords which may result in temporary or permanent vocal cord injury that may require surgical repair
      6. Injury to artery or vein entered or studied
      7. Injury to teeth, gums, or throat, esophageal bleeding, laceration or perforation which may require surgical repair
    - J. Exercise Treadmill and Bicycle Stress Testing
      1. Death
      2. Myocardial infarction (cardiac arrest/heart attack)
      3. Arrhythmias and conduction disturbances (irregular heartbeat)
      4. Prolonged angina (chest pain)
      5. Hypotension/Hypertension (abnormally low blood pressure/high blood pressure)
      6. Brain damage (stroke)
      7. Syncope (fainting)
      8. Musculoskeletal injuries (injuries to bones, muscles, and/or joints)
    - K. Dobutamine Stress Testing
      1. Death
      2. Myocardial infarction (cardiac arrest/heart attack)
      3. Prolonged angina (chest pain)
      4. Hypotension/Hypertension (abnormally low blood pressure/high blood pressure)
      5. Brain damage (stroke)
      6. Arrhythmias and conduction disturbances (irregular heartbeat)
      7. Syncope (fainting)
      8. Injury to artery or vein entered or studied
    - L. Automatic Implantable Cardioverter Defibrillator Implantation (Permanent Pacemaker)
      1. Bleeding requiring blood transfusion or surgery
      2. Hemorrhage (bleeding) into the lungs, the pericardium (sac which surrounds the heart), and the chest cavity.
      3. Pericardial tamponade (compression of the heart due to accumulation of blood or fluid in the sac around the heart)
      4. Myocardial infarction (cardiac arrest/heart attack)
      5. Brain damage (stroke)
      6. Pneumothorax (collapse of lung)
      7. Perforation of heart or great vessels
      8. Injury to artery or vein entered or studied
      9. Possible need for surgery due to complications
      10. Arrhythmia and conduction disturbances (irregular heart beat)
      11. Damage to trachea (windpipe) and/or pharynx (throat)
      12. Trauma to vocal cords which may result in temporary or permanent vocal cord injury that may require surgical repair
    - M. Pericardiocentesis
      1. Perforation of heart or great vessels

2. Damage to coronary arteries including laceration
3. Possible need for surgery due to complications
4. Arrhythmia or conduction disturbances (irregular heart beat)

5. Myocardial infarction (cardiac arrest/heart attack)
6. Pneumothorax (collapse of lung)
7. Death
8. Pericardial tamponade (compression of the heart due to accumulation of blood or fluid in the sac around the heart)

N. Electrical Cardioversion

1. Electrical burns to the chest
2. Myocardial infarction (cardiac arrest/heart attack)
3. Embolic event to any portion of the body (e.g., brain, bowel, kidney, eyes, arm, leg) which may lead to loss of, or loss of function of, affected portion of body
4. Injury to artery or vein entered or studied
5. Death
6. Brain damage (stroke)
7. Arrhythmia and conduction disturbances (irregular heartbeat)

O. Endomyocardial Biopsy

1. Injury to artery or vein entered or studied
2. Hemorrhage (bleeding) into the lungs, the pericardium sac which surrounds the heart and the chest cavity
3. Pericardial tamponade (compression of the heart due to accumulation of blood in the sac around the heart)
4. Myocardial infarction (cardiac arrest/heart attack)
5. Arrhythmias and conduction disturbances (irregular heartbeat)
6. Pneumothorax (collapse of lung)
7. Perforation of heart or great vessels
8. Possible need for surgery due to complications
9. Damage to trachea (windpipe) and/or pharynx (throat)
10. Trauma to vocal cords which may result in temporary or permanent vocal cord injury that may require surgical repair
11. Displacement of stent or instrument requiring retrieval

12. Brain damage (stroke)
13. Bleeding requiring blood transfusion or surgery

P. Temporary Pacemaker Placement

1. Injury to artery or vein entered or studied
2. Hemorrhage (bleeding) into the lungs, the pericardium (sac which surrounds the heart), the chest cavity and elsewhere
3. Pericardial tamponade (compression of the heart due to accumulation of blood or fluid in the sac around the heart)
4. Brain damage (stroke)
5. Myocardial infarction (cardiac arrest/heart attack)
6. Pneumothorax (collapse of lung)
7. Perforation of heart or great vessels
8. Possible need for surgery due to complications
9. Arrhythmia and conduction disturbances (irregular heartbeat)

10. Trauma to vocal cords which may result in temporary or permanent vocal cord injury that may require surgical repair

11. Displacement of stent or instrument requiring retrieval

Q. Pulmonary Angiogram and/or Right Heart Catheterization

1. Injury to artery or vein entered or studied
2. Hemorrhage (bleeding) into the lungs, the pericardium (sac which surrounds the heart) and the chest cavity
3. Brain damage (stroke)
4. Pneumothorax (collapse of lung)
5. Myocardial infarction (cardiac arrest/heart attack)
6. Perforation of heart or great vessels
7. Possible need for surgery due to complications
8. Arrhythmia and conduction disturbances (irregular heart beat)
9. Shock
10. Infusion of fluid into the chest cavity, lungs, and pericardium
11. Contrast related anaphylactoid reactions (allergies)
12. Death
13. Aggravation of the condition that necessitated the procedure
14. Bleeding requiring transfusion or surgery
15. Kidney failure (partial or complete; may necessitate hemodialysis)
16. Respiratory complications (including need for prolonged ventilator (mechanical) support)
17. Loss or loss of function of an arm or leg

R. Cardiac Rehabilitation

1. Death
2. Arrhythmias and conduction disturbances (irregular heartbeat)
3. Myocardial infarction (cardiac arrest/heart attack)
4. Prolonged angina (chest pain)
5. Hypotension/Hypertension (low blood pressure/high blood pressure)
6. Brain damage (stroke)
7. Syncope (fainting)
8. Musculoskeletal injuries (injuries to bones, muscles and/or joints)
9. Drowning (if involving water activities)

S. Head up Tilt Test (Including vasoactive drugs)

1. Syncope (fainting)
2. Seizure (convulsions)
3. Hypotension/Hypertension (low blood pressure/high blood pressure)
4. Arrhythmia and conduction disturbances (irregular heartbeat)
5. Myocardial infarction (cardiac arrest/heart attack)
6. Brain damage (stroke)

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.40.E et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Medical Disclosure Panel, LR 18:1391 (April 1999), amended LR 25:1651 (September 1999).

David W. Hood  
Secretary

9909#048

**RULE**

**Department of Social Services  
Office of Community Services**

**Child Protection Investigation Report Acceptance  
(LAC 67:V.1301)**

The Department of Social Services, Office of Community Services, is amending the Rule entitled "Child Protection Investigation Report Acceptance" published in the Louisiana Register Vol. 19, No. 4, April 20, 1993, page 503.

This rule regards the acceptance of reports of child abuse and/or neglect for investigation by the Office of Community Services. The Office of Community Services will now accept for investigation all reports of suspected child abuse/neglect related deaths regardless of whether there are surviving children in the child victim's home.

**Title 67**

**SOCIAL SERVICES**

**Part V. Office of Community Services**

**Subpart 3. Child Protective Services**

**Chapter 13. Intake**

**§1301. Child Protection Investigation Report  
Acceptance**

A. - F. ...

G.2.a. Repealed.

b. - m. ...

AUTHORITY NOTE: Promulgated in accordance with the Louisiana Children's Code, Article 612.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Community Services, LR 17:387 (April 1991), amended LR 18:1246 (November 1992), repromulgated LR 19:165 (February 1993), LR 19:503 (April 1993), amended LR 25:1654 (September 1999).

Madlyn Bagneris  
Secretary

9909#082

**RULE**

**Department of Transportation and Development  
Office of the Secretary  
Crescent City Connection Division**

**Bridge Toll—Crescent City Connection Bridge No. 2  
Transit Lanes (LAC 70:I.515)**

The Department of Transportation and Development, Crescent City Connection Division, in accordance with the Administrative Procedure Act, R.S. 49:950 et seq., has amended LAC 70:I.515 to allow access to the transit lanes on the Crescent City Connection Bridge No. 2, New Orleans, Louisiana, by motorcycles.

The Rule Amendment is necessary to implement recent changes in federal law.

**Title 70**

**TRANSPORTATION AND DEVELOPMENT**

**Part I. Office of the General Counsel**

**Chapter 5. Tolls**

**§515. Crescent City Connection Transit Lanes**

A. Intent. It is the intent of this Rule to efficiently maximize the use of the vehicular traffic lanes of the Crescent City Connection for the increased mobility of individuals and goods across the Mississippi River at New Orleans, to encourage and promote mass transit and transportation such as the use of carpools and other high occupancy vehicle (HOV) use, while minimizing transportation related fuel consumption and air pollution, and to provide for one-way reversible traffic flow on the transit lanes of the Crescent City Connection Bridge No. 2, and the establishment of the requirements for vehicles operating on the transit lanes.

**B. Hours of Operation**

1. The transit lanes of the Crescent City Connection Bridge No. 2 will be open for use by eligible vehicles in accordance with the control signals posted by the Crescent City Connection Division through the Crescent City Connection Police.

2. Generally, the transit lanes of the Crescent City Connection Bridge No. 2 will be open for use by eligible vehicles with the traffic proceeding to the Eastbank in the morning and with the traffic proceeding to the Westbank in the afternoon.

3. However, the directional traffic flow of the transit lanes may be reconfigured by the Crescent City Connection Division in its sole discretion at such times and in such directions in order to protect the public safety during emergencies and to accommodate the public interest during special events.

C. Ineligible Vehicles. The objective of the transit lanes is to provide a free flowing facility for mass transit, high occupancy vehicles, and other eligible vehicles. Accordingly, the following vehicles are prohibited from using the transit lanes during the hours of operation even though they may satisfy the vehicle occupancy requirements:

1. trucks with more than two axles or having a gross weight capacity of one ton or more;
2. vehicles towing trailers;
3. parades;
4. funeral processions;
5. pedestrians;
6. bicycles; and
7. non-motorized vehicles.

D. Eligible Vehicles. The following vehicles are eligible to use the transit lanes during the hours of operation:

1. all public mass transit vehicles, including Regional Transit Authority buses and Jefferson Transit System buses;
2. school buses;
3. commercial passenger vehicles manufactured to carry seven (7) or more passengers and pre-qualified to use the transit lanes ("HOV-7");

4. other motor vehicles carrying more than a specified number of persons and properly displaying a valid toll tag issued by the Crescent City Connection Division ("HOV-2");

5. motorcycles properly displaying a valid toll tag issued by the Crescent City Connection Division ("Authorized Motorcycles"); and

E. Vehicle Occupancy Requirements. The minimum occupancy requirement for vehicles designated as HOV-2 shall be two or more persons during all hours of operation. The minimum occupancy requirement for vehicles designated as HOV-7 shall continue to be seven or more persons during all hours of operation. There are no minimum occupancy requirements for vehicles designated as Authorized Motorcycles during all hours of operation.

F. Qualifications

1. Eligible vehicles must be prequalified to use the transit lanes as follows.

a. Public Mass Transit Vehicles. All public mass transit vehicles shall continue to be pre-qualified to access the transit lanes toll-free during the hours of operation.

b. School Buses. All school buses shall continue to be authorized to access the transit lanes toll-free during the hours of operation upon compliance with the school buses exemption provided for under LAC 70:I.509(E).

c. HOV-7+. Eligible vehicles meeting the minimum occupancy requirement of seven or more persons must register with the Crescent City Connection Division by providing proof of:

i. current vehicle registration with the State of Louisiana or other jurisdiction;

ii. current and valid Driver's License; and

iii. current and fully-paid liability insurance coverage.

d. HOV-2+. Eligible vehicles meeting the minimum occupancy requirement of two or more persons and displaying a valid toll tag issued by the Crescent City Connection Division.

e. Authorized Motorcycles. Motorcycles displaying a valid toll tag issued by the Crescent City Connection Division.

2. Toll tags on HOV-2 vehicles, and Authorized Motorcycles, must be conspicuously displayed in accordance with the instructions of the Crescent City Connection Division at all times while operating on the transit lanes.

G. Enforcement. During all hours of operation, the Crescent Connection Police shall supervise and actively control access to the transit lanes, and enforce vehicle eligibility, minimum occupancy requirements and permit emblem display.

AUTHORITY NOTE: Promulgated in accordance with R.S. 48:25 et seq., and R.S. 48:1101.2.

HISTORICAL NOTE: Promulgated by the Department of Transportation and Development, Office of the Secretary, Crescent City Connection Division, LR 24:960 (May 1998), amended LR 25:1654 (September 1999).

Alan LeVasseur  
Executive Director

9909#050

**RULE**

**Department of the Treasury  
Board of Trustees of the Teachers'  
Retirement System of Louisiana**

Management of DROP Accounts  
(LAC 58:III.503)

In accordance with R.S. 49:950 et seq., the Administrative Procedure Act, the Board of Trustees of Teachers' Retirement System of Louisiana approved an amendment to policies governing the Management of DROP Accounts, LAC 58:III.503 as follows.

**Title 58**

**RETIREMENT**

**Part III. Teachers' Retirement System**

**Chapter 5. Deferred Retirement Option Plan**

**§503. Management of DROP Accounts**

A. - B.2. ...

3. Interest earnings will begin accruing the day after termination of DROP participation and will be compounded daily. Interest will be deposited to DROP accounts once a year when the actuarially realized rate of return is approved by the Public Retirement Systems' Actuarial Committee. Interest deposits will reflect the interest earned on the account during the previous fiscal year and will be entered on quarterly statements issued after this approval is obtained. No interest will accrue on the DROP account after the date the account has been liquidated. No interest is paid on an interest only balance. Liquidated means all funds have been withdrawn from the DROP account except for the possible final interest earnings due but not yet posted.

B.4. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 11:739 and R.S. 11:786 - 791.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Board of Trustees of the Teachers' Retirement System of Louisiana, LR 18:621 (June 1992), amended LR 18:1419 (December 1992), LR 19:1601 (December 1993), LR 20:1020 (September 1994), LR 21:1267 (November 1995), LR 23:85 (January 1997), repromulgated LR 24:500 (March 1998), amended LR 25:1655 (September 1999).

James P. Hadley, Jr.  
Director

9909#030

**RULE**

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

Deer Management Assistance Program  
(LAC 76:V.111)

The Wildlife and Fisheries Commission does hereby give notice of its intent to amend rules and regulations governing participation in the deer management assistance program.

**Title 76  
WILDLIFE AND FISHERIES**

**Part V. Wild Quadrupeds and Wild Birds**

**Chapter 1. Wild Quadrupeds**

**§111. Rules and Regulations for Participation in the Deer Management Assistance Program**

A. The following rules and regulations shall govern the Deer Management Assistance Program

1. Application Procedure

a. Application for enrollment in Deer Management Assistance Program (DMAP) must be submitted to the Department of Wildlife and Fisheries annually by September 1.

b. Each application must be accompanied by a legal description of lands to be enrolled and a map of the property. This information will remain on file in the appropriate regional office. The applicant must have under lease or otherwise control a minimum of 500 acres of contiguous deer habitat of which up to 250 acres may be agricultural lands, provided the remainder is in forest and/or marsh. Private lands within Wildlife Management Area boundaries shall be enrolled in DMAP regardless of size.

c. Each cooperator will be assessed a \$25 enrollment fee and \$.05/acre for participation in the program. DMAP fees must be paid prior to October 1.

d. An agreement must be completed and signed by the official representative of the cooperator and submitted to the appropriate regional wildlife office for his approval. This agreement must be completed and signed annually.

e. Boundaries of lands enrolled in DMAP shall be clearly marked and posted with DMAP signs in compliance with R.S. 56:110 and LAC 76:V.109. DMAP signs shall be removed if the land is no longer enrolled in DMAP.

f. By enrolling in the DMAP, cooperators agree to allow Department personnel access to their lands for management surveys, investigation of violations and other inspections deemed appropriate by the Department. The person listed on the DMAP application as the contact person will serve as the liaison between the DMAP Cooperator and the Department.

g. Each cooperator that enrolls in DMAP is strongly encouraged to provide keys or lock combinations annually to the Enforcement Division of the Department of Wildlife and Fisheries for access to main entrances of the DMAP property. Provision of keys is voluntary; however, the cooperator's compliance will ensure that DMAP enrolled properties will be properly and regularly patrolled.

2. Tags

a. A fixed number of special tags will be provided by the Department to each cooperator in DMAP to affix to deer taken as authorized by the program. These tags shall be used only on DMAP lands for which the tags were issued.

b. All antlerless deer taken shall be tagged, including those taken during archery season, muzzleloader, and on either-sex days of gun season.

c. Each hunter must have a tag in his possession while hunting on DMAP land in order to harvest an antlerless deer. The tag shall be attached through the hock in

such a manner that it cannot be removed before the deer is transported. The DMAP tag will remain with the deer so long as the deer is kept in the camp or field, is in route to the domicile of its possessor, or until it has been stored at the domicile of its possessor, or divided at a cold storage facility and has become identifiable as food rather than as wild game. The DMAP number shall be recorded on the possession tag of the deer or any part of the animal when divided and properly tagged.

d. All unused tags shall be returned by March 1 to the regional wildlife office which issued the tags.

3. Records

a. Cooperators are responsible for keeping accurate records on forms provided by the Department for all deer harvested on lands enrolled in the program. Mandatory information includes tag number, sex of deer, date of kill and name of person taking the deer. Documentation of harvested deer shall be kept daily by the Cooperator. Additional information may be requested depending on management goals of the cooperator.

b. Information on deer harvested shall be submitted by March 1 to the regional wildlife office handling the particular cooperator.

c. The Contact person shall provide this documentation of harvested deer to the Department upon request. Cooperators who do not have a field camp will be given 48 hours to provide this requested documentation.

B. Suspension and cancellation of DMAP Cooperators

1. Failure of the cooperator to follow these rules and regulations may result in suspension and cancellation of the program on those lands involved. Failure to make a good faith attempt to follow harvest recommendations may also result in suspension and cancellation of the program.

a. Suspension of Cooperator from DMAP—Suspension of the Cooperator from DMAP, including forfeiture of unused tags, will occur immediately for any misuse of tags, failure to tag any antlerless deer, or failure to submit records to the Department for examination in a timely fashion. Suspension of the Cooperator, including forfeiture of unused tags, may also occur immediately if other DMAP rules or wildlife regulations are violated. Upon suspension of the Cooperator from DMAP, the Contact Person may request an administrative hearing within 10 working days to appeal said suspension. Cooperation by the DMAP Cooperator with the investigation of the violation will be taken into account by the Department when considering cancellation of the program following a suspension for any of the above listed reasons. The Cooperator may be allowed to continue with the program on a probational status if, in the judgement of the Department, the facts relevant to a suspension do not warrant cancellation.

b. Cancellation of Cooperator from DMAP—Cancellation of a cooperator from DMAP may occur following a guilty plea or conviction for a DMAP rule or regulation violation and the Cooperator may not be allowed to participate in DMAP for one year following the cancellation for such guilty pleas or conviction. Upon

cancellation of the Cooperator from DMAP, the Contact Person may request an administrative hearing within 10 working days to appeal said cancellation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 56:115.

HISTORICAL NOTE: Promulgated by the Department of Wildlife and Fisheries, Wildlife and Fisheries Commission, LR 17:204 (February 1991), amended LR 25:1656 (September 1999).

Bill A. Busbice, Jr.  
Chairman

9909#023

## RULE

### Department of Wildlife and Fisheries Wildlife and Fisheries Commission

Isles Dernieres Barrier Islands Refuge  
(LAC 76:III.321 and 331)

The Wildlife and Fisheries Commission does hereby adopt regulations for the Isles of Dernieres Barrier Islands Refuge.

#### Title 76

#### WILDLIFE AND FISHERIES

### Part III. State Game and Fish Preserves and Sanctuaries Chapter 3. Particular Game and Fish Preserves and Commission

#### §321. Terrebonne Barrier Islands Refuge

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 56:6(18), R.S. 56:761 and R.S. 56:785.

HISTORICAL NOTE: Promulgated by the Department of Wildlife and Fisheries, Wildlife and Fisheries Commission, LR 19:910 (July 1993), repealed LR 25:

#### §331. Isles Dernieres Barrier Islands Refuge

##### A. Regulations for Isles Dernieres Barrier Islands Refuge

##### 1. Regulations for Wine Island, East Island, Whiskey Island, and Raccoon Island

a. Public access by any means to the exposed land areas, wetlands and interior waterways of these islands is prohibited. Requests to access exposed land areas, wetlands and interior waterways shall be considered on a case-by-case basis and may be permitted by the Secretary or his designee in the interest of conducting research on fauna and flora, of advancing educational pursuits related to barrier islands, or of planning and implementing island restoration projects.

b. Disturbing, injuring, collecting, or attempting to disturb, injure, or collect any flora, fauna, or other property is prohibited, unless expressly permitted in writing by the Secretary or his designee for the uses provided for in Paragraph 1.a. above.

c. Boat traffic is allowed adjacent to the islands in the open waters of the Gulf and bays; however, boat traffic is prohibited in waterways extending into the interior of the islands or within any land-locked open waters or wetlands of the islands.

d. Fishing from boats along the shore and wade fishing in the surf areas of the islands is allowed.

e. Littering on the islands or in Louisiana waters or wetlands is prohibited.

f. Proposals to conduct oil and gas activities, including seismic exploration, shall be considered on a case-by-case basis and may be permitted by the Secretary or his

designee, consistent with provisions of the Act of Donation executed by the Louisiana Land and Exploration Company on July 24, 1997.

#### 2. Regulations for Trinity Island

a. Public access is allowed in a designated public use area. An area approximately 3,000 linear feet by 500 linear feet is designated as a public use area, the boundaries of which will be marked and maintained by the Department. The designated public use area shall extend westward from the western boundary of the servitude area reserved by Louisiana Land and Exploration Company in the Act of Donation a distance of approximately 3,000 linear feet and northward from the southern shoreline within this area by a distance of approximately 500 linear feet. Public recreation such as bird-watching, picnicking, fishing and overnight camping is allowed in this area. Travel on or across this area shall be limited to foot or bicycle traffic only. No use of all-terrain vehicles or other vehicles powered by internal combustion engines or electric motors shall be allowed.

b. Public access to all exposed land areas of Trinity Island, other than the public use area, is prohibited. Requests to access these exposed land areas shall be considered on a case-by-case basis and may be permitted by the Secretary or his designee in the interest of conducting research on fauna and flora, of advancing educational pursuits related to barrier islands or of planning and implementing island restoration projects.

c. Disturbing, injuring, collecting, or attempting to disturb, injure, or collect any flora, fauna, or other property is prohibited, unless expressly permitted in writing by the Secretary or his designee for the uses provided for in Paragraph 2.b. above.

d. Any member of the public utilizing the designated public use area shall be required to have a portable waste disposal container to collect all human wastes and to remove same upon leaving the island. Discharge of human wastes, including that within the disposal container, onto the island or into Louisiana waters or wetlands is prohibited.

e. Littering on the island or in Louisiana waters or wetlands is prohibited.

f. Carrying, possessing, or discharging firearms, fireworks, or explosives in the designated public use area is prohibited.

g. Boat traffic is allowed adjacent to the island in open waters of the Gulf and bays and within the man-made canal commonly known as California Canal for its entire length to its terminus at the bulkhead on the western end of the canal. No boat traffic is allowed in other man-made or natural waterways extending into the interior of the island or in any land-locked open waters or wetlands of the island.

h. Fishing from boats or wade fishing in the surf areas of the island is allowed.

i. Houseboats may be moored in designated areas along the California Canal. An annual permit shall be required to moor a houseboat in the canal. The required permit may be obtained from the Department of Wildlife and Fisheries New Iberia Office.

j. Proposals to conduct oil and gas activities, including seismic exploration, shall be considered on a case-by-case basis and may be permitted by the Secretary or his designee, consistent with provisions of the Act of Donation

executed by the Louisiana Land and Exploration Company on July 24, 1997.

B. Violation of any provision of these regulations shall be considered a Class Two Violation, as described in R.S. 56:115(D), 56:764, and 56:787.

AUTHORITY NOTE: Promulgated in accordance with R.S. 56:6(18), R.S. 56:109, and R.S. 56:781 et seq.

HISTORICAL NOTE: Promulgated by the Department of Wildlife and Fisheries, Wildlife and Fisheries Commission, LR 25:1657 (September 1999).

Bill A. Busbice, Jr.  
Chairman

9909#028