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# Executive Orders

## EXECUTIVE ORDER MJF 96 - 2

### Louisiana Interagency Action Council for the Homeless

WHEREAS: the number of homeless persons and families in the nation and this state has increased in recent years; and

WHEREAS: the causes of homelessness are many and complex and homeless individuals have diverse needs; and

WHEREAS: effective use of the state's resources and programs to alleviate the plight of homeless persons requires coordination of efforts by interested persons, agencies and organizations, both public and private, including participation at the federal, state and local levels;

NOW THEREFORE I, MURPHY J. FOSTER, JR., Governor of the State of Louisiana, do hereby order and direct as follows:

SECTION 1: There shall be created the Louisiana Interagency Action Council for the Homeless. The council shall consist of:

1. one representative from each of the following agencies, appointed by the secretary, assistant secretary, executive director or chairman of each respective agency:

A. Department of Health and Hospitals, Bureau of Health Services Financing;

B. Department of Health and Hospitals, Office of Public Health;

C. Department of Health and Hospitals (one representative each from the Office of Mental Health, Office for Citizens with Developmental Disabilities, and Office of Alcohol and Drug Abuse);

D. Department of Social Services, Office of Community Services (one representative each from the Divisions of Child Welfare and Grants Management);

E. Department of Social Services, Rehabilitation Services;

F. Department of Social Services, Office of Family Support;

G. Department of Labor;

H. Department of Education;

I. Louisiana Housing Finance Agency;

J. Office of Elderly Affairs;

K. Office of Veterans Affairs;

L. Governor's Office of Women's Services;

M. Department of Public Safety and Corrections (one representative each from the Office of Adult Services and the Office of Juvenile Services);

2. one member of the Drug Policy Board (or appropriate board/commission in the area of drug prevention and treatment), appointed by the governor;

3. three members representing providers of services to the homeless, appointed by the governor;

4. two members representing local government agencies, appointed by the governor;

5. two members representing local advocacy groups for populations affected by homelessness, appointed by the governor;

6. two members of the state legislature (one member of the House of Representatives, designated by the speaker of the house; and one member of the Senate, designated by the president of the senate), appointed by the governor;

7. one member representing the governor's executive office;

8. one member representing the nonprofit legal services of Louisiana, appointed by the governor;

9. four at-large members, appointed by the governor.

A member shall serve at the pleasure of the appointing official or until termination of the member's employment with the entity the member represents.

The council shall meet at least quarterly but as necessary to conduct its activities.

The agencies, departments and entities represented on the council may provide technical assistance and support as are available and deemed necessary by the council. The council shall elect a chairperson and vice chairperson from among its members.

SECTION 2: The Interagency Action Council for the Homeless shall:

1. conduct an annual assessment and evaluation of service needs and resources for the homeless of the state;

2. research and assist in the development of funding resources for homeless services;

3. insure the services for all homeless persons of the state are appropriately planned and coordinated thereby reducing duplication among programs and activities by state agencies and other providers of services. The council shall participate in the development of all planning related to the McKinney Act;

4. monitor and evaluate assistance to homeless persons provided by all levels of government and the private sector and make or recommend policy changes to improve such assistance;

5. assure flow of information among separate service providers, government agencies and appropriation authorities;

6. disseminate timely information of federal, state or private resources available to assist the homeless population;

7. consult and coordinate all activities with the Federal Interagency Council for the Homeless, HUD and all other federal agencies that provide assistance to the homeless;

8. submit an annual report of its activities to the governing bodies of the agencies represented on the council;

9. at least 30 days prior to the opening of the legislative session, the council shall submit a report to the governor and the legislature recommending improvements to the service delivery system for the homeless. The report shall also detail any actions taken by the council to improve the provision of services for the homeless. The report may also include recommendations to improve the operation of the council.

SECTION 3: This Executive Order shall remain in effect until amended, modified, or rescinded by operation of law.

IN WITNESS WHEREOF, I have set my hand officially and caused to be affixed the Great Seal of the State of Louisiana, at the Capitol, in the City of Baton Rouge, on this 7th day of February, 1996.

M. J. "Mike" Foster, Jr.  
Governor

ATTEST BY  
THE GOVERNOR  
Fox McKeithen  
Secretary of State  
9603#002

### EXECUTIVE ORDER MJF 96 - 3

#### Affirmative Action

WHEREAS: it is the policy of the state of Louisiana to enhance the ability of all Louisiana citizens, without regard to race or gender, to avail themselves of educational, contractual, employment, economic and cultural opportunities afforded by our state; and

WHEREAS: Executive Order MJF 96-1 acknowledges that, notwithstanding the above stated policy, set aside laws and affirmative action programs which authorize quotas or guarantee outcomes based only on race or gender are unconstitutional, cannot be defended as lawful and, therefore, must be abolished; and

WHEREAS: the United States Supreme Court has held that race and gender cannot be the decisive or predominant factor in decisions made by the state in the allocation of educational, contractual, employment, economic, and other opportunities, although such factors may be considered by the state in making such decisions; and

WHEREAS: it is essential to the economic health of this state that all Louisiana citizens who are economically disadvantaged, regardless of race or gender, be given an opportunity to become economically self-sufficient; and

WHEREAS: a significant percentage of the population of this state is economically disadvantaged and needs active state assistance in order to gain the skills or credit opportunities necessary to obtain contracts and jobs in a nonpreferential competitive process; and

WHEREAS: economic self-sufficiency enhances the individual's sense of personal dignity and pride in community; and

WHEREAS: programs which enable people to help themselves in becoming economically self-sufficient through job training and which assist all economically disadvantaged businesses and persons in acquiring the necessary skills to become successful in obtaining contracts and jobs through a nonpreferential competitive process are beneficial to this state;

NOW, THEREFORE I, M. J. "MIKE" FOSTER, JR., Governor of the State of Louisiana, by virtue of the power and authority vested in me by the Constitution and statutes of the State of Louisiana, do hereby order the following:

SECTION 1: that it is the policy of the State of Louisiana to advance inclusion, impartiality, mutual understanding, and respect for diversity among all people, without regard to race or gender;

SECTION 2: that it is the policy of the State of Louisiana, in accordance with rulings by the United States Supreme Court, that race and gender may be considered in decisions to allocate educational, contractual, employment, economic, and other opportunities in this state but that these factors shall not be the decisive or predominant factors in such decisions unless required or mandated by federal statutes, regulations or court orders.

SECTION 3: that it is the policy of the State of Louisiana to eliminate any statutes or regulations authorizing quotas or guaranteeing outcomes based only on race or gender, except as required or mandated by federal statutes, regulation or court orders, and accordingly Executive Order MJF 96-1 is hereby affirmed;

SECTION 4: that the Department of Economic Development, the Department of Labor, the Division of Administration and the Office of the Governor shall develop programs to assure that all economically disadvantaged persons and businesses, regardless of race or gender, have access to training and technical assistance in order that they may strive to achieve success in a competitive market;

SECTION 5: that the Department of Economic Development develop a program in accordance with the attached proposal to assist all economically disadvantaged businesses to gain the technical expertise and to obtain credit opportunities necessary to bid successfully on contracts to provide goods and services to the state;

SECTION 6: that the Department of Labor report within 60 days to the assistant chief of staff of the Office of the Governor any program or programs presently in effect which are designed to assist economically disadvantaged persons achieve success in obtaining jobs in both the private or public sectors;

SECTION 7: that the Department of Economic Development determine within 60 days the appropriate quantifiable economic criteria to be utilized in deciding which businesses and persons may be certified as economically disadvantaged;

SECTION 8: that the commissioner of Administration assist the secretary of the Department of Economic Development in identifying all economically disadvantaged Louisiana businesses seeking state assistance.

IN WITNESS WHEREOF, I have set my hand officially and caused to be affixed the Great Seal of the State of Louisiana, at the Capitol, in the City of Baton Rouge, on this 14th day of February, 1996.

M. J. "Mike" Foster, Jr.  
Governor

ATTEST BY  
THE GOVERNOR  
Fox McKeithen  
Secretary of State  
9603#001

Inmate Labor

WHEREAS: During the 1988 Regular Session, the Louisiana Legislature enacted Act 933 relative to correctional facilities inmate labor; and

WHEREAS: said act, among other things, authorizes the governor to use inmate labor in certain projects or maintenance or repair work; and

WHEREAS: the act provides that the governor, upon determining that it is appropriate and in furtherance of the rehabilitation and training of inmates, may, by executive order, authorize the use of inmates of a penal or correctional facility owned by the state of Louisiana for necessary labor in connection with a particular project;

NOW THEREFORE I, MURPHY J. FOSTER, JR., Governor of the State of Louisiana, do hereby order the following:

SECTION 1: That inmate labor be and is hereby authorized to perform security enhancements at various locations at the Elayn Hunt Correctional Center, St. Gabriel, Louisiana, S.P. # 08-413-94B-4.

IN WITNESS WHEREOF, I have set my hand officially and caused to be affixed the Great Seal of the State of Louisiana, at the Capitol, in the City of Baton Rouge, on this 4th day of March, 1996.

M. J. "Mike" Foster, Jr.  
Governor

ATTEST BY  
THE GOVERNOR  
Fox McKeithen  
Secretary of State  
9603#019

TITLE 46  
PROFESSIONAL AND OCCUPATIONAL  
STANDARDS

Part LXVII. Real Estate

Chapter 7. Fees

§705. Returned Checks Due to Insufficient Funds

A. Payment of any fee with a check which is returned by a financial institution due to insufficient funds wherein the reason for not paying the check is not a fault of the financial institution shall be grounds for cancellation of the transaction for which the fee was submitted and/or the suspension or revocation of a license, registration or certificate.

B. Persons issuing checks to the commission which are returned by financial institutions for insufficient funds will be notified of the return of the check by certified mail to the address registered by that person with the commission. Within 10 days from the mailing of the notification, the person issuing the check will remit a certified check, cashier's check or money order payable to the Louisiana Real Estate Commission in the amount of the returned check plus a \$25 processing fee.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1435 and 37:1443.

HISTORICAL NOTE: Promulgated by the Department of Commerce, Real Estate Commission, LR 3:397 (October 1977), amended LR 9:315 (May 1983), LR 10:874 (November 1984), LR 11:6 (January 1985), amended by the Department of Economic Development, Real Estate Commission, LR 22:

J.C. Willie  
Executive Director

9603#003

DECLARATION OF EMERGENCY

Department of Environmental Quality  
Office of Air Quality and Radiation Protection  
Air Quality Division

Chemical Accident Prevention  
(LAC 33:III.Chapter 59)(AQ126E)

In accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B), and under the authority of R.S. 30:2011, the secretary of the Department of Environmental Quality (DEQ) declares that an emergency action is necessary because the current rule LAC 33:III.Chapter 59 provides only for the registration of facilities with regulated substances over a threshold quantity. In the wake of recent events, it is apparent that a problem with accidents and accidental releases involving toxic, flammable or explosive substances needs immediate attention. Without these rules, the people and environment of the state of Louisiana could be exposed to imminent peril from this problem. Failure to adopt these rules through the emergency procedure will delay the implementation of procedures required to provide for the prevention of accidents and the minimization of the off-site consequences of such accidents.

# Emergency Rules

DECLARATION OF EMERGENCY

Department of Economic Development  
Real Estate Commission

Checks Returned for Insufficient Funds  
(LAC 46:LXVII.705)

In accordance with the provisions of R.S. 49:953(B) of the Administrative Procedure Act, the Louisiana Real Estate Commission has adopted emergency revisions to the rules and regulations affecting fees. This action is taken in an effort to impede any fiscal impact which may occur as the result of fees paid with checks that are returned by financial institutions for insufficient funds and to maintain the procedure in which the LREC processes these checks. The effective date of this emergency rule is February 18, 1996, for 120 days or until the final rule takes effect through the normal promulgation process, whichever occurs first.

This emergency rule is effective March 7, 1996, and shall remain in effect for a maximum of 120 days or until a final rule is promulgated, whichever occurs first. For more information concerning AQ126E, you may contact DEQ's Investigations and Regulation Development Division at (504) 765-0399.

The full text of these rules may be obtained from the Department of Environmental Quality, Investigations and Regulation Development Division, 7290 Bluebonnet Boulevard, Baton Rouge, LA or from the Office of the State Register, 1051 North Third Street, Baton Rouge, LA, (504) 342-5015. Please refer to document 9511#083 (AQ126E) when inquiring about this emergency rule.

Adopted this 7th day of March, 1996.

J. Dale Givens  
Secretary

9603#024

### DECLARATION OF EMERGENCY

#### Department of Environmental Quality Office of the Secretary

#### Repeal of Previous Emergency Rule on Waste Tires (LAC 33:VII.Chapter 105)(SW020E)

In accordance with the emergency provisions of the Administrative Procedure Act, R.S. 49:953(B), and under authority of R.S. 30:2011, the secretary of the Department of Environmental Quality declares that an emergency action is necessary to repeal the provisions of SW019E. This emergency rule is imperative to limit the unnecessary depletion of the Waste Tire Management Fund due to the provisions of SW019E. This emergency rule in no way prohibits the department from addressing similar provisions through formal rulemaking pursuant to the Administrative Procedure Act, R.S. 49:953(B), and under authority of R.S. 30:2011.

On December 19, 1995, the department adopted an emergency rule, SW019E, published in the *Louisiana Register*, January 20, 1996, pages 3-4, which claimed emergency action was necessary, due to the ever increasing number of waste tires being generated, to provide incentives and assistance for the collection and transportation of waste tires, required by R.S. 30:2418(H)(5). The Declaration of Emergency for SW019E provided in part as follows:

"Presently, there is no economic incentive to process waste tires not located near permitted waste tire processors. Accordingly, many waste tires may not be processed and disposed of in accordance with LAC 33:VII.10531 et seq. The DEQ is preparing a rule which includes similar provisions to those contained in this emergency rule. The intent of this emergency rule is to make funds available from the Waste Tire Management Fund to provide for the processing and disposal of waste tires, which are presently not economically feasible to process and dispose of due to the remoteness of the site of generation from the processing facilities."

After review of SW019E, the department has determined that at present there is insufficient information to substantiate the need for Emergency Rule SW019E. Until additional information is assembled that validates the need for the provisions of Emergency Rule SW019E, it is not prudent to continue the depletion of the Waste Tire Management Fund in such a manner.

This emergency rule is effective on February 19, 1996. For more information concerning SW020E, you may contact DEQ's Investigations and Regulation Development Division at (504) 765-0399.

#### Emergency Rule

Effective February 19, 1996, the department repeals the provisions of Emergency Rule in LAC 33:VII.Chapter 105 (SW019E), published in the *Louisiana Register*, January 20, 1996, pages 3-4.

J. Dale Givens  
Secretary

9603#005

### DECLARATION OF EMERGENCY

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

#### Case Management Reimbursement

The Department of Health and Hospitals, Office of Secretary, Bureau of Health Services Financing, has adopted the following rule in the Medicaid Program as authorized by R.S. 46:153 and pursuant to Title XIX of the Social Security Act. This emergency rule is in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq. and shall be in effect for the maximum period allowed under the Administrative Procedure Act or adoption of the rule, whichever occurs first.

The Bureau of Health Services Financing reimburses optional targeted case management services for the following specific population groups:

- 1) mentally retarded or developmentally disabled individuals;
- 2) developmentally disabled infants and toddlers;
- 3) high-risk pregnant women (limited to the metropolitan New Orleans area);
- 4) HIV infected individuals;
- 5) seriously mentally ill individuals.

In addition reimbursement is provided under the Home and Community-Based Services Waiver Program for case management services provided to participants in the Home Care for the Elderly Waiver.

The department adopted emergency rules which enhanced program requirements by setting uniform standards for case management services delivered to the above referenced populations and specified the reimbursement methodology based on the provision of a 15-minute unit of service for the

on-going services component of case management services. These rules were adopted effective July 22, 1994 and August 13, 1994 (*Louisiana Register*, Volume 20, Numbers 6 and 7). Subsequent emergency rulemaking continued this initiative in force as published in the *Louisiana Register*, (November 20, 1994, Volume 20, Number 11; April 20, 1995, Volume 21, Number 4; August 20, 1995, Volume 21, Number 8); and November 20, 1995, Volume 21, Number 11).

Subsequently the department determined that it was necessary to discontinue the unit of service reimbursement methodology and instituted a revised methodology through emergency rulemaking (*Louisiana Register*, Volume 21, Number and Volume 22, Number 2). This revised methodology included a monthly reimbursement rate for both components of case management services, the initial assessment/service plan development and the ongoing services. This methodology also provided for the following two exceptions:

1) both payment methods, assessment fee and the monthly rate for on-going services, were retained for the high-risk pregnant women group; and

2) assessments prior authorized for the MR/DD and the seriously mentally ill populations through September 30, 1995 and completed by October 31, 1995 were to be reimbursed in accordance with the prior payment methodology.

Monthly reimbursement rates were assigned for each population group based upon minimum standards for service delivery for each of these groups.

Current required standards for the provision of case management services mandate that an hourly minimum number of documented services be provided in each month for which services are billed. Program reports indicate that utilization has decreased significantly for this program area and the department has determined that certain members of the populations served may not be able to receive case management services due to the absence of payment provisions for services of less than the hour minimum cited in the rule entitled "Case Management Services for Optional Targeted Population Groups and Waiver Programs." Therefore, the department has adopted the following emergency rule which amends the rule cited above by providing for the payment of a one hour minimum of service delivery and fifteen incremental units up to the minimum hourly service requirement once the initial one hour service minimum is met. This action is necessary to assure that the following fragile and vulnerable groups, the seriously mentally ill, mentally retarded/developmentally disabled populations, including infants and toddlers, and the elderly persons included under the Home Care for the Elderly Waiver receive case management services essential to their obtaining needed medical services thereby preventing imminent peril to the health, safety, and welfare.

It is anticipated that implementation of this emergency rule will increase program expenditures by approximately \$602,057 for case management services.

**Emergency Rule**

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

following revisions governing the reimbursement and minimum program standards for both optional targeted and waiver case management services under the Medicaid Program.

1. A minimum of 60 minutes of case management services must be provided in order to bill the initial hour of case management services for any month. This must include a face to face encounter.

2. Additional case management services beyond the initial hour up to the required minimum number of hours shall be billed in 15 minute increments in order to receive payment of the monthly fee.

3. Payment for the initial hour and the additional 15 minute increments of case management services shall be made as follows:

SERVICES	HOUR RATE	15 MINUTE RATE
CM-Elderly Waiver	\$49.50	\$12.38
CM-Seriously Mentally Ill	\$55.75	\$13.94
CM-MR/DD (Waiver and Non-Waiver)	\$49.00	\$12.25
CM-Infants and Toddlers	\$66.50	\$16.63

4. The monthly fee shall not be exceeded even if more than the required monthly minimum number of hours are provided.

Interested persons may submit written comments to the following address: Thomas D. Collins, Bureau of Health Services Financing, Box 91030, Baton Rouge, LA 70821-9030. He is the person responsible for responding to inquiries regarding this emergency rule.

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

Bobby P. Jindal  
Secretary

9603#016

**DECLARATION OF EMERGENCY**

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

Disproportionate Share - Hospital Payment Methodology  
(FY 1995-96)

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing has adopted the following emergency rule under the Medical Assistance Program as authorized by R.S. 46:153 et seq., and pursuant to Title XIX of the Social Security Act and as directed by the 1995-96 General Appropriation Act, which states: "The Secretary shall implement reductions in the Medicaid program as necessary to control expenditures to the level approved in this schedule. The Secretary is hereby directed to utilize various cost containment measures to accomplish these reductions, including but not limited to pre-certification, pre-admission screening, and utilization review, and other

measures as allowed by federal law." This emergency rule is in accordance with the Administrative Procedure Act, R.S. 49:950 et seq., and shall be in effect for the maximum period allowed under the Administrative Procedure Act or until adoption of the rule, whichever occurs first.

The Medicaid Program previously reimbursed private hospitals and publicly-owned or operated hospitals serving a disproportionate share of low income patients via 12 pools with payments based on Medicaid days. This payment methodology was implemented effective February 1, 1994 to comply with the Health Care Financing Administration's policy on Section 1923 (Adjustment in Payments for Inpatient Hospital Services Furnished by Disproportionate Share Hospitals) of the Social Security Act (42 U.S.C. Section 1396r-4). In addition, disproportionate share payments for indigent care based on free care days were made by establishment of a payment methodology which reimbursed providers for indigent care days based on a Medicaid per diem equivalent amount.

The Omnibus Budget Reconciliation Act of 1993 (P.L. 103-66) amended Section 1923 of the Social Security Act by establishing individual hospital disproportionate share payment limits. To comply with these new provisions, the bureau's disproportionate share payment methodology which included provisions governing the qualifications applicable to private and public hospitals and payment methodology applicable to publicly-owned or operated hospitals was amended effective on July 1, 1994 and was published in the *Louisiana Register* Volume 20, Number 7. In addition, the qualification applicable to both public and private hospitals was included in the July 1, 1994 emergency rule which requires a disproportionate share hospital to have a Medicaid inpatient utilization rate of at least 1 percent is incorporated in the following emergency rule. These regulations continued to govern DSH payments through June 30, 1995.

In order to comply with the Omnibus Budget Reconciliation Act of 1993 (P.L. 103-66) requirements for the upcoming federal fiscal year and in order to avoid a budget deficit in the medical assistance programs, the bureau has determined that the following changes are necessary in the payment methodologies for public state-operated hospitals, private hospitals and public nonstate hospitals. The following emergency rule replaces all prior regulations governing disproportionate share payment methodologies (excluding disproportionate share qualification criteria).

It is estimated that implementation of this rule will reduce expenditures for disproportionate share payments in the Medicaid Program by approximately \$136,000,000 for state fiscal year 1995-1996. Therefore, adoption of the following emergency rule is necessary to avoid a budget deficit in the medical assistance programs as state general fund revenues are not available to expend these additional monies.

#### **Emergency Rule**

Effective for dates of service on or after February 25, 1996 the Department of Health and Hospitals, Bureau of Health Services Financing replaces prior regulations governing disproportionate share hospital payment methodologies

(excluding disproportionate share qualification criteria) and establishes the following regulations to govern the disproportionate share hospital payment methodologies for public state-operated, private hospitals and public nonstate hospitals.

#### **Disproportionate Share Hospital Payments Public State-Operated Hospitals**

DSH payments to individual public state-owned or operated hospitals as defined below will be equal to 100 percent of the hospital's net uncompensated costs as defined below subject to the adjustment provision described below.

Definitions:

*Public State Operated Hospital*—a hospital that is owned or operated by the State of Louisiana.

*(Net) Uncompensated Cost*—costs incurred during the state fiscal year of furnishing inpatient and outpatient hospital services net of Medicare costs, Medicaid payments (excluding disproportionate share payments), costs associated with patients who have insurance for services provided, private payor payments and all other inpatient and outpatient payments received from uninsured and Medicaid patients.

Final payment will be based on the uncompensated cost data per the audited cost report for the period(s) covering the state fiscal year.

#### **Private Hospitals and Public Nonstate Hospitals**

A. Reimbursement will no longer be provided for indigent care in private hospitals or public nonstate hospitals qualifying for disproportionate share payments.

B. The following pools, public local government acute care hospital and public local government distinct part psychiatric units/free-standing psychiatric hospitals are added to the six pools. These hospitals will no longer receive a DSH payment equal to each hospital's net uncompensated costs. Disproportionate share reimbursement for these qualifying hospitals will be based on methodology described below.

C. Each private or public nonstate hospital qualifying for participation in the eight disproportionate share pools with payments based on Medicaid days will receive payments which are the lesser of 100 percent of its net uncompensated costs of providing services to Medicaid recipients and uninsured patients or their disproportionate share payment calculated by the bureau via the pool methodology.

D. Annualization of days for the purposes of the Medicaid days pools is not permitted.

E. Qualification for and payment adjustment for DSH shall be based on the hospital's year end cost report for the year ended during the period July 1 through June 30 of the previous year.

F. Reimbursement will be based on Medicaid days included (based on qualification) in the eight pools listed in Item I below.

G. For hospitals with distinct part psychiatric units, qualification is based on the entire hospital's utilization, but for purposes of disproportionate share hospital payment adjustments, the distinct part psychiatric units shall be placed in the psychiatric pools while the acute medical/surgical unit(s) shall be included in the appropriate teaching or



nonteaching pool. Hospitals must meet the criteria for the pool classification based on their fiscal year-end cost report as of June 30 of the previous year.

H. For purposes of the pools defined below, service district hospitals/beds located outside the service district will be classified by the bureau as privately-owned and operated and shall be placed in the appropriate private hospital/unit pools.

I. The eight pools are as follows:

1. *Private Rural Acute Hospitals*—privately-owned acute care general rehabilitation and long term care hospitals (exclusive of distinct part psychiatric units) which are designated as a rural hospital under criteria specified below. This includes public local government acute hospital days attributable to beds/units located in an area which is designated as rural and is located outside the service district area.

2. *Private Rural Distinct Part Psychiatric Units/Freestanding Psychiatric Hospitals*—privately-owned distinct part psychiatric units/freestanding psychiatric hospitals which are located in a rural area under criteria specified below. This includes public local governmental psychiatric hospital days attributable to beds/units located in an area which is designated as rural and is located outside the service district area.

3. *Private Teaching Hospitals*—privately-owned acute care general rehabilitation, and long term care hospitals (exclusive of distinct part psychiatric units) which are recognized as approved teaching hospitals under criteria specified below. This includes public local government acute hospital days attributable to beds/units located in an area which is designated as urban and is located outside the service district area.

4. *Private Urban Nonteaching Hospitals*—privately-owned acute care general hospitals and long term care hospitals (exclusive of distinct part psychiatric units) which are designated as urban hospitals and not recognized as approved teaching hospitals, under criteria specified below.

5. *Private Teaching Distinct Part Psychiatric Units/Freestanding Psychiatric Hospitals*—privately-owned distinct part psychiatric units/freestanding psychiatric hospitals which meet the criteria for recognition as approved teaching hospitals, under criteria specified below.

6. *Private Urban Nonteaching Distinct Part Psychiatric Units/Freestanding Psychiatric Hospitals*—privately-owned distinct part psychiatric units/freestanding psychiatric hospitals which are located in an urban area and do not meet the criteria for recognition as approved teaching hospitals, under criteria specified below. This includes public local government psychiatric hospital days attributable to beds/units located in an area which is designated as urban and is located outside the service district area.

7. *Public Local Government Acute Hospitals*—local government-owned acute care general rehabilitation and long term care hospitals (exclusive of distinct part psychiatric units). Only days attributable to beds/units located within the service district area qualify for inclusion to the pool.

8. *Public Local Government Distinct Part Psychiatric Units/Freestanding Psychiatric Hospitals*—local government-

owned distinct part psychiatric units/freestanding psychiatric hospitals. Only days attributable to beds/units located within the service district area qualify for inclusion in this pool.

J. The definitions for hospital classifications applicable to the above Medicaid days pools are given below.

1. *Teaching Hospital*—A teaching hospital is defined as a licensed acute care hospital in compliance with the Medicare regulations regarding such facilities, or a specialty hospital with a graduate medical education program that is excluded from the prospective payment system as defined by Medicare. A specialty teaching hospital must have a written affiliation agreement with an accredited medical school to provide post graduate medical resident training in the hospital for the specialty services provided in the specialty hospital. The affiliation agreement must contain an outline of its program in regard to staffing, residents at the facility, etc. A distinct part or carve-out unit of a hospital shall not be considered a teaching hospital separate from the hospital as a whole. Teaching specialty hospitals that are not recognized by Medicare as an approved teaching hospital must furnish to the department, copies of graduate medical education program assignment schedules and rotation schedules which document actual on-going resident training throughout the applicable cost reporting period and shall only be included in the teaching hospital pool for those days that graduate medical education is being provided.

2. *Nonteaching Hospital*—an acute care general hospital or specialty hospital not recognized as an approved teaching hospital by the department or under Medicare principles for the fiscal year-end cost report as of June 30 of the previous year.

3. *Urban Hospital*—a hospital located in a Metropolitan Statistical Area as defined per the 1990 census. This excludes any reclassification under Medicare.

4. *Rural Hospital*—a hospital that is not located in a Metropolitan Statistical Area as defined per the 1990 census. This excludes any reclassification for Medicare.

5. *Distinct Part Psychiatric Unit/Free-standing Psychiatric Hospital*—distinct part psychiatric units of acute care general hospitals or psychiatric units in long term care and rehabilitation hospitals meeting the Medicare criteria for PPS exempt units and enrolled under a separate Medicaid provider number and freestanding psychiatric hospitals enrolled as such.

K. Disproportionate share payments for each pool shall be calculated based on the product of the ratio determined by dividing each qualifying hospital's total Medicaid inpatient days for the applicable cost report by the total Medicaid inpatient days provided by all such hospitals in the state qualifying as disproportionate share hospitals in their respective pools, and then multiplying by an amount of funds for each respective pool to be determined by the director of the Bureau of Health Services Financing. Total Medicaid inpatient days include Medicaid nursery days but do not include skilled nursing facility or swing-bed days. Pool amounts shall be allocated based on the consideration of the volume of days in each pool or the average cost per day for hospitals in each pool.

L. If at audit or final settlement of the cost reports on which the pools are based, the above qualifying criteria are not met, or the number of Medicaid inpatient days are reduced from those originally reported, appropriate action shall be taken to recover any over payments resulting from the use of erroneous data. No additional payments shall be made if an increase in days is determined after audit. Recoupment of overpayment from reductions in pool days originally reported shall be redistributed to the hospital that has the largest number of inpatient days attributable to individuals entitled to benefits under the State Plan of any hospitals in the state for the year in which the recoupment is applicable.

M. Hospitals/units which close or withdraw from the Medicaid Program shall become ineligible for further DSH pool payments.

#### General Provisions

Disapproval of any one of these payment methodology(ies) by the Health Care Financing Administration does not invalidate one remaining methodology(ies).

Disproportionate share payments cumulative for all DSH payments under all DSH payment methodologies shall not exceed the federal disproportionate share state allotment for each federal fiscal year and the state appropriation for disproportionate share payments for each state fiscal year. The department shall make necessary downward adjustments to hospitals' disproportionate share payments to remain within the federal disproportionate share allotment or the state disproportionate share appropriated amount necessary to reduce the amount of disproportionate share payments to remain within the federal disproportionate share allotment each year, the department shall calculate a pro rata decrease for each public (state) hospital based on the ratio determined by dividing that hospital's uncompensated cost by the total uncompensated cost for all qualifying public hospitals during the state fiscal year and then multiplying by the amount of disproportionate share payments calculated in excess of the federal disproportionate allotment. A pro rata decrease for nonstate hospitals will be calculated based on the ratio determined by dividing the hospitals Medicaid days by the days for all qualifying nonstate hospitals and then multiplying by the amount of disproportionate share payments calculated in excess of the federal disproportionate share allotment or the state disproportionate share appropriated amount.

Interested persons may submit comments to the following address: Thomas D. Collins, Office of the Secretary, Bureau of Health Services Financing, Box 91030, Baton Rouge, LA 70821-9030. He is the person responsible for responding to inquiries regarding this emergency rule.

Bobby P. Jindal  
Secretary

9603#007

## DECLARATION OF EMERGENCY

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

#### Mental Health Rehabilitation

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing is proposing to adopt the following rule in the Medicaid Program as authorized by R.S. 46:153 and pursuant to Title XIX of the Social Security Act and as directed by the 1995-96 General Appropriation Act, which states: "The Secretary shall implement reductions in the Medicaid program as necessary to control expenditures to the level approved in this schedule. The Secretary is hereby directed to utilize various cost containment measures to accomplish these reductions, including but not limited to recertification, preadmission screening, and utilization review, and other measures as allowed by federal law."

The Office of the Secretary, Bureau of Health Services Financing adopted a rule on April 20, 1993 and published in the *Louisiana Register*, Volume 19, Number 4, which established the standards for participation for the Mental Health Rehabilitation Program and the provider reimbursement requirements.

The Department of Health and Hospitals, Office of Mental Health adopted a rule defining adults with serious mental illness and children with emotional/behavioral disorders on September 20, 1994 (*Louisiana Register*, Volume 20, Number 9).

Also the bureau adopted a rule for the Mental Health Rehabilitation Program which requires recipients to meet the definition of serious mental illness as defined by the Office of Mental Health and to be prior authorized to receive services (*Louisiana Register*, November 1995, Volume 21, Number 11).

Subsequently, the department determined that further revisions and amendments to these rules are needed to insure effective delivery of services and to control cost in the Mental Health Rehabilitation Program in accordance with the budget appropriation contained in the General Appropriation Act of the 1995-96 Regular Legislative Session and an emergency rule was adopted on the following provisions and was published in the *Louisiana Register*, Volume 21, Number 11. These revisions and amendments included a change in reimbursement from the unit of service methodology to a flat rate based on the level of need of the recipient. Programmatic revisions to the Mental Health Rehabilitation Program necessitated that the bureau specify the reimbursement was not available to the same Medicaid recipient for both mental health rehabilitation services and optional targeted case management services. Program enhancements required a standardized clinical evaluation which must be completed by professional staff who meet the appropriate criteria. Also, the following revisions to the Mental Health Rehabilitation Program established a single provider agency which required that all current providers of Mental Health Rehabilitation

Services are required to meet new standards for continued enrollment in the Medicaid program in addition to adherence to previously published regulations. Providers must apply to the bureau through the Office of Mental Health for a transitional certification to assure continued enrollment until an on-site visit can be conducted by the BHSF or its designee. A notice of intent was published on these provisions in the *Louisiana Register* (Volume 21 Number 12). The following emergency rule continues these provisions in force until adoption of the rule. This action is necessary to avoid a budget deficit in the medical assistance programs and to maintain continued compliance with the General Appropriation Act of the 1995-96 Regular Legislative Session. It is estimated that the continued implementation of these provisions under emergency rulemaking will save the state approximately \$22,665,062 for state fiscal year 1995-1996.

### Emergency Rule

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing has amended the rule entitled Mental Health Rehabilitation adopted April 20, 1993 (*Louisiana Register*, Volume 19, Number 4), by adopting the following provisions governing recipient eligibility, service delivery requirements and reimbursement methodology. All mental health rehabilitation services must be prior authorized by the bureau or its designee prior to the provision of these services.

#### I. Recipient Eligibility

Recipients must qualify as a member of the target population by meeting the definition of *seriously mentally ill* as defined by rule (*Louisiana Register*, Volume 20, Number 9) and by meeting the medical necessity criteria for mental health rehabilitation services as measured by the *North Carolina Functional Assessment Scale* for adults and the *Child and Adolescent Functional Assessment Scale* for children/youth. The measurement derived from these scales must indicate that the Medicaid recipient has a high need for mental health rehabilitation services as determined by the Office of Mental Health. Providers must include all information essential for a determination of level of need. All Medicaid recipients of mental health rehabilitation services must also meet the level of need required for the specific services they are receiving. As Medicaid recipients progress in their rehabilitation, services will be authorized and reimbursed at the medium and low levels of care.

The *North Carolina Functional Assessment Scale* provides a rating of the extent to which an adult recipient's mental health disorder is disruptive of functioning in each of six major areas: emotional health, behavior, self/other, thinking, role performance, basic needs, and substance abuse. Each subscale is rated according to explicit criteria, and the scores are summed to obtain a total functional assessment score.

The *Child and Adolescent Functional Assessment Scale* provides a rating of the extent to which a child/adolescent recipient's mental health disorder is disruptive of functioning in each of five major areas: moods/self-harm, behavior toward others, thinking, role performance, and substance abuse. Two additional subscales assess the extent to which the youth's care

giver is able to provide for the needs and support of the youth. Each subscale is rated according to explicit criteria, and the scores are summed to obtain a total functional assessment score for both the child and the care giver.

#### II. Provider Participation

A. The enrolled mental health rehabilitation provider or case management provider must apply to the BHSF through the Office of Mental Health for transitional certification as a mental health rehabilitation provider. The enrolled provider has the ultimate responsibility for the delivery of all services, including those delivered through contractual agreement(s). The enrolled provider must meet the following requirements and assurances and submit the information to the regional Office of Mental Health:

1. PE-50 completed after October 1, 1995;
  2. disclosure of ownership form completed after October 1, 1995;
  3. statement identifying the population to be served: adults with serious mental illness, children with emotional/behavioral disorders or both;
  4. résumés of the current mental health rehabilitation program director, the psychiatric director, and all clinical managers, including documentation of licensure;
  5. identification of the agency's main office, all offices billing with the main office's Medicaid provider number and all regions in which the agency conducts business;
  6. proof of general liability of at least \$100,000 and professional liability insurance of at least \$300,000. The certificate holder shall be the Department of Health and Hospitals to receive notice of insurance changes;
  7. assure that the following requirements are met and/or agreed to as evidenced by completion of the "Request for Mental Health Rehabilitation Transitional Certification" form provided by the BHSF.
    - a. assure that the enrolled MHR agency will provide clinical management, the MHR assessment and the MHR service agreement for all recipients served;
    - b. have the capacity to provide the full range of services to the full range of recipients served by the Mental Health Rehabilitation Program;
    - c. assure that all services provided by the MHR agency or through contractual arrangement are provided in conformity with all applicable federal and state regulations.
    - d. assure that all the service delivery staff meets the requirements as specified in the Mental Health Rehabilitation Program Manual.
    - e. assure that the enrolled agency and subcontractors will participate in the Mental Health Rehabilitation data system and provide data on a weekly basis to the Medicaid office or its designee;
    - f. assure that the enrolled agency will meet all new certification and enrollment standards as required by the Bureau of Health Services Financing by July 1, 1996 or by the on-site certification visit which is not to occur prior to May 1, 1996. Compliance with the new certification enrollment standards is required by the first occurrence of either of these two events.
- B. The enrolled MHR agency must submit the "Request for Mental Health Rehabilitation Transitional Certification" to

the regional Office of Mental Health. If the enrolled agency fails to meet the standards or does not submit the proper documentation, the agency will not be authorized to bill for services delivered after October 31, 1995. Those agencies that have submitted applications for enrollment to the BHSF prior to October 31, 1995, but have not received a Medicaid provider number may also apply for transitional certification by following the guidelines outlined above. Agencies applying for enrollment after October 31, 1995 will have to meet all licensing requirements, current enrollment requirements, participate in an on-site visit by the regional Office of Mental Health and meet the transitional certification requirements.

C. Enrolled case management agencies may also be eligible for transitional certification as a mental health rehabilitation provider by applying for transitional certification through the regional Office of Mental Health. The agency must meet the standards for transitional certification and submit the "Request for Mental Health Rehabilitation Transitional Certification" to the regional Office of Mental Health no later than the close of business January 31, 1996. The agency will not be considered an enrolled MHR agency until the approval of the transitional certification has been granted.

D. Transitional certification for those agencies who meet the requirements outlined above will be effective until July 1, 1996 or until the on-site certification process is completed, whichever occurs first.

### III. Administrative Requirements

A. Psychiatric Director. Each agency is required to have a licensed psychiatrist on staff as the psychiatric director. The director is required to provide a minimum of two hours of on-site clinical supervision/consultation per month for every 10 recipients.

B. Clinical Manager. Each agency is required to have a clinical manager. The clinical manager is a licensed mental health professional who is responsible for an identified caseload. The clinical manager must be an employee of the mental health rehabilitation agency. The clinical manager provides ongoing clinical direction. The clinical manager must provide the following minimum requirements for clinical management:

1. The clinical manager must have one face-to-face contact with the adult recipient or two face-to-face contacts with the child and family every 30 days.
2. The clinical manager must provide at least five hours of clinical management for adults and 12 hours of clinical management for children during each 90-day action strategy period.
3. The clinical manager must document at least two contacts with other community providers or significant others each month.
4. The clinical manager must provide lead responsibility for the MHR assessment team.
5. The clinical manager must provide lead responsibility for development and oversight of the MHR agreement.
6. The clinical manager must assure that all activity plans are developed and implemented.

7. The clinical manager must write the Quarterly Summary Progress Report.

8. The clinical manager provides oversight and access and coordination of all services for the MHR recipient. This includes but is not limited to the provision of the following:

- a. assurance of active recipient involvement in all aspects of care;
- b. coordination and management of all services provided through the MHR agency;
- c. access and coordination of services provided through non-MHR agencies.

#### C. Staffing Definitions

1. *Mental Health Service Delivery Experience*—mental health service delivery experience at the professional or paraprofessional level delivered in an organized mental health or psychiatric rehabilitation setting such as a psychiatric hospital, day treatment or mental health case management program, or community mental health center. Evidence of such service delivery experience must be provided by the agency in which the experience occurred.

2. *Supervised Experience*—experience supervised by a mental health professional is mental health services provided under a formal plan of supervision documented by a plan of professional supervision. Evidence of such supervised experience must be provided by the supervising professional and/or agency in which the supervision occurred.

3. *Core Mental Health Disciplines*—academic training programs in psychiatry, psychology, social work, and psychiatric nursing.

4. *Mental-Health-Related Field*—academic training programs based on the principles, teachings, research and body of scientific knowledge of the core mental health disciplines. To qualify as a related field there must be substantial evidence that the academic program has a curriculum content in which at least 70 percent of the required courses for graduation are based on the knowledge base of the core mental health disciplines. Programs which may qualify include but are not limited to sociology, criminal justice, nursing, marriage and family counseling, rehabilitation counseling, psychological counseling, and other professional counseling.

5. *Licensed Mental Health Professional*—an individual qualified to provide professional mental health services. A LMHP is one who meets one of the following education and experience requirements:

- a. a physician who is duly licensed to practice medicine in the state of Louisiana and has completed an accredited training program in psychiatry; or
- b. a psychologist who is licensed as a practicing psychologist under the provisions of state law; or
- c. a social worker who holds a master's degree in social work from an accredited school of social work and is a board-certified social worker under the provisions of R.S. 37:2701-2718; or
- d. a nurse who is licensed to act as a registered nurse in the state of Louisiana by the Board of Nursing, and is a graduate of an accredited master's level program in psychiatric nursing plus two years of post-masters, supervised experience in mental-health-related field; or has a master's degree in

nursing or a mental-health-related field plus two years of post-master's, supervised experience in the delivery of mental health services; or has a bachelor's degree in nursing plus four years of post-bachelor's degree, supervised experience in the delivery of mental health services; or

e. a licensed professional counselor who is licensed as such under the provision of state law plus two years supervised experience in the delivery of mental health services post-master's degree.

#### IV. The Mental Health Rehabilitation Assessment

The mental health rehabilitation assessment for children/youth and mental health rehabilitation assessment for adults includes an initial MHR assessment and one update, development of an initial service agreement and one update of the service agreement.

A. The MHR assessment is a comprehensive, integrated series of assessment procedures conducted largely in the recipient's or his family's daily living environments to determine strengths and needs with regard to functional skills and environmental resources that will enable the mental health rehabilitation recipient to attain a successful and satisfactory community adjustment. The assessment and service agreement must be submitted in the format and utilize the protocols defined by the Office of Mental Health.

B. Assessment procedures at a minimum include but are not limited to the following:

1. review of the standardized clinical evaluation(s) and other pertinent records;

2. face-to-face strengths assessment with the recipient or child/family which must be completed by the clinical manager. The strengths assessment must be in the format defined by the Office of Mental Health;

3. key informant interview(s) (for example: family member, teacher, friend, employer, job coach). For children an interview with the teacher is required;

4. observation(s) in natural settings(s) (for example: home, school, job site, community). For children an observation in the home and school is required;

5. interview by licensed physician to assess past history of all medications and current medication, specifying issues of polypharmacy and untoward responses;

6. standardized functional assessment scale;

7. integrated summary and prioritized strengths/need list must be organized by the life areas;

8. update of the MHR assessment.

C. The assessment team must include the clinical manager and a licensed physician, at a minimum. Other professionals and paraprofessionals are included as indicated by recipient/family need.

D. The standardized clinical evaluation submitted by providers for prior authorization of mental health rehabilitation services (MHR) must meet the following criteria. The standardized clinical evaluation must be completed by either a Louisiana licensed (1) board-certified social worker and a board-certified or board-eligible psychiatrist or licensed psychologist; or (2) board-certified or board-eligible psychiatrist; or (3) licensed psychologist. This evaluation must include a face-to-face interview with the recipient by all professionals signing the evaluation and must

provide detailed descriptive information about the recipient's functional status in life areas as defined by the Office of Mental Health. The information must be submitted on the Standardized Clinical Evaluation form which is available through the regional offices of mental health. Key symptoms and functional behaviors are to be identified in sufficient detail so that the impact on the consumer's functioning can be judged independently by an outside reviewer.

#### V. The Mental Health Rehabilitation Service Agreement

The service agreement is a written document which identifies the goals, objectives, action strategies and services which have been agreed to by the MHR agency and the adult recipient or the child and family. The service agreement must be based on the mental health rehabilitation assessment and must address at least two life areas. The agreement is to be submitted in the format defined by the Office of Mental Health and must be approved by the Office of Mental Health prior to the delivery of services. The service agreement is developed by a team which at a minimum consists of the clinical manager, a physician, and the recipient or the child and family. The clinical manager has lead responsibility for oversight of the process.

#### VI. Service Package

A service package is a defined range of interventions appropriate for a determined level of need for care (high, medium and low). The service packages are derived from the following menu of services:

- clinical management;
- individual intervention (child/youth only);
- supportive counseling (adults only);
- parent/family intervention (child/youth only);
- group counseling;
- medication management;
- behavior intervention plan development (child/youth only);
- individual psychosocial skills training;
- group psychosocial skills training;
- service integration.

The individualized mix of services for any individual is specified on the 90-day action strategy of the MHR service agreement. The MHR service agreement is derived from the MHR assessment.

#### VII. Reimbursement

Reimbursement is made by a prospective, negotiated and noncapitated rate based on the delivery of services as specified in the service agreement and the service package as required for the adult and child/youth populations.

Adult assessment/service agreement \$ 700

Child/youth assessment/service agreement \$ 800

The MHR assessment/service agreement is reimbursed based on the approval of a MHR assessment and MHR service agreement and is paid semiannually.

Adult:		Child/Youth:	
High need	\$1,300	High need	\$1,375
Medium need	\$ 550	Medium need	\$ 800
Low need	\$ 250	Low need	\$ 250

Services are reimbursed based on services specified in the 90-day action strategy plan and are paid monthly contingent upon the delivery of 80 percent of the prorated 90-day

services approved in the MHR service agreement. As Medicaid recipients progress in their rehabilitation services and the level of need decreases, services will transition from the high to medium and/or low level of need. Reimbursement will be made in the amounts specified above for the medium and low levels of need as determined by the bureau or its designee.

Reimbursement for the delivery of services under the Mental Health Rehabilitation Program and Optional Targeted Case Management Program is not provided to the same Medicaid recipient.

#### **VIII. Crisis Services**

The MHR provider is required to maintain a 24-hour on-call system with the capacity to provide 24-hour face-to-face services. With respect to a psychiatric emergency, the MHR physician must first screen the recipient and determine if referral to the Office of Mental Health Crisis Response System is warranted. The format for screening and referral is defined by the Office of Mental Health.

Bobby P. Jindal  
Secretary

9602#026

### **DECLARATION OF EMERGENCY**

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

**Optional Targeted Case Management  
Services—Reimbursement**

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, has adopted the following rule in the Medicaid Program as authorized by R.S. 46:153 and pursuant to Title XIX of the Social Security Act. This emergency rule is in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq. and shall be in effect for the maximum period allowed under the Administrative Procedure Act or adoption of the rule, whichever occurs first.

The Bureau of Health Services Financing currently funds case management services to the following specific population groups: 1) mentally retarded or developmentally disabled individuals including developmentally delayed infants and toddlers (termed infants and toddlers with special needs under this emergency rule); 2) pregnant women in need of extra perinatal care (termed high-risk pregnant women under this emergency rule) (limited to the metropolitan New Orleans area); 3) HIV disabled individuals (termed persons infected with HIV under this emergency rule); 4) chronically mentally ill (termed seriously mentally ill individuals - for adults and children/youths with emotional/behavioral disorders under

this emergency rule); 5) participants in waivers which include case management as a service; and 6) ventilator-assisted children. The bureau has adopted rules governing case management services as the needs of the population groups for these services became apparent and in accordance with available funding.

There has been a tremendous growth in interest on behalf of the public in providing these services to the Medicaid populations. In addition, as these services have been implemented and governed under specific program regulations over the past five years, the department now seeks to enhance all these services to the optimal level while streamlining their administration. In addition this emergency rule establishes enhanced regulations governing consumer eligibility, provider enrollment, provider standards for participation and payment, and general provisions. The department adopted emergency rules to ensure uniform standards for the quality of the services delivered to these persons with special physical and/or health needs and conditions effective July 22, 1994 and August 13, 1994 (*Louisiana Register*, Volume 20, Numbers 6 and 7). Subsequent emergency rules continued this initiative in force as published in the (*Louisiana Register*, November 20, 1994, Volume 20, Number 11, April 20, 1995, Volume 21, Number 4), August 20, 1995 (Volume 21, Number 8), and November 20, 1995, Volume 21, Number 11. The following emergency rule is being adopted to continue these provisions in force in order to assure that the fragile and vulnerable population groups identified above receive case management services essential to their obtaining needed medical services thereby preventing imminent peril to the health, safety, and welfare. An emergency rule was adopted on October 1, 1995 (*Louisiana Register*, Volume 21, Number 10) and subsequently amended effective March 1, 1996 (*Louisiana Register*, Volume 22, Number 3) which established the reimbursement methodology and regulations governing the payment for these services.

#### **Emergency Rule**

Effective March 9, 1996 the Bureau of Health Services Financing adopts regulations governing case management services including consumer eligibility requirements, provider enrollment, provider standards for participation and payment, and general provisions. This emergency rule applies to case management services provided either to targeted population groups or under a waiver program(s) in which case management services are included. This emergency rule governs case management services for the following specific population groups: 1) mentally retarded/developmentally disabled individuals; 2) infants and toddlers with special needs; 3) high-risk pregnant women; 4) persons infected with HIV; 5) seriously mentally ill individuals; and 6) persons in waiver program(s) in which case management services are included. Services for ventilator-assisted children are terminated as a specific targeted group but these children may be eligible under the other target groups listed above. All case management providers must follow the policies and procedures included in this emergency rule as well as in the Department of Health and Hospitals *Case Management Provider Manual*. Under this rule the term *case management*

has the same meaning as the term *family service coordination*. Case management services must be delivered in accordance with all applicable federal and state laws and regulations.

### **I. Standards of Participation**

In order to be reimbursed by the Medicaid Program, a provider of targeted or waiver case management service must comply with all of the requirements listed below. Exceptions may be granted by the secretary on a case-by-case basis based on an assessment of available services in the community.

A. Provider Enrollment Requirements. Case management agencies who wish to provide Medicaid funded targeted or waiver case management services must contact the department to request an enrollment packet and copy of the *DHH Case Management Provider Manual*. Applicants must indicate the population(s) and the geographical areas they wish to serve. The provider must meet all applicable licensure, general standards for participation in the Medicaid Program and specific provider enrollment and participation requirements for the population(s) to be served. Each enrolling agency must also submit a separate provider agreement (Form PE-50) and Disclosure of Ownership form to DHH for each targeted or waiver population and geographical area (DHH region) the agency plans to serve. Providers of services to the seriously mentally ill must meet the re-enrollment requirements of the Medicaid Program.

Each office site of a case management agency must be enrolled separately. Approval by DHH entitles the agency to provide services in the parishes of that DHH region only. This requirement is applicable to both new providers and existing providers already enrolled. When an agency wishes to provide case management services in a parish in another region and that parish is not contiguous to the parish in which an enrolled office site is located, the agency must establish an office in other region, submit a separate enrollment packet, and receive DHH approval to provide services in that DHH region regardless of the number of case managers providing services in the new region. When there are less than three case managers providing services in a parish in another region and that parish is contiguous to the parish in which an enrolled office site is located, the agency is not required to establish an office in the other region.

In accordance with Section 4118(I) of the Omnibus Budget Reconciliation Act (OBRA) of 1987, Public Law 100-203, the department may restrict enrollment and service areas of agencies that are enrolled in the Medicaid Program to provide case management services to seriously mentally ill and developmentally disabled consumers including infants and toddlers with special needs in order to ensure that the case management providers available to these targeted groups and any subgroups are capable of ensuring that the targeted consumers receive the full range of needed services. Case management agencies must meet the enrollment requirements listed below to be approved for enrollment.

All applicant case management agencies must meet the requirements 1-15 listed below to participate as a case management provider in the Medicaid Program, regardless of the targeted or waiver group served:

1. has demonstrated direct experience in successfully serving the target population and demonstrated knowledge of available community services and methods for accessing them including all of the following:
  - a. has established linkages with the resources available in the consumer's community;
  - b. maintains a current resource file of medical, mental health, social, financial assistance, vocational, educational, housing and other support services available to the target population; and
  - c. demonstrates knowledge of the eligibility requirements and application procedures of federal, state, and local government assistance programs which are applicable to consumers served;
  - d. employs a sufficient number of qualified case manager and supervisory staff who meet the skills, knowledge, abilities, education, training, supervision, staff coverage and maximum caseload size requirements described in Section C below;
2. possesses a current license to provide case management/service coordination in Louisiana or written proof of application for licensure;
3. demonstrates administrative capacity to provide all core elements of case management and insure effective case management services to the target population in accordance with licensing and DHH requirements by DHH review of the following:
  - a. current detailed budget for case management;
  - b. report of annual outside audit by a CPA performed in accordance with generally accepted accounting principles;
  - c. cost report by September 30 of each year following 12 months of operation;
  - d. provider policies and procedures;
  - e. functional organization chart depicting lines of authority; and
  - f. program philosophy, goals, services provided, and eligibility criteria that defines the target population or waiver group to be served;
4. assures that all case manager staff is employed by the agency in accordance with Internal Revenue Service (IRS) regulations (including submission of a W-2 form on each case manager). Contracting case manager staff is prohibited. Contracting of supervisors must comply with IRS regulations. Each case manager must be employed 20 hours per week;
5. assures that all new staff satisfactorily complete an orientation and training program in the first 90 days of employment and possess adequate case management abilities, skills and knowledge before assuming sole responsibility for their caseload and each case manager and supervisor satisfactorily complete case management related training on an annual basis to meet at least minimum training requirements described below. The provision and/or arranging of such training is the responsibility of the provider;
6. has a written plan to determine the effectiveness of the program and agrees to implement a continuous quality improvement plan approved by the department;

7. documents and maintains an individual record on each consumer which includes all of the elements described in licensing standards for case management and Section III.A. below;

8. agrees to safeguard the confidentiality of the consumer's records in accordance with federal and state laws and regulations governing confidentiality;

9. assures a consumer's right to elect to receive case management as an optional service and the consumer's right to terminate such services;

10. assures that no restriction will be placed on the consumer's right to elect to choose a case management agency, a qualified case manager, and other service providers and change the case management agency, case manager and service providers consistent with Section 1902(a)(23) of the Social Security Act;

11. if currently enrolled as a Medicaid case management provider, assures that case managers will not provide case management and Medicaid reimbursed direct services to the same consumer(s). If enrolled as a case management provider assure that the agency will not provide case management and other Medicaid reimbursed direct services to the same consumers.

12. has financial resources and a financial management system capable of:

- a. adequately funding required qualified staff and services;
- b. providing documentation of services and costs;
- c. complying with state and federal financial reporting requirements; and
- d. submitting reports in the manner specified by Medicaid;

13. maintains a written policy for intake screening, including referral criteria;

14. maintains a written policy for transition and closure;

15. with the consumer's permission, agrees to maintain regular contact with, share relevant information and coordinate medical services with the consumer's primary care or attending physician or clinic;

16. fully complies with the Code of Governmental Ethics.

Applicants must meet the following additional enrollment requirements for specific target groups:

17. has a working relationship with a local inpatient hospital and a 24-hour crisis response system (applicable to seriously mentally ill case management only);

18. demonstrates the capacity to participate and agrees to participate in the Case Management Information System (CAMIS) and provide up-to-date data to the regional office on a monthly basis via electronic mail (applicable to seriously mentally ill, infants and toddlers with special needs, and developmentally disabled children 3 years and older and adults only). CAMIS and electronic mail software will be provided without charge to the provider;

19. has demonstrated successful experience with delivery and/or coordination of services for pregnant women; Has a working relationship with a local obstetrical provider/acute care hospital providing deliveries for 24-hour medical consultation; has a multi-disciplinary team consisting, at a

minimum, of: a physician, primary nurse associate, registered nurse; social worker; and nutritionist; all members must meet DHH licensure and perinatal experience requirements (applicable to high risk pregnant women only),

20. satisfactorily complete a one-day training provided by the Delta Region AIDs Education and Training Center (applicable to HIV infected).

An enrolled case management provider must re-enroll requesting a separate Medicaid provider number and is subject to the above-described enrollment requirements and procedures in order to provide case management services to an additional target population.

Applicants will be subject to review by DHH to determine ability and capacity to serve the target population and a site visit to verify compliance with all provider enrollment requirements prior to a decision by the Medicaid Program on enrollment as a case management provider or at any time subsequent to enrollment. Enrolled case management providers will be subject to review by the DHH and the U.S. Department of Health and Human Services to verify compliance with all provider enrollment requirements at any time subsequent to enrollment.

If the applicant agency is determined to be eligible for enrollment, the agency will be notified in writing by the Medicaid Program of the effective date of enrollment and the unique Medicaid case management provider number for each office site and targeted or waiver group. If the department determines that the applicant case management agency does not meet the general or specific enrollment requirements listed above, the applicant agency will be notified in writing of the deficiencies needing correction. The applicant agency must submit appropriate documentation of corrective action taken. If the applicant agency fails to submit the required documentation of corrective action taken within 30 days of the notice, the application will be rejected. If the case management agency does not meet all of the requirements 1-14 in Section A above, the applicant agency will be ineligible to provide case management services to any targeted or waiver group.

## II. Standards of Payment

In order to be reimbursed by the Medicaid Program, an enrolled provider of targeted or waiver case management service must comply with all of the requirements listed below. Exceptions may be granted by the secretary on a case-by-case basis based on an assessment of available services in the community.

A. Staff Coverage. All case managers must be employed by the case management agency a minimum of 20 hours per week and work at least 50 percent of the time during normal business hours (8 a.m. to 5 p.m., Monday through Friday). Contracting of case manager staff is prohibited. Case management supervisors must be employed a minimum of eight hours per week for each full-time case manager (four hours a week for each part-time case manager) they supervise and maintain on-site office hours at least 50 percent of the time. A supervisor must be continuously available to case managers by telephone or beeper at all other times when not on site when case management services are provided. The provider agency must ensure that case management services are available 24 hours a day, seven days a week.



B. Staff Qualifications. Each Medicaid enrolled provider must ensure that all staff providing targeted case management services have the skills, qualifications, training and supervision in accordance with licensing standards and the department requirements listed below. In addition, the provider must maintain sufficient staff to serve consumers within mandated caseload sizes described below:

1. Education and Experience for Case Managers. All case managers hired or promoted must meet all of the following minimum qualifications for education and experience:

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

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

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

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

The above general minimum qualifications for case managers are applicable for all targeted and waiver groups. Additional qualifications for specific targeted or waiver groups are delineated below:

**High Risk Pregnant Women.** Each Medicaid enrolled provider must ensure that all case managers providing targeted case management services to high risk pregnant women meet the following qualifications:

a. a bachelor's degree in a human service-related field such as psychology, education, rehabilitation counseling, or counseling from an accredited institution; AND one year of paid experience in a human service-related field providing direct consumer services or case management in the human-service-related field; AND demonstrated knowledge about perinatal care;

b. a licensed registered nurse; AND one year of paid experience as a registered nurse in public health or a human service-related field providing direct consumer services or case management in the human service-related field; AND demonstrated knowledge about perinatal care; OR

c. a bachelor's or master's degree in social work from a social work program accredited by the Council on Social Work Education; AND demonstrated knowledge about perinatal care; OR

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

**Developmentally Disabled Waiver Participants.** Each Medicaid enrolled provider of case management services to developmentally disabled under the waiver must ensure that all case managers have a minimum of one year of paid post-degree experience working directly with persons with mental retardation or developmentally disabilities.

2. Education and Experience for Case Management Supervisors. A case management supervisor hired or promoted or any other individual supervising case managers must meet all of the education and experience requirements listed below. Staff supervising case management for high risk pregnant women and individuals with acquired head injuries must meet the same qualifications as the case managers for these populations:

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

b. a bachelor's or master's degree in social work from a social work program accredited by the Council on Social Work Education; AND two years of paid post-bachelor's degree experience in a human service-related field providing direct consumer services or case management in the human service-related field. One year of this experience must be in providing direct services to the target population to be served; OR

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

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

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

The above general minimum qualifications for case management supervisors are applicable for all targeted and waiver groups. Additional qualifications for specific targeted or waiver groups are delineated below:

**High Risk Pregnant Women.** Each Medicaid enrolled provider must ensure that all case management supervisory staff for high risk pregnant women meet the following qualifications:

a. a bachelor's degree in a human-service-related field such as psychology, education, rehabilitation counseling, or counseling from an accredited institution; AND four years of paid post-bachelor's degree experience in a human-service-related field providing direct consumer services or case management in the human-service-related field; two years of this experience must be in providing direct services to the target population to be served; AND demonstrated knowledge about perinatal care;

b. a licensed registered nurse; AND three years of paid post-bachelor's degree experience in a human-service-related field providing direct consumer services or case management in the human-service-related field; two years of this experience must be in providing direct services to the target population to be served; AND demonstrated knowledge about perinatal care; OR

c. a bachelor's or master's degree in social work from a social work program accredited by the Council on Social Work Education; AND two years of paid post-bachelor's degree experience in a human-service-related field providing direct consumer services or case management in the human-service-related field. One year of this experience must be in providing direct services to the target population to be served; AND demonstrated knowledge about perinatal care; OR

d. a registered dietician; AND three years of paid post-bachelor's degree experience in a human-service-related field providing direct consumer services or case management in the human-service-related field; two years of this experience must be in providing direct services to pregnant women.

3. **Requisite Knowledge, Skills and Abilities.** Each Medicaid enrolled provider must look for the following knowledge, skills and abilities in hiring case management staff and must ensure that all staff providing targeted or waiver case management services possess the following basic knowledge, skills, and abilities prior to assuming full caseload responsibilities:

a. **Knowledge:**

- (1) community resources;
- (2) medical terminology;
- (3) case management principles and practices;
- (4) consumer rights;
- (5) state and federal laws for public assistance;

b. **Skills:**

- (1) time management;
- (2) assessment;
- (3) interviewing;
- (4) listening;

c. **Abilities:**

- (1) preparing service plans;
- (2) coordinating delivery of services;
- (3) advocating for the consumer;
- (4) communicating both orally and in writing;
- (5) establishing and maintaining cooperative

working relationships;

- (6) maintaining accurate and concise records;
- (7) assessing medical and social aspects of each case and formulating service plans accordingly;
- (8) problem solving;
- (9) remaining objective while accepting the consumer's lifestyle.

4. **Training.** Case manager and supervisor training must be provided by or arranged by the case manager's employer at the employer's expense.

**Training for New Case Managers.** Orientation of at least 16 hours must be provided to all staff, volunteers, and students within one week of employment which must include, at a minimum:

- a. provider policies and procedures;

- b. Medicaid/Program Office policies and procedures;
- c. confidentiality;
- d. documentation in case records;
- e. consumer rights protection and reporting of violations;
- f. consumer abuse and neglect policies and procedures;
- g. professional ethics;
- h. emergency and safety procedures;
- i. data management and record keeping;
- j. infection control and universal precautions;
- k. working with the target population.

A minimum of eight hours of the orientation training must cover orientation on the target population including but not limited to specific service needs and resources. In addition to the required 16 hours of orientation, all new employees with no documented required experience and training must receive a minimum of 16 hours of training during the first 90 calendar days of employment which is related to the target population served and specific knowledge, skills, and techniques necessary to provide case management to the target population. This training must be provided by an individual with demonstrated knowledge of the training topics and the target population. This training must include the following at a minimum:

- a. assessment techniques;
- b. service planning;
- c. resource identification;
- d. interviewing and interpersonal skills;
- e. data management and record keeping;
- f. communication skills.

**Annual Training.** A case manager must satisfactorily complete 40 hours of case-management related training annually which may include training updates on subjects covered in orientation and initial training. For new employees, the 16 hours of orientation training are not included in the 40-hour minimum annual training requirement. The 16 hours of training for new staff required in the first 90 days of employment may be part of this 40-hour minimum annual training requirement. Appropriate updates of topics covered in orientation and training for a new case manager must be included in the required 40 hours of annual training. The following is a list of suggested additional topics for training:

- a. nature of illness or disability, including symptoms and behavior;
- b. pharmacology;
- c. potential array of services for the population;
- d. building natural support systems;
- e. family dynamics;
- f. developmental life stages;
- g. crisis management;
- h. first aid/CPR;
- i. signs and symptoms of mental illness, alcohol and drug addiction, mental retardation/developmental disabilities and head injuries;
- j. recognition of illegal substances;
- k. monitoring techniques;
- l. advocacy;
- m. behavior management techniques;
- n. value clarification/goals and objectives;

- o. available community resources;
- p. accessing special education services;
- q. cultural diversity;
- r. pregnancy and prenatal care;
- s. health management;
- t. team building/interagency collaboration;
- u. transition/closure;
- v. age and condition-appropriate preventive health care;
- w. facilitating team meetings;
- x. computers;
- y. stress and time management;
- z. legal issues.

Each case management supervisor must complete 40 hours of training a year, at a minimum. In addition to the required and suggested topics for case managers, the following are suggested topics for supervisory training:

- a. professional identification/ethics;
- b. process for interviewing, screening, and hiring of staff;
- c. orientation/in-service training of staff;
- d. evaluating staff;
- e. approaches to supervision;
- f. managing caseload size;
- g. conflict resolution;
- h. documentation;
- i. time management;

The required orientation and training for case managers and supervisors described above must be documented in the employee's personnel record including: dates and hours of specific training, trainer or presenter's name, title, agency affiliation or qualification, other sources of training and orientation/training agenda.

**Training-Infants and Toddlers with Special Needs.** A minimum of eight hours of orientation for new family service coordination staff must be ChildNet specific training as defined by the Department of Education. A minimum of 24 additional hours of training must be provided to new family service coordinators hired in the first 90 days of employment. This training must cover advanced subjects as defined by the Department of Education in addition to the subjects listed above. Initial training specific to ChildNet must be arranged and/or coordinated by the Regional Infant/Toddler Coordinator. Specific ChildNet training content must be approved by a sub-committee of the State Interagency Coordinating Council. Advanced training in specific subjects must be satisfactorily completed prior to the case manager/family service coordinator assuming those duties. Ongoing annual training is the responsibility of the family service coordination agency.

New family service coordination supervisors must satisfactorily complete a minimum of 40 hours of family service coordination training before assuming supervisory duties for this target population. Experienced supervisors must also complete a minimum of 40 hours per calendar year on advanced ChildNet specific subjects defined by the Department of Education.

**Mandatory Medicaid Training.** Enrolled case management agencies must ensure that all case management

staff satisfactorily complete DHH provider required training on case management policies and procedures contained on this document and the *DHH Case Management Provider Manual*.

C. Supervision. Each case management agency must have and implement a written plan for supervision of all case management staff. Face-to-face supervision must occur at least one time per week per case manager for a minimum of one hour per week. Supervisors must review at least 10 percent of each case manager's case records each month for completeness, compliance with these standards, and quality of service delivery. Case managers must be evaluated at least annually by their supervisor according to written provider policy on evaluating their performance. Supervision of individual staff must include the following:

- a. direct review, assessment, problem solving, and feedback regarding the delivery of case management services;
- b. teaching and monitoring of the application of consumer centered principles and practices;
- c. assuring quality delivery of services;
- d. managing assignment of caseloads; and
- e. arranging for training as appropriate.

The case manager supervisor must utilize by a combination of more than one of the following means:

- a. individual, face-to-face sessions with staff to review cases, assess performance and give feedback;
- b. group face-to-face sessions with all case management staff to problem solve, provide feedback and support to case managers;

c. sessions in which the supervisor accompanies a case manager to meet with consumers; The supervisor assesses, teaches, and gives feedback regarding the case managers's performance related to the particular consumer.

Each supervisor must maintain a file on each case manager supervised and hold supervisory sessions on at least a weekly basis. The file on the case manager must include, at a minimum:

- a. date and content of the supervisory sessions; and
- b. results of the supervisory case review which shall address, at a minimum: completeness and adequacy of records; compliance with standards; and, effectiveness of services.

Each case management supervisor must not supervise more than five full-time case managers or a combination of full-time case managers and other human service staff. A supervisor may carry one-fifth of a caseload for each case manager supervised less than five supervisees. If the supervisor carries a caseload, he or she must be supervised by an individual who meets the supervisor qualifications in Section A above.

D. Caseload Size Standards. Each full-time case manager is subject to a maximum caseload of consumers as indicated below:

	Case Weight
Infants and toddlers with special needs	351.14
Developmentally disabled (age 3 and older)	45.888
High risk pregnant women	60.666
HIV infected	45.888
Seriously mentally ill	251.60
Fragile elderly	45.888

*Mixed* caseloads are those where a case manager serves at least five consumers from a second target population or five waiver participants. For caseloads containing consumers who are seriously mentally ill in addition to those who are developmentally disabled or are infants and toddlers with special needs, the maximum caseload is 35. For other "mixed" caseloads, the number of cases must be likewise prorated.

E. Consumer Eligibility Requirements for Targeted Populations. Case management providers must ensure that consumers of Medicaid funded targeted case management services are Medicaid eligible and meet the additional eligibility requirements specific to the targeted or waiver population group. The eligibility requirements for each targeted and waiver group are listed below. With respect to infants and toddlers with special needs, this determination is made through the Multi-disciplinary Evaluation (MDE) process and is not the responsibility of the case management/family service coordination agency. Also, the service plan for case management services provided to mentally retarded/developmentally disabled individuals and infants and toddlers with special needs is subject to prior authorization by the Medicaid agency or its designee. Providers are required to participate in provider training and technical assistance as required by the Medicaid agency or its designee.

1. Infants and Toddlers with Special Needs

a. a documented established medical condition determined by a licensed medical doctor. In the case of a hearing impairment, licensed audiologist or licensed medical doctor must make the determination; OR

b. a developmental delay in one or more of the following areas:

- (1) cognitive development;
- (2) physical development, including vision and hearing eligibility must be based on a documented diagnosis made by a licensed medical doctor (vision) or a licensed medical doctor or licensed audiologist (hearing);
- (3) communication development;
- (4) social or emotional development;
- (5) adaptive development;

The determination of a developmental delay must be made in accordance with applicable federal regulations and ChildNet policies and procedures.

2. Developmentally Disabled Children Ages 3 Years and Older and Adults must meet the following definition of *developmental disability*:

a. a severe chronic disability of a person which is attributable to: mental retardation, cerebral palsy, autism or epilepsy; OR any other condition, other than mental illness, found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, or requires treatment or services similar to those required for these persons; AND

b. which is manifested before the person reaches age 22; AND

c. which is likely to continue indefinitely; AND

d. which results in substantial functional limitations in three or more of the following areas of major life

activities. Substantial functional limitation means more than two standard deviations below the mean obtained by assessment with one or more standardized evaluation instruments which measure the following areas of major life activities:

- (1) self care;
- (2) understanding and use of language;
- (3) learning;
- (4) mobility;
- (5) self-direction;
- (6) capacity for independent living; AND

e. the consumer must require and is unable to access services from multiple services providers, except in the instance of consumers eligible for waiver services; AND

f. the consumer is at risk of becoming homeless or in need of protection from harm due to environmental or life circumstances, need for supervision, or potential threat of abuse or neglect; OR the consumer has been institutionalized, is at risk of becoming institutionalized or would otherwise require ICF/MR level of care.

3. High-Risk Pregnant Women

a. Pregnancy must be verified by a licensed physician, licensed primary nurse associate, or certified nurse midwife;

b. Reside in the metropolitan New Orleans area including Orleans, Jefferson, St. Charles, St. John and St. Tammany parishes;

c. Be determined high risk based on a standardized medical risk assessment. A *medical risk assessment (screening)* must be performed by a licensed physician, a licensed primary nurse associate, or a certified nurse-midwife to determine if the patient is high risk. A pregnant woman is considered high risk if one or more risk factors are indicated on the form used for risk screening. Providers of medical risk assessment must use the standardized Risk Screening Form approved DHH.

d. Must require services from multiple health, social, informal and formal service providers and is unable to access the necessary services.

4. HIV Infected

a. Written verification of HIV infection by a licensed physician or laboratory test result is required.

b. The *adult* consumer must have reached, as documented by a physician, a level 70 on the Karnofsky scale (or cares for self but is unable to carry on normal activity or do active work) at some time during the course of HIV infection.

c. The *pediatric* consumer must display symptoms of illness related to HIV infection. All consumers must require services from multiple health, social, informal and formal service providers and is unable to access the necessary services.

5. Seriously Mentally Ill

a. *Adults 18 years and older* must meet all of the following criteria for (1), (2), (3) and (4) for serious mental illness (SMI):

(1) Age: 18 years or older; and

(2) Diagnosis: severe non-organic mental illnesses including, but not limited to schizophrenia, schizoaffective disorders, mood disorders, and severe personality disorders,

that substantially interfere with a person's ability to carry out such primary aspects of daily living as self-care, household management, interpersonal relationships and work or school; and

(3) Disability: impaired role functioning, caused by mental illness, as indicated by at least two of the following functional areas: unemployed or has markedly limited skills and a poor work history, or if retired, is unable to engage in normal activities to manage income; employed in a sheltered setting; requires public financial assistance for out-of-hospital maintenance (e.g., SSI, and/or is unable to procure such without help, does not apply to regular retirement benefits); severely lacks social support systems in the natural environment, (e.g., no close friends or group affiliations, lives alone, or is highly transient); requires assistance in basic life skills, (e.g., must be reminded to take medicine, must have transportation arranged for them, needs assistance in household management tasks); exhibits social behavior which results in demand for intervention by the mental and/or judicial/legal system; and

(4) Duration: must meet at least one of the following indicators of duration: psychiatric hospitalizations of at least six months in the last five years (cumulative total); two or more hospitalizations for mental disorders in the last twelve-month period; a single episode of continuous structural supportive residential care other than hospitalization for a duration of at least six months; a previous psychiatric evaluation indicating a history of treatment for severe psychiatric disability of at least six months duration.

b. *Children/youth (under age 18) with emotional/behavioral disorders* is defined as follows: behavioral or emotional responses so different from appropriate age, cultural, or ethnic norms that they adversely affect performance (including academic, social, vocational or personal skills); a disability which is more than a temporary, expected response to stressful events in the environment, is consistently exhibited in two different settings and persists despite individualized intervention within general education and other settings. Emotional and behavioral disorders can co-exist with other disabilities.

The following criteria are being established for children/youth with emotional/behavioral disorders and requires that (1), (2), and (3) described below, be met before someone can be described as having an emotional/behavioral disorder. For the purposes of eligibility for Medicaid case management services, there must be a diagnosis as contained in section (2) below, and, a disability as described in section (3) and, a duration of impairment or patterns of inappropriate behavior which has persisted for at least three months and will persist for at least a year.

(1) Age: under age 18; and

(2) Diagnosis: meets one of the following criteria which operationalize the above definition:

(a) exhibits seriously impaired contact with reality, and severely impaired social, academic, and self-care functioning, whose thinking is frequently confused, whose behavior may be grossly inappropriate and bizarre, and whose emotional reactions are frequently inappropriate to the situation; or

(b) manifest long-term patterns of inappropriate behaviors, which may include but are not limited to aggressiveness, anti-social acts, refusal to accept adult requests or rules, suicidal behavior, developmentally inappropriate inattention, hyperactivity, or impulsiveness; or

(c) experience serious discomfort from anxiety, depression, or irrational fears and concerns whose symptoms may include but are not limited to serious eating and/or sleeping disturbances, extreme sadness, suicidal ideation, persistent refusal to attend school or excessive avoidance of unfamiliar people, maladaptive dependence on parents, or non-organic failure to thrive; or

(d) have a DSM-III-R (or successor) diagnosis indicating a severe mental disorder, such as, but not limited to psychosis, schizophrenia, major affective disorders, reactive attachment disorder of infancy or early childhood (non-organic failure to thrive) or severe conduct disorder. This category does not include children/youth who are socially maladjusted unless it is determined that they also meet the criteria for emotional/behavior disorders; and

(3) Disability: there is evidence of severe, disruptive and/or incapacitating functional limitations of behavior characterized by at least two of the following: inability to routinely exhibit appropriate behavior under normal circumstances; tendency to develop physical symptoms or fears associated with personal or school problems; inability to learn or work that cannot be explained by intellectual, sensory, or health factors; inability to build or maintain satisfactory interpersonal relationships with peers and adults; a general pervasive mood of unhappiness or depression; conduct characterized by lack of behavioral control or adherence to social norms which is secondary to an emotional disorder. If all other criteria are met, then "conduct disorders" are eligible; and

(4) Duration: impairment or patterns of inappropriate behavior must have persisted for at least three months and will persist for at least a year.

6. Frail Elderly. The consumer must be a participant in the Home Care for the Elderly waiver.

F. Description of Case Management Services/Provider Responsibilities. The definition of *case management* adopted by the department is "services provided by qualified staff to the targeted or waiver population to assist them in gaining access to the full range of needed services including medical, social, educational, and other support services." Targeted and waiver case management services consists of intake, assessment, service planning, linkage/service coordination, monitoring/follow-up, reassessment, and transition/closure. The department utilizes a broker model of case management in which consumers are referred to other agencies for specific services they need. These services are determined by professional assessment of the consumer's needs and provided according to a comprehensive individualized written service plan. All case management services must be provided by qualified staff as defined in Section A above. The provider must ensure that there is no duplication of payment, that there is only one case manager for each eligible consumer and that the consumer is not receiving other targeted case management services from any other provider.

The required core elements of targeted or waiver case management services and provider responsibilities which all Medicaid enrolled case management agencies must comply with are described below:

1. **Case Management Intake.** *Intake* is defined as the determination of eligibility and need for targeted case management services. Intake is the entry point into case management. The purpose of intake is to gather baseline information to determine the consumer's need, appropriateness, eligibility and desire for case management. The case management provider must have written eligibility criteria for case management services provided by the agency. The required procedures of intake screening are:

- a. interview the consumer within *three working days* of receipt of a referral, preferably face-to-face;
- b. determine if the consumer is currently Medicaid-eligible;
- c. determine if the consumer is eligible for services by virtue of the eligibility requirements of the target population described in Section B above;
- d. determine if the consumer's needs require case management services;
- e. inform the family of procedural safeguards, rights and grievance/appeal procedure and which includes the following:

- (1) determine if the consumer freely accepts case management as optional;
  - (2) provide the consumer freedom of choice of available targeted case management providers as well as case managers. Advise the consumer of his right to change case management providers and case managers;
  - (3) provide the consumer freedom of choice of available service providers. The consumer must sign a standardized intake form to verify the above procedural safeguards;
- f. obtain signed release form(s) from the consumer/guardian.

Intake activities performed solely to determine eligibility and need for targeted case management are not billable to Medicaid (unless they are performed as part of the case management assessment process and the consumer meets the eligibility requirements for the target or waiver population.

The above general case management intake procedures are applicable for all targeted and waiver groups. Additional or other procedures for specific targeted or waiver groups are delineated below.

**Intake for Infants and Toddlers with Special Needs.** *Intake for infants and toddlers with special needs* is defined as a comprehensive interagency multi-disciplinary, ongoing process which ensures that eligible children are appropriately identified, located, referred and evaluated for early intervention services. The child search coordinator in the local education agency is the single point of entry into ChildNet. The child search coordinator is responsible for completion of the following intake procedures:

- a. upon receipt of a referral, the child search coordinator must assist the family in identifying and choosing an enrolled family service coordinator provider to assist in the

MDE process. Referrals received directly by a family service coordination provider must be immediately referred to the appropriate child search coordinator;

- b. the child search coordinator must provide the family freedom of choice to select an enrolled family service coordination provider, and advise the family of the right to change family service coordinator provider agencies, family service coordinators and other service providers;

- c. the child search coordinator must advise the family of their procedural safeguards and provide them with a copy of their rights under ChildNet.

**Intake for High Risk Pregnant Women.** Intake must include a standardized medical risk assessment described in Section E3 above.

**Intake for Seriously Mentally Ill.** All case management services to seriously mentally ill adults and children are subject to prior authorization by the department including eligibility of the consumer for the target population. The case management provider must submit certain required information including the CAMIS Data Form to enable the regional office to certify that the consumer meets the target population definition. If the consumer does not meet the target population definition, written notification will be sent to the consumer.

**Intake for Frail Elderly.** Intake procedures for waiver services are described in the appropriate *Waiver Provider Manual*.

2. **Case Management Assessment.** *Assessment* is defined as the process of gathering and integrating formal/professional and informal information concerning a consumer's goals, strengths, and needs to assist in the development of a comprehensive, individualized service plan. The purpose of assessment is to establish a service plan and contract between the case manager and consumer. The following areas must be addressed in the assessment when relevant: identifying information; medical/physical; psychosocial/behavioral; developmental/intellectual; socialization/recreational; financial; educational/vocational; family functioning; personal and community support systems; housing/physical environment; and status of other functional areas or domains.

Providers may be required to use standardized assessment instruments for certain targeted populations. The assessment must identify the consumer's strengths, needs and priorities. The assessment must be conducted by the case manager through in-person contact, individualized observations and questions with the consumer and, where appropriate, in consultation with the consumer's family and support network, other professionals, and service providers. The assessment must identify areas where a professional evaluation is necessary to determine appropriate services or interventions. The case manager must arrange for any necessary professional/clinical evaluations needed to clearly define the consumer's specific problem areas. Authorization must be obtained from the consumer/guardian to secure appropriate services.

The assessment must be initiated as soon as possible, preferably within *seven calendar days* of receipt of the referral and must be completed no later than *30 days* after the referral for case management services. A *face-to-face*

interview with the consumer is required as part of the assessment process. The initial assessment interview with the consumer must be conducted in the consumer's home to accurately assess the actual living conditions and health and mental status of the consumer unless this is not the consumer's preference or there are genuine concerns regarding safety. If the interview cannot be conducted in the consumer's home, an alternative setting in the consumer's community must be chosen jointly with the consumer and documented in the case record. All assessments must be written, signed, dated, and documented in the case record.

Assessments performed on children in the custody of the Office of Community Services(OCS) or Office of Youth Development(OYD) must actively involve the assigned foster care worker or probation officer and must be approved by the agency with legal custody of the child. Assessments performed on consumers in the custody of the Office of Developmental Disabilities (OCDD) must actively involve the assigned regional office OCDD staff and must be approved by OCDD.

The above general case management assessment procedures are applicable for all targeted and waiver groups. Additional procedures for specific targeted or waiver groups are delineated below:

**Assessment for Infants and Toddlers with Special Needs.** The child search coordinator is responsible for ensuring all the components of the assessment/multi-disciplinary evaluation (MDE) are fulfilled within the required timeliness. In addition, the child search coordinator must coordinate with the family service coordinator to ensure the development of the initial Individualized Family Service Plan within the required 45 day time lines. The case manager/family service coordinator is responsible for assisting the family through the multi-disciplinary evaluation process including the following:

- a. informing the family of the steps involved in the MDE process, explaining their rights and procedural safeguards and securing their participation;
- b. reviewing relevant medical information and prior evaluations;
- c. coordinating the performance of identified or necessary evaluations and KIDMED screenings and immunizations and an examination by a licensed physician to ensure timely completion of the MDE and IFSP;
- d. identifying or coordinating the identification of the family's concerns, priorities and resources;

The MDE must include the following:

- a. a review of pertinent records related to the child's current health status and medical history;
- b. results of a KIDMED screening or documented referral for KIDMED screening;
- c. an evaluation of the child's level of functioning in each of the following developmental areas: cognitive development, physical development, including vision and hearing (by a licensed physician or hearing by a licensed audiologist); communication development; social or emotional development; and adaptive development;
- d. an assessment of the child's strengths and needs and the identification of appropriate early intervention services to meet those needs; and

- e. with family consent, the family's identification of their concerns, priorities and resources related to enhancing the development of their child;

- f. be signed and dated by multi-disciplinary team participants.

### **Assessment of Developmentally Disabled Children Three Years and Older and Adults**

- a. **Comprehensive Strengths Assessments.** The case manager must complete this standardized strengths assessment form in a face-to-face interview with the consumer. The assessment must identify current status in identified areas of community living, the desired outcomes, as well as strategies which have worked in the past to meet the needs or desired outcomes. The strengths assessment must also include a summary paragraph of the need for case management services, identifying current needs and factors by history which emphasize the need for services.

- b. **CAMIS Initial Assessment**

**Assessment for Seriously Mentally Ill.** Upon approval of the consumer's eligibility for the target population, the regional office will notify the provider of authorization to submit a completed assessment and service plan. A unique authorization number will be issued to the provider which must be used to bill Medicaid upon completion of the assessment and the service plan. The provider must submit the following properly completed assessment documents and service plan forum to the regional office for approval as soon as possible but no later than 30 calendar days from the date of authorization:

- a. **Comprehensive Strengths Assessment.** The case manager must complete this standardized strengths assessment form in a face-to-face interview with the consumer. The assessment must identify current status in identified areas of community living, the desired outcomes, as well as strategies which have worked in the past to meet the needs or desired outcomes. The strengths assessment must also include a summary paragraph of the need for case management services, identifying current needs and factors by history which emphasize the need for services.

- b. **CAMIS Initial Assessment**

**Assessment for High Risk Pregnant Women.** Assessment of pregnant women is a multi-disciplinary evaluation of the high risk patient to identify factors that may adversely affect health status. Professionals from nursing, nutrition and social work disciplines working as a team must each evaluate the consumer and family needs through interactions and interviews. Each professional assessment must reflect the identified areas for counseling, intervention and follow up services. The nursing, nutritional, and psychosocial assessments must be documented on standardized forms approved by the department. Assessments must be completed within *14 calendar days* after the risk assessment is completed or receipt of the referral. There may be extenuating circumstances with certain patients that may hinder compliance with this time frame for assessment.

The case manager is responsible for assisting the family through the multi-disciplinary evaluation process including the following:

a. coordinating the performance of identified or necessary evaluations to ensure timely completion in preparation for the multi-disciplinary team staffing;

b. identifying or coordinating the identification of the consumer's concerns, priorities and resources.

A home assessment must be completed by the case manager as part of the initial assessment. If a home visit is refused by the consumer/guardian or there are genuine concerns regarding safety, an alternative setting in the consumer's community may be chosen jointly with the consumer and documented in the case record.

**Assessment for Frail Elderly.** Assessment procedures for waiver services are described in the appropriate *Waiver Provider Manual*.

3. Case Management Service Planning. *Service planning* is defined as the development of a written agreement based upon assessment data (which may be multi-disciplinary), observations and other sources of information which reflect the consumer's needs, capacities and priorities and specifies the services and resources required to meet these needs. The service plan must be developed through a collaborative process involving the consumer, family, case manager, other support systems and appropriate professionals and service providers. It should be developed in the presence of the consumer and, therefore, cannot be completed prior to a meeting with the consumer. The consumer, case manager, support system and appropriate professional personnel must be directly involved and have agreed to assume specific functions and responsibilities.

The service plan must be completed within 45 calendar days of the referral for case management services. The consumer must be informed of his or her right to refuse a service plan after carefully reviewing it. The service plan must be signed and dated by the consumer and the case manager. Although service plans may have different formats, all plans must incorporate all of the following required components:

a. statement of prioritized long-range goals (problems or needs) which have been identified in the assessment;

b. one or more short-term objectives or expected outcomes linked to each goal that is to be addressed in order of priority;

c. specification of action steps, services or interventions planned, and payment mechanism, if applicable;

d. assignment of individual responsibility for goal accomplishment; and

e. time frames for completion or review.

The service plan must document frequency and/or intensity of contacts between the consumer and case manager, service providers and others, the persons to be contacted and whether the visits must be to the consumer's place of residence or to another location, such as a service delivery site. Each service plan must be written and kept in the consumer's record. The assessment and service plan must be completed prior to providing ongoing case management services.

The above general case management service planning procedures are applicable for all targeted and waiver groups. Additional procedures for specific targeted or waiver groups are delineated below.

**Service Planning for Infants and Toddlers with Special Needs.** The family service coordinator's responsibilities in the Individual Family Service Plan (IFSP) must include all of the following:

a. convening a meeting to develop the IFSP within 45 calendar days of referral;

b. attending the IFSP meeting;

c. ensuring that the IFSP meeting is conducted in settings and at times that are convenient to families; in the native language of the family or other mode of communication used by documentation to the regional office within prescribed time lines in accordance with Office of Mental Health procedures.

**Service Planning for Frail Elderly.** Service planning procedures for waiver services are described in the appropriate Waiver Provider Manual.

4. Case Management Linkage. *Linkage* is defined as the implementation of the service plan involving the arranging for a continuum of both informal and formal services. After obtaining authorization from the consumer, the case manager must contract with the direct service providers or direct the consumer to contact the service providers, as appropriate. The case manager must contract with the consumer for formal and informal services and supports to be arranged. Attempts must be made to meet service needs with informal service providers as much as possible. The responsibilities of the case manager in service coordination are:

a. translating assessment findings into services;

b. determining which services and connections are needed;

c. being aware of community resources (Food Stamps, SSI, Medicaid, etc.);

d. exploration of both formal and informal services for consumers;

e. communicating and negotiating with service providers;

f. training and support of the consumer in the use of personal and community resources identified in the service plan;

g. linking consumers through referrals to services that meet their needs as identified in the service plan; and

h. advocacy on behalf of the consumer to assist them in accessing appropriate benefits or services.

5. Case Management Follow-Up/Monitoring. *Follow-up or Case Management Monitoring* is defined as the follow-up mechanism to assure applicability of the service plan. The purpose of monitoring/follow-up contacts made by the case manager is to determine if the services are being delivered as planned, and/or services adequately meet consumer needs and to determine effectiveness of the services and the consumer's satisfaction with them.

The consumer must be contacted within the first 10 working days after the initial service plan is completed to assure appropriateness and adequacy of service delivery. Thereafter, face-to-face follow up visits must be made with the consumer/guardian at least monthly as part of the linkage and monitoring follow-up process, or more frequently as dictated by the service plan or determined by the needs of the consumer/guardian. In addition, visits must be



made to consumer's home on a quarterly basis, at a minimum. If the consumer refuses home visits or there are genuine concerns regarding safety, an alternative setting in the consumer's community may be chosen jointly with the consumer.

The case manager must communicate regularly by telephone, in writing and in face-to-face meetings and home visits with the consumer/guardian, professionals and service providers involved in the implementation of the service plan. The nature of these follow-up contacts (i.e. telephone, home visit) and the individuals contacted be determined by the status and needs of the consumer, as identified in the service plan and determined by the case manager.

Through this activity, the case manager must determine whether or not the service plan is effective in meeting the consumer's needs and identify when changes in the consumer's status occur, necessitating a revision in the service plan. Reassessment is required when a major change in status of the consumer/guardian occurs.

Monitoring of services provided includes the following:

- a. following up to assure that the consumer actually received the services as scheduled;
- b. assuring that consumer/consumer's family is able and willing to comply with recommendations of service providers;
- c. measuring progress of consumer in meeting service plan goals and objectives and determining whether the services adequately address the consumer's needs.

Monitoring information must be obtained by the case manager through direct observation and direct feedback. The case manager must gather information from direct service providers for monitoring purposes. The case manager must obtain verbal or written service reports from direct service providers.

The above general case management service planning procedures are applicable for all targeted and waiver groups. Additional procedures for specific targeted or waiver groups are delineated below.

**Follow-Up/Monitoring for High Risk Pregnant Women.** The case manager must maintain at least weekly face-to-face or telephone contact with the consumer/guardian, family, informal and/or formal providers to implement the service plan and follow up/ monitoring service provision and the consumer's progress in accordance with the service plan.

**Follow-Up/Monitoring for Seriously Mentally Ill.** The case manager must have at least weekly face-to-face or telephone contact with the consumer/guardian.

6. Case Management Reassessment. *Reassessment* is defined as the process by which the baseline assessment is reviewed. It provides the opportunity to gather information for evaluating and revising the overall service plan. After the initial assessment is completed and initial service plan is implemented, the consumer's needs and progress toward accomplishing the goals listed in the service plan goals must be reevaluated on a routine basis or when a significant change in status or needs occurs. Reassessment is accomplished through interviews and periodic observations.

The purpose of reassessment is to determine if the consumer's condition, situation or needs have significantly

changed and to evaluate the effectiveness of the service plan in meeting predetermined goals. If indicated, the identified needs, short-term goals or objectives, services, and/or service providers must be revised. A schedule for reassessing and modifying the initial goals and service plans must be part of the initial workup. Reassessment and review and/or updating of the service plan must be done at intervals of no less than 90 calendar days. If there is a minor change in the service plan, the case manager must revise the plan and initial and date the change. More frequent reassessments may be required, depending upon the consumer's situation.

At least every *six months*, a complete review of the service plan must be done to assure that goals and services are appropriate to the consumer's needs identified in the assessment/reassessment process. A home-based reassessment must be done on at least an *annual* basis unless this is not the consumer's preference or there are genuine concerns regarding safety. If the reassessment cannot be conducted in the consumer's home, an alternative setting in the consumer's community must be chosen jointly with the consumer and documented in the case record.

The above general case management reassessment procedures are applicable for all targeted and waiver groups. Additional procedures for specific targeted or waiver groups are delineated below.

**Reassessment for Infants and Toddlers with Special Needs.** Ongoing assessment is a component of the IFSP process. A review of the IFSP must be conducted at least every six months, or more often if conditions warrant, or if the family requests a review to determine the following:

- a. the degree to which progress is being made toward achieving the outcomes; and
- b. whether modifications or revisions of the outcomes or services are necessary.

The review may be carried out by a meeting or by other means that is acceptable to the families and other participants.

An annual meeting must be conducted to evaluate the IFSP and, as appropriate, revise the IFSP. The results of any ongoing assessments of the child and family, and any other pertinent information must be used in determining what early intervention services are needed and will be provided.

7. Case Management Transition/Closure. Discharge from case management must occur when the consumer no longer needs or desires the services, or becomes ineligible for them. The closure process must ease the transition to other services or care systems. When closure is deemed appropriate, the consumer must be notified immediately so that appropriate arrangements can be made. The case manager must complete a final reassessment identifying any unresolved problems or needs and discussing with the consumer methods of arranging for their own services.

Criteria for closure include but are not limited to the following:

- a. resolution of the consumer's service needs with low probability of recurrence;
- b. consumer requests termination of services;
- c. death;
- d. permanent relocation out of the service area;
- e. long term admission to a hospital, institution or nursing facility;

f. does not meet the criteria for the case management established by the funding source (e.g., Medicaid or the Program Office);

g. the consumer requires a level of care beyond that which can safely be provided through case management;

h. the safety of the case manager is in question; or

i. noncompliance.

All cases which do not have an active service plan and necessary linkage or monitoring activities must be closed. Infants and toddlers eligible under ChildNet are no longer eligible for Medicaid funded case management services if the only service in the IFSP is case management/family service coordination.

8. **Procedures for Changing Providers.** A consumer may freely change case management providers or case managers or terminate services at any time. DHH maintains a listing of enrolled and approved case management providers for each target and waiver population which consumers and service providers may access for referral purposes. Once the consumer has chosen a new case management provider, the new provider must complete the standardized "Provider Change Notification" form), obtain the consumer's written consent and forward the original change form to the previous case management provider. Upon receipt of the completed form, the previous provider must send copies of the following information as required by licensing standards within 10 working days:

- a. most current service plan;
- b. current assessments on which service plan is based;
- c. number of services used in the calendar year;
- d. current and previous quarter's progress notes.

The new provider must bear the cost of copying which cannot exceed the community's competitive copying rate. The previous provider may not provide case management services after the date the notification is received.

The above general procedures for changing case management providers are applicable for all targeted and waiver groups except as otherwise specified for particular groups delineated below.

**Procedures for Changing Family Service Coordination Providers-Infants and Toddlers with Special Needs.** If a family chooses to change family service coordination agencies or a change is necessary for any reason, the following procedures will be followed:

a. the family will be referred back to the child search coordinator. This referral can be made by the family, the current family service coordinator, or other service providers;

b. the child search coordinator will provide the family with the official list of family service coordination providers and the freedom of choice form;

c. the child search coordinator will review the family's rights under ChildNet with the family including the right to change family service coordinators or agencies;

d. the child search coordinator or the family, if the family chooses, will notify the newly selected agency;

e. the child search coordinator will notify the old agency at termination;

f. after receiving written informed parental consent, the new agency will request records from the previous

agency. The previous agency will make these records available within 10 working days of receipt of the request.

### III. General Provisions

A. **Documentation.** The provider must keep sufficient records to document compliance with licensing and Medicaid case management requirements for the target population served and provision of case management services. Separate case management records must be maintained on each consumer which fully document services for which Medicaid payments have been made. The provider must maintain sufficient documentation to enable the Medicaid Program to verify that each charge is due and proper prior to payment. The provider must make available all records which the Medicaid Program finds necessary to determine compliance with any federal or state law, rule, or regulation promulgated by the Medicaid Program, DHH or DHHS or other applicable state agency.

The consumer's case record must consist of the following information, at a minimum:

1. Medicaid eligibility information;
2. documentation verifying that the consumer meets the requirements of the targeted population;
3. a copy of the standardized procedural safeguard form signed by the consumer;
4. copies of any professional evaluations and other reports used to formulate the service plan;
5. case management assessment;
6. progress notes;
7. service logs;
8. copies of correspondence;
9. at least six months of current pertinent information relating to services provided. (Records older than six months may be kept in storage files or folders, but must be available for review.);
10. if the provider is aware that a consumer has been interdicted, a statement to this effect must be noted.

**Service Logs.** Service logs are the means for recording units of billable time. There must be case notes corresponding to each recorded time of case management activity. The notes should not be a narrative with every detail of the circumstances. Service logs must reflect service delivered, the "paper trail" for each service billed. Logs must clearly demonstrate allowable services billed. Services billed must clearly be related to the current service plan. Billable activities must be of reasonable duration and must agree with the billing claim. All case notes must be clear as to who was contacted and what allowable case management activity took place. Use of general terms such as "assisted consumer to" and "supported consumer" do not constitute adequate documentation.

Logs must be reviewed by the supervisor to insure that all billable activities are appropriate in terms of the nature and time and documentation is sufficient. Federal requirements for documenting case management claims require the following information must be entered on the service log to provide a clear audit trail:

1. name of consumer;
2. name of provider and person providing the service;
3. names and telephone numbers of persons contacted;

4. start and stop time of service contact and date of service contact;
5. place of service contact;
6. purpose of service contact;
7. content and outcome of service contact.

**Progress Notes.** Progress notes are the means of summarizing billable activities, observations and progress toward meeting service goals in the case management record. Progress notes must:

1. be clear as to who was contacted and what case management activity took place for each recorded time of case management. It must be clear why that time period was billed;
2. record activities and actions taken, by whom, progress made and indicate how goals in the service plan are progressing;
3. document delivery of each service identified on the service plan;
4. record any changes in the consumer's medical condition, behavior or home situation which may indicate a need for a reassessment and service plan change;
5. be legible, as well as legibly signed, including functional title, and fully dated; and
6. be complete, entered in the record preferably *weekly* but at least *monthly* and signed by the primary case manager.

Progress notes must be recorded more frequently (weekly) when there is frequent activity or significant changes occur in the consumer's service needs and progress. Quarterly progress notes are required in addition to the minimum monthly recording. A summary must also be entered in the consumer's record when a case is transferred or closed.

The organization of individual case management records on consumers and location of documents within the record must conform with state licensing standards and be consistent among records. All entries made by staff in consumer records must be legible, fully dated, legibly signed and include the functional title of the individual. Any error made by the staff in a consumer's record must be corrected using the legal method which is to draw a line through the erroneous information, write "error" by it and initial the correction. Correction fluid cannot be used in consumer records.

Providers must make all necessary consumer records available to appropriate state and federal personnel at all reasonable times. Providers must always safeguard the confidentiality of consumer information. Under no circumstances should providers allow case management staff to take records home. The case management agency can release confidential information only under the following conditions:

1. by court order; OR
2. by the consumer's written informed consent for release of the information. In cases where the consumer has been declared legally incompetent, the individual to whom the consumer's rights have devolved must provide informed written consent.

Providers must provide reasonable protection of consumer records against loss, damage, destruction, and unauthorized use. Administrative, personnel and consumer records must be

retained until records are audited and all audit questions are answered or three years from the date of the last payment, whichever is longer.

#### B. Reimbursement

1. **General Requirements.** As with all Medicaid services, payment for targeted or waiver case management services is dictated by the nature of the activity and the purpose for which the activity is performed. All case management services billed must be provided by qualified case managers and meet the definition of *case management*—services provided by qualified staff to the targeted or waiver population to assist them in gaining access to the full range of needed services including medical, social, educational, and other support services. This definition encompasses *assisting eligible consumers* in gaining access to needed services including:

- a. identifying services needed;
- b. linking consumer with the most appropriate providers of services; and
- c. monitoring to ensure needed services are received.

Case management does not consist of the provision of other needed services, but is to be used as a *vehicle* to help an eligible consumer gain access to them. A general rule of thumb for providers to follow is if there is no interaction in person, by telephone or in correspondence on behalf of the consumer, it is most likely not a billable case management activity.

2. **Reimbursement Requirements for Infants and Toddlers with Special Needs.**

- a. Candidates for case management services must be Medicaid eligible.
- b. Medicaid eligibles must be certified as a member of the targeted populations by the Medicaid agency or its designee.
- c. The case management service plan is subject to prior authorization by Medicaid agency or its designee.
- d. Providers of case management services are required to participate in provider training and technical assistance as required by the Medicaid agency or its designee.

C. **Non-billable Activities.** Federal regulations require that the Medicaid Program ensure that payments made to providers do not duplicate payments for the same or similar services furnished by other providers or under other authority as an administrative function or as an integral part of a covered service.

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

Time spent in activities which are not a direct part of a contact are not Medicaid reimbursable. Activities that, while

they may be necessary, do not result in a service identified in the service plan being provided to the consumer are not reimbursed. The following examples of activities are not considered targeted case management services for Medicaid purposes and are not reimbursable by the Medicaid Program as case management:

1. outreach, case finding or marketing;
2. counseling or any form of therapeutic intervention;
3. developing general community or placement resources or a community resource directory;
4. legislative or general advocacy;
5. professional evaluations;
6. training;
7. providing transportation;
8. telephone calls to a busy number, leaving messages, FAXing or mailing information;
9. travel to a consumer's home for a home visit, and the consumer is not at home so that the visit cannot be held but a note is left;
10. "housekeeping" activities in connection with record keeping. (Recording a contact in the case record at the time service is provided is billable.);
11. in-service training, supervision;
12. discharge planning; EXCEPTION: 10 days (30 days for developmentally disabled waiver participant) before discharge from an inpatient facility to assist the consumer in the transition from inpatient to outpatient status, and in arranging appropriate services and 10 days after institutionalization or hospitalization to arrange for closure of community services;
13. intake screening which takes place prior to and is separate from assessment;
14. general administrative, supervisory or clerical activities;
15. record keeping;
16. general interagency coordination;
17. program planning;
18. Medicaid billing or communications with Medicaid Program;
19. running errands for family (shopping, picking up medication, etc.);
20. accompanying family to appointments or recreational activities, waiting for appointments with family;
21. lengthy interaction to "get acquainted", "provide support" or "hand holding";
22. activities performed by agency staff other than the primary case manager;
23. accompanying another case manager either because of or for safety reasons.

Bobby P. Jindal  
Secretary

9603#025

## DECLARATION OF EMERGENCY

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

### Private ICF/MR Facility Services

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing has adopted the following rule under the Medical Assistance Program as authorized by R.S. 46:153 et seq. and pursuant to Title XIX of the Social Security Act and as directed by the 1995-96 General Appropriation Act, which states: "The secretary shall implement reductions in the Medicaid program as necessary to control expenditures to the level approved in this schedule. The secretary is hereby directed to utilize various cost containment measures to accomplish these reductions, including but not limited to pre-certification, pre-admission screening, and utilization review, and other measures as allowed by federal law." This emergency rule is in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., and shall be in effect for the maximum period allowed under the Administrative Procedure Act or until adoption of the rule, whichever occurs first.

The Bureau of Health Services Financing provides coverage for Intermediate Care Facility Services for the Handicapped and/or Mentally Retarded (ICF/MR) provided by Private Intermediate Care Facilities and reimbursement is made according to prospective rates established under the Reimbursement for Private ICF/MR Facilities rule (*Louisiana Register*, October 20, 1989, Volume 15, Number 10). The department determined that it was necessary to reduce the reimbursement rates by limiting administrative and general support costs to 24 percent of all other programmatic costs including plant operation and maintenance, costs related to capital assets, dietary expenses, linen and laundry expenses, housekeeping expenses, personal recipient needs, medical and nursing expenses, therapeutic and training expenses, recreational expenses, consultant expenses, educational expenses and in house ancillary services expenses.

An emergency rule was adopted and published in the *Louisiana Register*, Volume 21, Number 10, which amended the rule on Reimbursement for Private ICF/MR Facilities cited above by limiting administrative and general support costs to 24 percent of all other programmatic costs. The following emergency rule continues this reduction methodology in force until adoption of the final rule on this provision. This action is necessary to avoid a budget deficit in the medical assistance programs.

It is anticipated that implementation of the following emergency rule will decrease program expenditures for private ICF/MR services by approximately \$6,700,190 for state fiscal year 1996.

### Emergency Rule

Effective for dates of service beginning February 25, 1996 and after, the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing amends

the rule on Reimbursement for Private ICF/MR Facilities (*Louisiana Register*, October 20, 1989, Volume 15, Number 10) by limiting administrative and general support costs to 24 percent of all other programmatic costs including plant operation and maintenance, costs related to capital assets, dietary expenses, linen and laundry expenses, housekeeping expenses, personal recipient needs, medical and nursing expenses, therapeutic and training expenses, recreational expenses, consultant expenses, educational expenses and in-house ancillary services expenses.

Interested persons may submit written comments to the following address: Thomas D. Collins, Office of the Secretary, Bureau of Health Services Financing, Box 91030, Baton Rouge, LA 70821-9030. He is the person responsible for responding to inquiries regarding this emergency rule.

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

Bobby P. Jindal  
Secretary

9603#006

## DECLARATION OF EMERGENCY

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

Transplant Services-Reimbursement

The Department of Health and Hospitals, Bureau of Health Services Financing has adopted the following emergency rule under the Medical Assistance Program as authorized by R. S. 46:46:153 and pursuant Title XIX of the Social Security Act. This emergency rule is in accordance with the Administrative Procedure Act R. S. 49:953(B) et seq. and shall be in effect for the maximum period allowed or until adoption of the rule, whichever occurs first..

On July 1, 1994 the Department adopted the Prospective Payment Reimbursement Methodology for inpatient hospital services (referenced in *Louisiana Register* June 20, 1994 Volume 20 Number 6.) which included specific methodology for the reimbursement of transplant services. Subsequently the department determined that systems limitations prohibit the implementation of the transplant reimbursement provision of the Prospective Payment Reimbursement Methodology. Therefore, the department adopted the following rule to re-instituted the provisions of the Tax Equity and Fiscal Responsibility Act (TEFRA) for the reimbursement of transplant services. This emergency rule has been published in the *Louisiana Register* on April, August and December 20, 1995 Volume 21, Numbers 4, 8, and 12. The following emergency rule has been adopted to keep the above provision in force until adoption of the rule. This emergency rule is necessary to avoid a budget deficit in the medical assistance programs. It is anticipated that the continued implementation

of this rule will reduce program expenditures by approximately \$268,328 for state fiscal year 1996 and \$281,475 for state fiscal year 1997.

### Emergency Rule

Effective March 24, 1996 the Department Health and Hospitals, Bureau of Health Services Financing repeals the reimbursement provisions governing organ transplant services contained in the "Hospital Prospective Reimbursement Methodology" rule referenced in the June 20, 1994 *Louisiana Register* (Volume 20, Number 6) and adopts the following provisions to govern Medicaid reimbursement for non-experimental organ transplant services which are prior authorized by the Medicaid Program. Payment is allowable only in accordance with a per diem limitation established for inpatient discharges for organ transplant services reflected for a distinct carve out unit. Each type of organ transplant service must be reported as a separate distinct carve-out unit cost. Organ procurement costs shall be included in the distinct carve-out unit cost and shall be subject to the per diem limitation. The per diem limitation shall be calculated based on inpatient routine and ancillary costs for the transplant carve-out discharges derived from each hospital's base period. The base period is the first cost reporting period beginning with September 30, 1983 through August 31, 1984 in which an allowable transplant was performed on a Medicaid patient. The base period per diem costs for transplant distinct carve-out units shall be inflated annually using the target rate percentage increase for inpatient prospective payment systems (PPS) exempt hospitals' operating costs established by federal statute and published annually in the *Federal Register*. Reimbursement for transplant distinct carve-out unit services shall not exceed the per diem limitation and no incentive payment shall be allowed. The Tax Equity and Fiscal Responsibility Act (TEFRA) provisions governing exceptions and adjustments for inpatient hospital services shall also apply to the per diem limitation for the reimbursement of distinct carve-out units for organ transplant services. The Medicaid share of each transplant unit's costs subject to the per diem limitation shall be included in the total Medicaid reimbursement at the hospital's cost settlement at fiscal year end.

Bobby P. Jindal  
Secretary

9603#041

## DECLARATION OF EMERGENCY

**Department of Labor  
Office of Employment Security**

Electronic Transfer as Method of Payment  
(LAC 40:IV.375)

In accordance with the emergency provisions of R.S. 49:953(B) of the Administrative Procedure Act, and under the statutory authority of R.S. 23:1653, the administrator of the Office of Employment Security declares that the following

emergency rule is adopted March 7, 1996, to become effective on the future date of May 2, 1996, and shall remain effective thereafter for the maximum period of 120 days allowable under R.S. 23:954(B)(2), or until final rule is adopted, whichever occurs first.

The adoption of such emergency and initial rule is necessary to implement and abide by Act 46 of the 1995 Regular Session of the Louisiana Legislature. Such statutory amendment of R.S. 23:1532.1 requires, in part, that post-defeasance proceeds of the special assessment for debt service, collected subsequent to September 1, 1993, be pledged and dedicated to the establishment of an electronic transfer system for the administration of the state unemployment compensation program. This emergency rule is herein adopted during promulgation of the final rule and is necessary to continue to permit the procedure and criteria for electronic transfer of payment of employer contributions. Such emergency rule further supports the commitment of the department for electronic transfer services under current banking contract. This emergency rule shall facilitate the uninterrupted continuation of accounting procedures of employers for electronic-transfer payments for each quarter of 1996.

The notice of intent for promulgation of the permanent rule is being published in this March, 1996 issue of the *Louisiana Register*.

**Title 40**

**LABOR AND EMPLOYMENT**

**Part IV. Employment Security**

**Subpart 3. Unemployment Compensation and Contributions**

**Chapter 3. Employment Security Law**

**§ 375. Electronic Transfer as Method of Payment**

A. Any taxable employer which reports 250 or more employees in any calendar quarter, including any agent or entity which pays contributions either on behalf of any such employer or on behalf of a multiple of 50 or more taxable employers in any calendar quarter, shall remit any such payment(s) by electronic-fund transfer on or before the last day of the calendar month following the calendar quarter in which contributions accrue, subject to penalty and interest under R.S. 23: 1543 for failure to timely remit electronic transfer of funds for any such payment(s).

B. Any reimbursable employer which employs 250 or more employees in any calendar quarter, including any agent or entity which pays reimbursement either on behalf of any such employer or on behalf of a multiple of 50 or more reimbursable employers in any calendar quarter, shall remit any such payment(s) of reimbursement by electronic-fund transfer not later than 30 days after quarterly billing was mailed by the administrator or was otherwise delivered to such employer or designated agent or entity, subject to penalty and interest under R.S. 23:1543 for failure to timely remit electronic transfer of funds for any such payment(s).

C. Any agent or entity which pays on behalf of any combination of a multiple of 50 or more of taxable and reimbursable employers shall remit any such payment(s) of contributions or reimbursements by electronic transfer pursuant to the respective statutory due-dates for each such employer, as recited in above Subsections A and B.

D. The requirement of such form of payment under this rule shall commence with the first calendar quarter of 1996, ending March 31, 1996, and shall continue each calendar quarter thereafter.

E. Such payment(s) by electronic transfer shall be in accordance with the manner or format prescribed by the administrator and shall include reporting of all pertinent tax information.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1653.

HISTORICAL NOTE: Promulgated by the Department of Labor, Office of Employment Security, LR 22:

Gayle F. Truly  
Secretary

9603#020

**DECLARATION OF EMERGENCY**

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

**Red Snapper Commercial Size Limit (LAC 76:VII.335)**

In accordance with the emergency provisions of R.S. 49:953(B), the Administrative Procedure Act, the secretary of the Department of Wildlife and Fisheries, upon authority granted by resolution dated February 8, 1996 by the Louisiana Wildlife and Fisheries Commission under authority of R.S. 56:326.1, hereby finds that an imminent peril to the public welfare exists and accordingly adopts the following emergency rule. This emergency rule shall be effective at 12:01 a.m., February 20, 1996, and shall remain in effect for the maximum period allowed under the Administrative Procedure Act or until adoption of the final rule, whichever occurs first.

The secretary has been notified by the Gulf of Mexico Fishery Management Council that on February 15, 1996, the council reviewed a request to lower the commercial red snapper minimum size, and has failed to find that emergency action to lower the present commercial minimum size limit was warranted. Therefore, the commercial minimum size limit will remain 15 inches total length in federal waters. The present action by the secretary shall provide consistent regulations within both federal and state jurisdictions. Action was not taken prior to this time by the department or commission due to the uncertainty surrounding the potential for changes in the commercial size limit in federal waters.

**Title 76**

**WILDLIFE AND FISHERIES**

**Part VII. Fish and Other Aquatic Life**

**Chapter 3. Saltwater Sport and Commercial Fishery**

**§335. Daily Take, Possession and Size Limits Set by Commission, Reef Fish**

\*\*\*

G. Species	Minimum Size Limits
1. Red Snapper	15 inches total length (commercial)
	15 inches total length (recreational)

\*\*\*

AUTHORITY NOTE: Promulgated in accordance with R.S. 56:6(25)(a), 56:326.1 and 326.3.

HISTORICAL NOTE: Promulgated by the Department of Wildlife and Fisheries, Wildlife and Fisheries Commission, LR 16:539 (June 1990), amended LR 19:1442 (November 1993), LR 20:797 (July 1994), LR 21:1267 (November 1995); LR 22:

James H. Jenkins, Jr.  
Secretary

9603#004

# Rules

## RULE

### Department of Economic Development Office of Financial Institutions

#### Bond for Deed Escrow Agents (LAC 10:XV.Chapter 9)

Under the authority of the Administrative Procedure Act, R.S. 49:950 et seq., and in accordance with R.S. 6:414(B), the commissioner hereby amends the existing rule, originally published in the *Louisiana Register*, Volume 20, page 412 (April 1994), regarding the licensing, regulation and supervision of persons performing bond for deed escrow agent services. The amended rule provides specifically for the definition of terms; license requirements; application procedures; fees; submission of surety bonds; record keeping and retention; visitations and examinations; submission of reports; reporting significant changes in status; procedures for license suspension and revocation; and the enforcement powers of the commissioner.

#### Title 10

#### FINANCIAL INSTITUTIONS, CONSUMER CREDIT, INVESTMENT SECURITIES, AND UCC

#### Part XV. Other Regulated Entities

#### Chapter 9. Bond For Deed Escrow Agents

#### §901. Definitions

*Bond for Deed*—a contract to sell real property, in which the purchase price is to be paid by the buyer to the seller in installments and in which the seller, after payment of a stipulated sum, agrees to deliver title to the buyer.

*Buyer*—a prospective transferee of title to real property which is the subject of the bond for deed transaction.

*Commissioner*—the commissioner of the Office of Financial Institutions.

*Escrow Agent*—a person designated by the parties to a bond for deed transaction who distributes payments made by the buyer to the seller, or on behalf of the seller, to any person in accordance with a written bond for deed escrow agent agreement.

*Person*—any individual, firm, corporation, limited liability company, partnership, association, trust, or legal or commercial entity, or other group of individuals, however organized.

*Principal Shareholder*—a person owning in excess of 10

percent of the total outstanding shares of a corporation, a limited liability company or other legal or commercial entity.

*Real Property*—immovable property located in Louisiana.

*Seller*—a prospective transferor of title to real property which is the subject of the bond for deed transaction.

AUTHORITY NOTE: Promulgated in accordance with R.S. 6:414(B).

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Office of Financial Institutions, LR 20:412 (April 1994), amended LR 22:187 (March 1996)

#### §903. License Requirement, Ownership Change, Location Change, Name Change, Ceasing to Do Business

A. No person, other than a financial institution or other person subject to the general supervision or regulation of the commissioner pursuant to Title 6 or Title 9 of the Louisiana Revised Statutes of 1950, as amended, shall engage in business as a bond for deed escrow agent, unless such person has first obtained a license in conformity with this rule. Licenses are only required for those persons who wish to act as escrow agent, pursuant to written agreement, for the transfer of real property located within the boundaries of the state of Louisiana. The license must be prominently displayed at each location where business as a bond for deed escrow agent is conducted.

B. A license issued in accordance with this rule shall be nontransferable. A licensee shall give 30 days prior written notification to the Office of Financial Institutions of any change in ownership of 25 percent or more of its outstanding voting securities or equity ownership. A change in ownership of more than 50 percent shall require the acquiring person to apply for a new license in accordance with the provisions of §905 before ownership transfer occurs.

C. No licensee shall change its name or the location of any office without prior written notification to the commissioner. Written notification should be submitted 30 days prior to the anticipated date of change.

D. No licensee shall cease doing business without providing 30 days prior written notification to the commissioner and shall also provide therewith evidence of full compliance with all applicable laws and regulations.

AUTHORITY NOTE: Promulgated in accordance with R.S. 6:414(B).

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Office of Financial Institutions, LR 20:412 (April 1994), amended LR 22:187 (March 1996)

#### §905. Application For License and Renewal, Forms, Contents, Fees

A. Applications for licensure shall be in such form and contain such information as the commissioner may from time to time prescribe. Application forms may be obtained from the Office of Financial Institutions. The application shall contain a public section and a confidential section as determined by the commissioner.

1. The original of the application accompanied by a nonrefundable license fee of \$150 shall be submitted by U.S. mail or private mail courier in completed form to the commissioner. Any other method of delivery shall cause the application to be returned.

2. Upon receipt of the application the commissioner, or his designee, shall conduct an investigation. Additional

information not included in the application, which is necessary to determine qualification for licensing, may be requested from the applicant. Failure to provide the information requested on a timely basis may necessitate the return of the application to the applicant or may necessitate denial of the application by the commissioner. Processing of an application will not be completed until the satisfactory conclusion of such required investigation.

B. Each applicant shall possess and maintain a net worth of \$25,000. Further, the financial condition, business experience and background of the applicant shall be such as to reasonably warrant the commissioner's belief that the applicant's business shall be conducted honestly, carefully and efficiently. The commissioner shall investigate and consider the qualifications of each sole proprietor, partner, director, officer, principal shareholder or member of an applicant in determining whether the applicant qualifies for licensure.

C. Effective January 1, 1995, and on or before March 15 of each year, each licensee shall file an application for renewal and shall pay to the Office of Financial Institutions a nonrefundable license renewal fee of \$100. If the renewal application and fee are mailed after March 15, but on or before April 15, an additional late penalty equal to 50 percent of the renewal fee shall be paid as a prerequisite for renewal of an existing license. Failure to mail an application for renewal with its accompanying fee on or before April 15 shall result in expiration of the existing license.

D. The application for renewal shall be in such form and require such information as prescribed from time to time by the commissioner. The licensee may be required to submit with the renewal application an annual report disclosing all business activities with regard to servicing escrow agent agreements conducted during the previous year. With any renewal application, the licensee shall also provide annual financial statements sufficient to determine each licensee's financial condition.

AUTHORITY NOTE: Promulgated in accordance with R.S. 6:414(B).

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Office of Financial Institutions, LR 20:412 (April 1994), amended LR 22:187 (March 1996)

#### **§907. Escrow Deposit Account**

A. No person shall engage in business as a bond for deed escrow agent without first providing evidence to the commissioner that an escrow deposit account has been established for the sole purpose of receiving the proceeds of monthly payments paid to the licensee by a buyer. The escrow deposit account shall be established with a federally-insured depository institution or branch thereof. The licensee shall give the commissioner written authority to examine the escrow deposit account and if said account is located in an institution domiciled outside of the state of Louisiana, the licensee shall pay any reasonable and necessary expenses, in addition to the examination fee permitted by §911 of this rule, incurred by the commissioner or his designated representatives to conduct such an examination. The licensee shall hold all proceeds of monthly payments in trust from the moment of their receipt. The licensee shall timely account for or deliver to any person any personal property obtained by the escrow agent as required by a written bond for deed escrow

agent agreement such as money, funds, deposits, checks, drafts or other property of any value which has come into his hands and which is not his property, or which he is not by law entitled to retain. The licensee shall not commingle the proceeds in the escrow account with his own property or funds. If the licensee commingles any proceeds received from a buyer with his own property or funds controlled by licensee, all commingled proceeds and other property shall be considered held in trust by licensee in an amount equal to the amount of the proceeds owed any person by a buyer, which is to be paid on behalf of a seller.

B. When a licensee ceases to do business as a bond for deed escrow agent for any reason, the licensee shall immediately supply the commissioner with a written list of all parties that are represented by the licensee under all bond for deed escrow agent agreements. The licensee shall also supply the commissioner with a written list of all persons to whom he/she is required to make payments on behalf of any parties to bond for deed escrow agreement. Said lists shall be certified by the escrow agent.

AUTHORITY NOTE: Promulgated in accordance with R.S. 6:414(B).

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Office of Financial Institutions, LR 20:412 (April 1994), amended LR 22:188 (March 1996)

#### **§909. Irrevocable Letter of Credit, Surety Bond, Other Security**

A. No person shall engage in business as a bond for deed escrow agent without having first issued, in favor of the Office of Financial Institutions, an irrevocable letter of credit in an amount to be determined by the commissioner, but in no event less than \$10,000, which letter of credit shall be issued by a federally insured financial institution. Each applicant shall enter into an Irrevocable Letter of Credit Agreement, an Escrow and Regulatory Agreement and Power of Attorney with the Office of Financial Institutions on forms supplied by the commissioner before being issued a license to commence business.

B. In lieu of such irrevocable letter of credit as required in Subsection A above, each applicant may post and maintain a surety bond issued by a bonding company or insurance company, either of which must be authorized to do business in Louisiana, in the amount of \$10,000, to cover the first year of operation as a licensed bond for deed escrow agent. The bond shall be in a form acceptable to the commissioner and shall run to the Office of Financial Institutions for the benefit and use of the Office of Financial Institutions, parties to the bond for deed agreement or any persons with a right to the payments made on behalf of any parties to a bond for deed escrow agreement for any liability incurred as a result of the failure of the licensee to perform under a bond for deed escrow agent agreement. Persons who have claims against the licensee or its agents may bring suit directly on the bond. The Louisiana attorney general may bring suit on the bond on behalf of claimants either in one action or successive actions.

C. In lieu of such an irrevocable letter of credit, corporate surety bond, or any portion of such instruments required by this section, the licensee may deposit in escrow with any federally-insured depository institution, or branch thereof, located in Louisiana, the substitution of cash in an amount not



less than that required by the irrevocable letter of credit or corporate surety bond, or any portion thereof to be determined by the commissioner. A deposit of cash shall be made in an interest bearing account which must be pledged to the commissioner. The licensee shall be entitled to receive all interest and dividends on the deposit placed in escrow.

D. The amount of the irrevocable letter of credit, surety bond or cash escrow deposit after the first year of operation may be determined by the commissioner based upon the following nonexclusive factors:

1. the highest level of bond for deed transaction activity performed by the licensee during any one month in the preceding calendar year.

2. the risk to the general public, if any, commensurate with the continuance of the existing surety bond amount established during the preceding period.

3. in no event shall the total amount of security be less than \$10,000.

AUTHORITY NOTE: Promulgated in accordance with R.S. 6:414(B).

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Office of Financial Institutions, LR 20:412 (April 1994), amended LR 22:188 (March 1996)

#### **§911. Record Keeping and Retention, Examination**

A. A bond for deed escrow agent required to be licensed under this Chapter shall maintain in his/her office such books, records and accounts as are reasonably necessary to allow the commissioner to determine whether such bond for deed escrow agent is complying with the provisions of this rule and with the provisions of all escrow servicing agreements entered into by him/her. Such books, records and accounts shall be maintained separate and apart from any other business in which the bond for deed escrow agent is involved and shall be kept at the licensed location unless otherwise permitted in writing by the commissioner. Further, each licensed bond for deed escrow agent shall maintain a record of all bond for deed transactions and escrow agent agreements effected by him/her for a period of three years following the expiration or termination of such escrow agent agreement. Each bond for deed escrow agent licensed by this office shall also maintain a file containing the original and/or copies of all complaints filed by sellers, buyers or other third parties affected by bond for deed transactions or escrow agent agreements entered into by the licensee.

B. The commissioner, or his designee, may visit and examine each licensee in accordance with a schedule consonant with the use, to the fullest extent possible, of the resources of the Office of Financial Institutions, in accordance with good examination practice, to determine compliance with this rule, to investigate complaints or for other good cause shown. If records are moved outside of the boundaries of Louisiana, the bond for deed escrow agent, at the commissioner's option, shall make such records available to the commissioner at a location within this state convenient to the commissioner or shall pay the reasonable and necessary expenses for the commissioner or his representatives to examine such records at the place where they are maintained.

C. The commissioner shall assess an examination and/or visitation fee of \$50 per hour per examiner. If this fee is not paid within 30 days after its assessment, the licensee

examined shall be subject to an administrative penalty of not more than \$50 for each day the fee is late. The penalty, together with the amount due, plus attorney fees and court cost, may be recovered by the commissioner in a civil action brought in any court of competent jurisdiction.

D. The commissioner shall have the authority to examine the books, records and accounts of any former licensee as they pertain to bond for deed escrow activities.

AUTHORITY NOTE: Promulgated in accordance with R.S. 6:414(B).

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Office of Financial Institutions, LR 20:412 (April 1994), amended LR 22:189 (March 1996)

#### **§913. Significant Developments**

Each licensee must report any significant developments immediately to the commissioner, including but not limited to:

1. the filing of any bankruptcy petitions by the licensee;
2. the indictment or conviction of a felony by any sole proprietor, partner, director, officer, principal shareholder, member or agent of licensee.

AUTHORITY NOTE: Promulgated in accordance with R.S. 6:414(B).

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Office of Financial Institutions, LR 20:412 (April 1994), amended LR 22:189 (March 1996)

#### **§915. Suspension or Revocation of License**

A. After the licensee has been given notice and an opportunity to be heard, the commissioner may suspend or revoke the license of a bond for deed escrow agent in accordance with R.S. 6:121.1, 6:122 and/or any other relevant provision of law, whenever it has been established that the licensee has:

1. violated any provisions of the law or regulations applicable hereto, or committed any act which would constitute grounds for the refusal of a new license;
  2. knowingly provided or caused to be made to the commissioner any false or fraudulent misrepresentation of material fact, or suppressed or withheld from the commissioner any information which, if submitted, would have rendered the licensee ineligible to be licensed under this Chapter;
  3. refused to permit examination by the commissioner of the licensee's books, records or affairs, or has refused or failed, within a reasonable time, to furnish information or to make a report that may be required by the commissioner under the provisions of any applicable law or regulation;
  4. violated the reporting requirements set out in §913;
- or
5. failed to pay all fees and/or assessments as may be imposed by the Office of Financial Institutions.

B. In the event the commissioner suspends the license of an escrow agent, the licensee may continue to service any existing escrow agent agreements entered into prior to the date of suspension but may not enter into new escrow agent agreements subsequent to the date of suspension.

C. In the event the commissioner revokes the license of an escrow agent, or if the license expires for failure to renew, the escrow agent may not enter into any new escrow agent agreements subsequent to the date of revocation or expiration and must further comply with one of the following conditions:

1. the licensee must sell all existing escrow agent agreements entered into prior to the date of revocation of the license to a duly licensed escrow agent; or

2. if the licensee is unable to sell the escrow agent agreement to another duly licensed escrow agent, then each escrow agent agreement entered into by licensee must be terminated.

AUTHORITY NOTE: Promulgated in accordance with R.S. 6:414(B).

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Office of Financial Institutions, LR 20:412 (April 1994), amended LR 22:189 (March 1996)

Larry L. Murray  
Commissioner

9603#009

## RULE

### Department of Economic Development Real Estate Commission

#### Checks Returned for Insufficient Funds (LAC 46:LXVII.705)

Notice is hereby given that the Real Estate Commission has adopted the following revisions to the existing rules and regulations of the agency.

#### TITLE 46

### PROFESSIONAL AND OCCUPATIONAL STANDARDS

#### Part LXVII. Real Estate

#### Chapter 7. Fees

#### §705. Returned Checks Due to Insufficient Funds

A. Payment of any fee with a check which is returned by a financial institution due to insufficient funds wherein the reason for not paying the check is not a fault of the financial institution shall be grounds for cancellation of the transaction for which the fee was submitted and/or the suspension or revocation of a license, registration or certificate.

B. Persons issuing checks to the commission which are returned by financial institutions for insufficient funds will be notified of the return of the check by certified mail to the address registered by that person with the commission. Within 10 days from the mailing of the notification, the person issuing the check will remit a certified check, cashier's check or money order payable to the Louisiana Real Estate Commission in the amount of the returned check plus a \$25 processing fee.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1435 and 37:1443.

HISTORICAL NOTE: Promulgated by the Department of Commerce, Real Estate Commission, LR 3:397 (October 1977), amended LR 9:315 (May 1983), LR 10:874 (November 1984), LR 11:6 (January 1985), amended by the Department of Economic Development, Real Estate Commission, LR 22:190 (March 1996).

J.C. Willie  
Executive Director

9603#012

## RULE

### Board of Elementary and Secondary Education

#### Bulletin 1706—Discipline Procedures

In accordance with R.S. 49:950 et seq., the Administrative Procedure Act, notice is hereby given that the Board of Elementary and Secondary Education amended Bulletin 1706, Regulations for Implementation of the Exceptional Children's Act, Section 459 (Discipline Procedures) as stated below:

#### Section 459. Discipline Procedures

\* \* \*

B. Procedures for Exclusion of Students with Disabilities and Students with Suspected Disabilities

\* \* \*

#### 2. Amend to read:

For exclusions of more than nine consecutive days, or when a pattern of exclusions has occurred, or upon the fourth suspension.

Delete the phrase:

"or upon reaching the maximum number of unexcused absences due to suspensions."

\* \* \*

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:1941-1958.

HISTORICAL NOTE: Amended by the Board of Elementary and Secondary Education, LR 22:190 (March 1996).

Carole Wallin  
Executive Director

9603#022

## RULE

### Student Financial Assistance Commission Office of Student Financial Assistance

#### Federal Family Educational Loan Program (FFELP) Common Manual

The Student Financial Assistance Commission (LASFAC) rescinds the May 20, 1992 *Louisiana Guaranteed Student Loan Program Policy and Procedure Manual* and its supplementing Loan Program Memoranda (LPMs), except for the following sections:

'Appeal of Adverse Discretionary Decisions', originally published in the *Louisiana Register*, Volume 17, Number 7, page 652 on July 20, 1991, with minor revisions referenced in the *Louisiana Register*, Volume 18, Number 5, page 492 on May 20, 1992. These procedures comprise Chapter 12 of the May 20, 1992 manual.

'Lender of Last Resort Programs', published in the *Louisiana Register*, Volume 20, Number 8, pages 871-872 on August 20, 1994. These procedures comprise Section 2.4 of the May 20, 1992 manual.

The Student Financial Assistance Commission promulgates the *Common Manual, Unified Student Loan Policy*, effective April 1, 1996.

LASFAC supplies copies of the manual to schools and lenders participating in the Federal Family Education Loan Program (FFELP) administered by the commission. The manual will be maintained in conformity with federal regulations by the issuance of updates.

Jack L. Guinn  
Executive Director

9603#014

## RULE

### Department of Health and Hospitals Board of Chiropractic Examiners

Professional Conduct; Ethics; Peer Review;  
Illegal Payments; and Financial Interests  
(LAC 46:XXVII.Chapters 3-9)

Pursuant to R.S. 49:950 et seq., the Board of Chiropractic Examiners has adopted additional rules and amended existing rules on the following subjects:

1. Advertising practices of chiropractors;
2. Peer review committee;
3. Complaints;
4. X-ray proficiency certificates;
5. Internships;
6. Payments for patient referrals;
7. Specialty register.

#### Title 46

### PROFESSIONAL AND OCCUPATIONAL STANDARDS

#### Part XXVII. Chiropractors

#### Chapter 3. Professional Conduct

#### §307. Advertising Practices

- A. False, deceptive or misleading advertising is prohibited.
  - B. Statements in advertising which claim that specific physical illnesses ailments or symptoms are alleviated by chiropractic care must be supported by clinical or scientific literature generally recognized by the chiropractic profession. The board may require the chiropractor making such assertions to provide the reference supporting the advertising claim.
  - C. Testimonials may be used if the word "ADVERTISEMENT" in capital letters of larger type size than the largest text of the testimonial appears directly over the testimonial. The doctor is responsible for any false, deceptive or misleading statements in the testimonial.
  - D. Advertisement may offer free goods or services or discounts in connection with chiropractic care only if the usual charge for those goods or services and the type of goods or services which are free or discounted are included in the advertising. In the case of print advertising the usual charges for the offered good or services must appear in bold print of the same or larger type size as the offer. In the case of television or radio advertising the ad must clearly state, verbally, the usual charges for the offered goods or services.
1. The doctor must also provide a disclosure statement to be signed by the patient which explains:

- a. specifically what services or goods are free or discounted;

- b. what services or goods are not included in the free or discounted services or goods offered in the advertisement;

- c. that additional services or goods which are subject to a charge shall not be rendered until such charges are disclosed in writing to the patient and that any services or goods provided prior to such written disclosure are free.

2. The signed disclosure statement must be provided to any third party liable for payment by inclusion of the disclosure statement with the first submission of a claim for payment for services.

3. This rule shall not be construed to relate to the negotiation of fees between a chiropractor and a patient or managed care organization or to prohibit the rendering of chiropractic services pro bono.

E.1 In all circumstances covered by Subsection D of this Section, and after services or goods have been provided, the chiropractor shall provide the patient with a written statement itemizing the services or goods provided and the charges for each service or item. The patient shall be given the itemized statement even if the patient has executed an assignment of insurance benefits or payment is anticipated from a third party.

2. The chiropractor must notify any third party liable for payment if any co-payment or deductible has been waived or met by a certificate issued by the chiropractor or an agent of the chiropractor. Such notification must be in writing and submitted with the first submission of a claim for payment for services.

F. Any advertisement that mentions automobile liability insurance shall state that "policy limitations apply" and must be in bold print. Television or radio advertisements must verbally state that policy limitations apply.

#### G. Free X-rays

1. A chiropractor shall not advertise "free x-rays" unless the advertisement states that:

- a. the x-rays shall be taken only if found necessary;

- b. more than one x-ray is necessary for diagnostic purposes;

2. Free x-rays shall include a minimum of two views.

3. Additional x-rays must meet the disclosure requirements of §307.D.

H. Computer-generated or live, unsolicited telephone canvassing to prospective new patients is prohibited.

- I. Cash payments for patient referrals is prohibited.

- J. Any violation of this section shall constitute grounds for disciplinary action or penalty by the board.

K. If any part of these rules or any rule herein is declared unlawful and/or unconstitutional such determination shall not affect the validity of any other part or rule herein.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:2816(F).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Board of Chiropractic Examiners, LR 2:51 (February 1976), amended LR 5:174 (July 1979), LR 13:343 (June 1987), amended by the Department of Health and Hospitals, Board of Chiropractic Examiners, LR 15:963 (November 1989), LR 22:191 (March 1996).

### §316. Internships

Certificates of internship must be displayed in a conspicuous place in the office in which the intern practices.

**AUTHORITY NOTE:** Promulgated in accordance with R.S. 37:2806.

**HISTORICAL NOTE:** Promulgated by the Department of Health and Hospitals, Board of Chiropractic Examiners, LR 22:192 (March 1996).

### §317. X-ray Proficiency Holders

A. ...

B. Any holder of said proficiency certificate must register annually with the board on or before July 31, beginning in 1996. The board shall maintain a list of all X-ray proficiency certificate holders. Failure to register with the board on an annual basis shall result in removal of that person's name from the board's list of X-ray proficiency certificate holders.

**AUTHORITY NOTE:** Promulgated in accordance with R.S. 37:2804(C).

**HISTORICAL NOTE:** Promulgated by the Department of Health and Human Resources, Board of Chiropractic Examiners, LR 13:344 (June 1987), amended by the Department of Health and Hospitals, Board of Chiropractic Examiners, LR 22: 192 (March 1996).

### §318. Specialty Register

A. Any Doctor of Chiropractic in the state of Louisiana who holds himself or herself out to the public as being a specialist in any area must register with the Louisiana Board of Chiropractic Examiners.

B. Only those licensees holding the final certification in post-graduate training and certification programs recognized by the board may hold themselves out to the public as possessing special knowledge, skills or training. Any advertisement which states that a licensee has special training or skills or is certified in a specialty not recognized by the board is engaged in deceptive and misleading advertising practices.

C. The use of the terms "certified" in or by, or the use of letters indicating a degree or certification on stationary, letterhead, business cards or other such publication is considered advertising for the purposes of this section. Generally recognized academic credentials such as BA, BS, MS, JD, MD, Ph.D., ETC. are excepted from this rule when awarded by a college or university fully accredited by an association recognized by the Department of Health, Education and Welfare.

1. Specialty training must meet the following criteria to qualify for Registry inclusion. The course of study must:

a. be conducted under the auspices of and taught by the post-graduate faculty of a chiropractic college fully accredited by the Council on Chiropractic Education;

b. consist of a minimum of 300 hours;

c. require completion of a certification examination given by a board independent of the entity which taught the course; and

d. meet such other criteria as the board deems appropriate.

2. The Louisiana Board of Chiropractic Examiners currently (December, 1995) recognizes the following specialties for recognition and listing in the Board's Specialty Registry:

a. Diplomate of the American Board of Chiropractic Nutrition (DABCN);

b. Certified Chiropractic Sports Physicians (CCSP);

c. Diplomate, American Board of Chiropractic Orthopedists (DABCO) or Fellow of the Academy of Chiropractic Orthopedists;

d. Diplomate, American Chiropractic Board of Roentgenologists (DACBR);

e. Diplomate, American Board of Chiropractic Internists (DABCI);

f. Diplomate, American Board of Chiropractic Pediatrics (DABCP);

g. Diplomate of the American Board of Chiropractic Neurology (DABCN); or

h. Diplomate of the American Chiropractic Academy of Neurology (DACAN).

3. The National Board of Chiropractic Examiners engages in testing preliminary to testing for basic licensure. It does not engage in specialty testing. The use of the designation Diplomate of the National Board of Chiropractic Examiners, or any derivative thereof, may give the false impression of certification or credentials beyond that required of all chiropractic licensees and is considered deceptive and misleading by the Louisiana Board of Chiropractic Examiners.

4. Any additional specialties which conform to these standards may be recognized by declaratory statement by the board of examiners.

**AUTHORITY NOTE:** Promulgated in accordance with R.S. 37:2801.

**HISTORICAL NOTE:** Promulgated by the Department of Health and Hospitals, Board of Chiropractic Examiners, LR 18: 1378 (December 1992), amended LR 22:192 (March 1996).

## Chapter 5. Due Process Procedures for Ethics Violations

### §511. Processing Complaints and Inquiries

A. ...

1. ...

2. If the information in the complaint is insufficient, the board may request further information by either written correspondence or an informal inquiry.

B. - F.4. ...

**AUTHORITY NOTE:** Promulgated in accordance with R.S. 37:2804(C).

**HISTORICAL NOTE:** Promulgated by the Department of Health and Human Resources, Board of Chiropractic Examiners, LR 10:327 (April 1984), amended LR 13:344 (June 1987), amended by the Department of Health and Hospitals LR 22:192 (March 1996).

### Chapter 7. Peer Review Committee

#### §701. Purpose and Composition of Committee

A. - B. ...

C. Purpose. The purpose of the committee is to review, upon request of any party involved, any matter relative to the appropriateness of care rendered by any Doctor of Chiropractic licensed to practice and practicing in the state of Louisiana.

D. - G.2. ...

**AUTHORITY NOTE:** Promulgated in accordance with R.S. 37:2804(G).

**HISTORICAL NOTE:** Promulgated by the Department of Health and Hospitals, Board of Chiropractic Examiners, LR 15:964 (November 1989), amended LR 22:192 (March 1996).

### §703. Procedure for Review

A. - D.2. ...

E. Appeals Process. An appeal of any decision rendered by the Peer Review Committee shall, at the option of the person appealing either be:

1.a. - f. ...

2. Placed in Binding Arbitration

a. Arbitration shall be conducted by a committee of three chiropractors; one chosen by the treating chiropractor, one by the insurer, patient, or whoever constitutes the opposite party in dispute, and the third chiropractor chosen by the originally selected two. If no agreement can be reached by the original two chiropractors as to the third, within 10 days of their appointment, the board of examiners shall appoint the third chiropractor within 30 days of receiving notice of such lack of agreement. All parties involved shall agree in advance to abide by the decision of the arbitration committee.

b. - h. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:2804(G).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Chiropractic Examiners, LR 15:964 (November 1989), amended LR 17:968 (October 1991), LR 22:193 (March 1996).

### Chapter 9. Illegal Payments; Required Disclosure of Financial Interests

#### Subchapter A. (Reserved)

#### §901. Scope and Purpose of Chapter

A. Scope of Chapter. The rules of this Chapter interpret, implement and provide for the enforcement of R.S. 37:1744 and R.S. 37:1745, requiring disclosure of a chiropractic physician's financial interest in another health care provider to whom or to which the chiropractic physician refers a patient and prohibiting certain payments in return for referring or soliciting patients.

B. Declaration of Purpose; Interpretation and Application. Chiropractic physicians owe a fiduciary duty to patients to exercise their professional judgment in the best interests of their patients in providing, furnishing, prescribing, recommending, or referring patients for health care items and services, without regard to personal financial recompense. The purpose of these rules and the laws they implement is to prevent payments by or to a chiropractic physician as a financial incentive for the referral of patients to a chiropractic physician or other health care provider for diagnostic or therapeutic services or items. These rules shall be interpreted, construed and applied so as to give effect to such purposes and intent.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1744 and R.S. 37:1745.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Chiropractic Examiners, LR 22:193 (March 1996).

#### §903. Definitions and Construction

A. Definitions. As used in this Chapter:

*Board*—the Louisiana State Board of Chiropractic Examiners.

*Chiropractic Physician*—a Doctor of Chiropractic pursuant to R.S. 37:2801 et seq.

*Financial Interest*—an ownership or investment interest established through debt, equity or other means and held, directly or indirectly, by a chiropractic physician or a member of the chiropractic physician's immediate family, or any form of direct or indirect remuneration for referral.

*Group Practice*—a group of two or more chiropractic physicians or other health care providers legally organized as a general partnership, registered limited liability partnership, professional corporation, limited liability company, foundation, nonprofit corporation, faculty practice plan, or similar organization or association:

a. in which each chiropractic physician who is a member of the group provides substantially the full range of services which the chiropractic physician routinely provides, including consultation, diagnosis, or treatment, through the joint use of shared office space, facilities, equipment and personnel;

b. for which substantially all of the services of the chiropractic physicians who are members of the group are provided through the group and are billed under a billing number assigned to the group and amounts so received are treated as receipts of the group;

c. in which the overhead expenses of and the income from the practice are distributed in accordance with methods previously determined;

d. in which no chiropractic physician who is a member of the group directly or indirectly receives compensation based on the volume or value of referrals by the chiropractic physician, except payment of a share of the overall profits of the group, which may include a productivity bonus based on services personally performed or services incident to such personally performed services, so long as the share of profits or bonus is not determined in any manner which is directly related to the volume or value of referrals by such chiropractic physician;

*Health Care Item*—any substance, product, device, equipment, supplies or other tangible good or article which is or may be used or useful in the provision of health care.

*Health Care Provider*—any person licensed by a department, board, commission or other agency of the state of Louisiana to provide, or which does in fact provide, preventive, diagnostic, or therapeutic health care services or items.

*Immediate Family*—as respects a chiropractic physician, the chiropractic physician's spouse, children, parents and siblings.

*Investment Interest*—a security issued by an entity, including, without limitation, shares in a corporation, interests in or units of a partnership, bonds, debentures, notes, or other debt instruments.

*Payments*—the tender, transfer, distribution, exchange or provision of money, goods, services, or anything of economic value.

*Person*—and includes a natural person or a partnership, corporation, organization, association, facility, institution, or any governmental subdivision, department, board, commission or other entity.

*Remuneration for Referral*—any arrangement or scheme, involving any remuneration, directly or indirectly, in cash or

in kind, between a chiropractic physician, or an immediate family member of such a chiropractic physician, and other health care provider which is intended to induce referrals by the chiropractic physician to the health care provider or by the health care provider to the chiropractic physician, other than any amount paid by an employer to an employee who has a bona fide employment relationship with the employer, for employment in the furnishing of any health care item or service.

B. Construction. Masculine terms whatsoever used in this Chapter shall be deemed to include the feminine.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1744 and R.S. 37:1745.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Chiropractic Examiners, LR 22:193 (March 1996).

## **Subchapter B. Illegal Payments**

### **§905. Prohibition of Payments for Referrals**

A. A chiropractic physician shall not knowingly and willfully make or offer to make any payment, directly or indirectly, overtly or covertly, in cash or in kind, to induce another person to refer an individual to the chiropractic physician for the furnishing or arranging for the furnishing of any health care item or service.

B. A chiropractic physician shall not knowingly and willfully solicit, receive or accept any payment, directly or indirectly, overtly or covertly, in cash or in kind, in return for referring patient to a health care provider for the furnishing or arranging for the furnishing of any health care item or service.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1744 and R.S. 37:1745.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Chiropractic Examiners, LR 22:194 (March 1996).

### **§907. Exceptions**

A. Proportionate Return on Investment. Payments or distributions by an entity representing a direct return on investment based upon a percentage of ownership shall not be deemed a payment prohibited by R.S. 37:1745(B) or by §905 of these rules, provided that:

1. the amount of payment to an investor in return for the investment interest is directly proportional to the amount or value of the capital investment (including the fair market value of any pre-operational services rendered) of that investor;

2. the terms on which an investment interest was or is offered to an investor who is in a position to make or influence referrals to, furnish items or services to, or otherwise generate business for the entity must be no different from the terms offered to other investors;

3. the terms on which an investment interest was or is offered to an investor who is in a position to make or influence referrals to, furnish items or services to, or otherwise generate business for the entity must not be related to the previous or expected volume of referrals, items or services furnished, or the amount of business otherwise generated from that investor to the entity;

4. there is no requirement that an investor make referrals to, be in a position to make or influence referrals to, furnish

items or services to, or otherwise generate business for the entity as a condition for becoming or remaining an investor;

5. the entity or any investor does not market or furnish the entity's items or services to investors differently than to non-investors; and

6. the entity does not loan funds to or guarantee a loan for an investor who is in a position to make or influence referrals to, furnish items or services to, or otherwise generate business for the entity if the investor uses any part of such loan to obtain the investment interest.

B. General Exceptions. Any payment, remuneration, practice or arrangement which is not prohibited by or unlawful under §1128B(b) of the Federal Security Act (Act), 42 U.S.C. §1320a-7b(b), as amended, with respect to health care items or services for which payment may be made under Title XVIII or Title XIX of the Act, including those payments and practices sanctioned by the Secretary of the United States Department of Health and Human Services, through the Office of the Inspector General, pursuant to §1128B(b)(3)(E) of the Act, through regulations promulgated at 42 C.F.R. §1001.952, as the same may hereafter be amended, shall not be deemed a payment prohibited by R.S. 37:1745(B) or by §905 of these rules with respect to health care items or services for which payment may be made by any patient or private or governmental payor.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1744 and R.S. 37:1745.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Chiropractic Examiners, LR22:194 (March 1996).

### **§909. Effect of Violation**

Any violation of or failure of compliance with the prohibitions and provisions of §905 of this Chapter shall be deemed a violation of the Chiropractic Practice Act, R.S. 37:2801 et seq., as applicable, providing cause for the board to suspend or revoke, refuse to issue, or impose probationary or other restrictions on any license or permit held or applied for by a chiropractic physician culpable of such violation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1744 and R.S. 37:1745.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Chiropractic Examiners, LR 22:194 (March 1996).

## **Subchapter C. Disclosure of Financial Interests in Third-Party Health Care Providers**

### **§911. Required Disclosure of Financial Interest**

Mandatory Disclosure. A chiropractic physician shall not make any referral of a patient outside the chiropractic physician's group practice for the provision of health care items or services by another health care provider in which the referring chiropractic physician has a financial interest (as defined by §903.A), unless, in advance of any referral, the referring chiropractic physician discloses to the patient, in accordance with §915 of this Chapter, the existence and nature of such financial interest.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1744 and R.S. 37:1745.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Chiropractic Examiners, LR 22:194 (March 1996).

**§913. Prohibited Arrangements**

Any arrangement or scheme, including cross-referral arrangements, which a chiropractic physician knows or should know has a principal purpose of ensuring or inducing referrals by the chiropractic physician to another health care provider, which, if made directly by the chiropractic physician would be a violation of §911, shall constitute a violation of §911.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1744 and R.S. 37:1745.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Chiropractic Examiners, LR 22:195 (March 1996).

**§915. Form of Disclosure**

A. Required Contents. The disclosure required by §911 of this Chapter shall be made in writing, shall be furnished to the patient, or the patient's authorized representative, prior to or at the time of making referral, and shall include:

1. the chiropractic physician's name, address and telephone number;
2. the name and address of the health care provider to whom the patient is being referred by the chiropractic physician;
3. the nature of the items or services which the patient is to receive from the health care provider to which the patient is being referred; and
4. the existence and nature of the chiropractic physician's financial interest in the health care provider to which the patient is being referred.

B. Permissible Contents. The form of disclosure required by §911 of this Chapter may include a signed acknowledgment by the patient or the patient's authorized representative that the required disclosure has been given.

C. Approved Form. Notice to a patient given substantially in the form of the Disclosure of Financial Interest form, which may be obtained from the Board of Examiners, shall be presumptively deemed to satisfy the disclosure requirements of this Subchapter.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1744 and R.S. 37:1745.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Chiropractic Examiners, LR 22:195 (March 1996).

**§917. Effect of Violation; Sanctions**

A. Effect of Violation. Any violation of or failure of compliance with the prohibitions and provisions of §911 of this Chapter shall be deemed a violation of the Chiropractic Practice Act, R.S. 37:2801 et seq., as applicable, providing cause for the board to suspend or revoke, refuse to issue, or impose probationary or other restrictions on any license or permit held or applied for by a chiropractic physician culpable of such violation.

B. Administrative Sanctions. In addition to the sanctions provided for by §917, upon proof of violation of §911 by a chiropractic physician, the board may order that all or any portion of any amounts paid by a patient, for health care items or services furnished upon a referral by the chiropractic physician in violation of §911, be refunded by the chiropractic physician to such patient and/or third-party payor, together with legal interest on such payments at the rate prescribed by

law calculated from the date on which any such payment was made by the patient and/or third party-payors.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1744 and R.S. 37:1745.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Chiropractic Examiners, LR 22:195 (March 1996).

Dr. Salvatore R. Giangrosso  
Board President

9603#010

**RULE**

**Department of Health and Hospitals  
Board of Medical Examiners**

**Clinical Laboratory Personnel (LAC 46:XLV.Chapter 111)**

Notice is hereby given, in accordance with R.S. 49:950 et seq., that the Board of Medical Examiners (board), pursuant to the authority vested in the board by R.S. 37:1311-1329 and 37:1270(A)(5), and the provisions of the Administrative Procedure Act, and on the recommendation of the Clinical Laboratory Personnel Committee constituted under R.S. 37:1314, hereby adopts rules governing the investigation of complaints, reports and information evidencing legal cause under the Louisiana Clinical Laboratory Personnel law for the suspension, revocation, imposition of probation on or other disciplinary action against persons holding licenses, certifications or permits under the Louisiana Clinical Laboratory Personnel law and the initiation of formal enforcement proceedings and adjudication of administrative complaints by the Clinical Laboratory Personnel Committee and the Louisiana State Board of Medical Examiners. LAC 46:XLV, Subpart 5, Chapter 111, §§11101-11145.

**Title 46**

**PROFESSIONAL AND OCCUPATIONAL  
STANDARDS**

**Part XLV. Medical Profession**

**Subpart 5. Rules of Procedure**

**Chapter 111. Clinical Laboratory Personnel**

**§11101. Scope of Chapter**

The rules of this Chapter prescribe the procedures governing the investigation of complaints, reports and information evidencing legal cause under the Louisiana Clinical Laboratory Personnel law for the suspension, revocation, imposition of probation on or other disciplinary action against persons holding licenses, certifications or permits under the Louisiana Clinical Laboratory Personnel law and the initiation of formal enforcement proceedings and adjudication of administrative complaints by the Clinical Laboratory Personnel Committee and the Louisiana State Board of Medical Examiners.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1311-1329 and R.S. 37:1270(A)(5).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 22:195 (March 1996).

### §11103. Definitions

As used in this Chapter:

*Board*—the Louisiana State Board of Medical Examiners.

*Committee*—the Clinical Laboratory Personnel Committee to the Louisiana State Board of Medical Examiners, as established and constituted under R.S. 37:1314.

*Law*—the Louisiana Clinical Laboratory Personnel Law, R.S. 37:1311-1329, as the same may be amended hereafter.

*Licensee*—a person who holds a license, certification or permit issued by the board, on the recommendation of the committee, under the law.

*Respondent*—a licensee who has been named in an administrative complaint filed with the committee, alleging cause under the law for revocation, suspension or the imposition of probation on the license, certification or permit of the licensee.

**AUTHORITY NOTE:** Promulgated in accordance with R.S. 37:1311-1329 and R.S. 37:1270(A)(5).

**HISTORICAL NOTE:** Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 22:196 (March 1996).

### §11105. Investigation

A. Upon receipt of information, by complaint, report or otherwise coming to its attention, which, if established as true, would constitute legal cause under the law for the revocation, suspension or the imposition of probation on the license, certification or permit of a licensee, the committee may designate one or more of its members, employees or agents as "investigating officers," to conduct such investigation or inquiry as they may deem appropriate to determine whether there is probable cause to initiate formal administrative proceedings against the subject licensee. To obtain evidence of violations of the law or otherwise to aid in an investigation, investigating officers may request that the board issue and serve investigative subpoenas to obtain documents or sworn testimony by deposition.

B. Except to the extent that disclosure of an investigation to the subject licensee would, in the judgment of the investigating officers, prejudice the investigation, notice of the initiation and pendency of an investigation, stating the nature and basis of the information prompting the investigation, shall promptly be given in writing to the subject licensee, who shall be requested and given an opportunity to respond to the complaint or other information giving rise to the investigation.

**AUTHORITY NOTE:** Promulgated in accordance with R.S. 37:1311-1329 and R.S. 37:1270(A)(5).

**HISTORICAL NOTE:** Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 22:196 (March 1996).

### §11107. Disposition of Investigation

A. If, having conducted an investigation, the investigating officers determine that there is probable cause to believe that a licensee has engaged or is engaging in conduct, acts or omissions constituting legal cause under the law for the revocation, suspension or the imposition of probation on the license, certification or permit of the subject licensee, the investigating officers shall file with the committee an administrative complaint against the licensee pursuant to

§11109. Before filing an administrative complaint with the committee, the investigating officers shall give notice by mail to the subject licensee of the intent to file an administrative complaint, including a copy of the proposed complaint or statement of the facts or conduct which the investigating officers believe warrant the initiation of enforcement proceedings by administrative complaint, and the licensee shall be given a reasonable opportunity to show compliance with all lawful requirements for the retention of licensure and to persuade the investigating officers that an administrative complaint is not justified or warranted.

B. If, having conducted an investigation, the investigating officers determine that there is insufficient evidence to establish legal cause for formal action by the committee, the investigating officers may recommend to the committee that the investigation be dismissed or concluded without formal action.

C. Investigating officers may also recommend that an investigation be concluded or otherwise disposed of pursuant to consent order or other informal disposition which has been agreed to in writing by the licensee.

**AUTHORITY NOTE:** Promulgated in accordance with R.S. 37:1311-1329 and R.S. 37:1270(A)(5).

**HISTORICAL NOTE:** Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 22:196 (March 1996).

### §11109. Complaint

A. Proceedings to adjudicate an administrative enforcement action shall be initiated by the filing of a written administrative complaint with the committee. The complaint shall be signed by investigating officers appointed and designated by the committee with respect to the subject matter of the complaint and shall name the accused licensee as respondent in the proceedings.

B. The complaint shall set forth, in separately numbered paragraphs, a concise statement of the material facts and matters alleged and to be proven by the investigating officers including the facts giving rise the committee's jurisdiction over the respondent, the facts constituting legal cause under law for administrative action against the respondent, and the statutory or regulatory provisions alleged to have been violated by respondent. The complaint shall conclude with a request for the administrative sanction or other relief sought by the investigating officers and shall bear the name, address and telephone number of complaint counsel, if any, engaged by the committee to present the case at evidentiary hearing before the committee. The complaint shall also contain the certificate of the investigating officer that the requirements of §11107.A of these Rules and of R.S. 37:916(C) have been satisfied.

**AUTHORITY NOTE:** Promulgated in accordance with R.S. 37:1311-1329 and R.S. 37:1270(A)(5).

**HISTORICAL NOTE:** Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 22:196 (March 1996).

### §11111. Notice of Hearing

A. Upon the filing of an administrative complaint pursuant to §11109, the committee shall docket the complaint and schedule the complaint for hearing before the committee not



less than 45 days nor more than 180 days thereafter; provided, however, that such time may be lengthened or shortened as the committee determines may be necessary or appropriate to protect the public interest or upon motion of the investigating officer or respondent pursuant to a showing of proper grounds. In the event that the respondent's license, permit, certification or registration has been suspended by the board pending hearing on the recommendation of the committee, pursuant to R.S. 49:961(C), evidentiary hearing on the complaint shall be noticed and scheduled not more than 45 days after the filing of the complaint.

B. A written notice of the complaint and the time, date and place of the scheduled hearing thereon shall be served upon the respondent by registered, return-receipt-requested mail, as well as by regular first class mail, at the most current address for the respondent reflected in the official records of the committee, or by personal delivery of the complaint to the respondent. The notice shall include a statement of the legal authority and jurisdiction under which the hearing is to be held and shall be accompanied by a certified copy of the administrative complaint.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1311-1329 and R.S. 37:1270(A)(5).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 22:196 (March 1996).

#### **§11113. Response to Complaint; Notice of Representation**

A. Within 15 days of service of the complaint, or such longer time as the committee, on motion of the respondent, may permit, the respondent may answer the complaint, admitting or denying each of the separate allegations of fact and of law set forth therein. Any matters admitted by respondent shall be deemed proven and established for purposes of adjudication. In the event that respondent does not file a response to the complaint, all matters asserted therein shall be deemed denied.

B. Any respondent may be represented in an adjudication proceeding before the committee by an attorney at law duly admitted to practice in any state. Upon receipt of service of a complaint pursuant to this Chapter, or thereafter, a respondent who is represented by legal counsel with respect to the proceeding shall, personally or through such counsel, give written notice to the committee of the name, address and telephone number of such counsel. Following receipt of proper notice of representation, all further notices, complaints, subpoenas, orders or other process related to the proceeding shall be served on respondent through his or her designated counsel of record.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1311-1329 and R.S. 37:1270(A)(5).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 22:197 (March 1996).

#### **§11115. Pleadings, Motions; Service**

A. All pleadings, motions or other papers permitted or required to be filed with the committee in connection with a pending adjudication proceeding shall be filed by personal delivery at or by mail to the office of the committee and shall

by the same method of delivery be concurrently served upon complaint counsel designated by the complaint, if filed by or on behalf of respondent, or upon respondent, through counsel of record, if any, if filed by complaint counsel.

B. All such pleadings, motions or other papers shall be submitted on plain white, letter-size (8½ by 11 inches) bond, with margins of at least one inch on all sides and text double-spaced except as to quotations and other matter customarily single-spaced, shall bear the caption and docket number of the case as it appears on the complaint and shall include the certificate of the attorney or person making the filing that service of a copy of the same has been effected in the manner prescribed by Subsection A of this Section.

C. The committee may refuse to accept for filing any pleading, motion or other paper not conforming to the requirements of this section.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1311-1329 and R.S. 37:1270(A)(5).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 22:197 (March 1996).

#### **§11117. Prehearing Motions**

Motions for continuance of hearing, for dismissal of the proceeding and all other prehearing motions shall be filed not later than 30 days following service of the complaint on the respondent or 15 days prior to the hearing, whichever is earlier. Each prehearing motion shall be accompanied by a memorandum which shall set forth a concise statement of the grounds upon which the relief sought is based and the legal authority therefor. A motion may be accompanied by an affidavit as necessary to establish facts alleged in support of the motion. Within 10 days of the filing of any such motion and memorandum or such shorter time as the committee may order, the investigating officers, through complaint counsel, may file a memorandum in opposition to or otherwise setting forth the investigating officers' position with respect to the motion.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1311-1329 and R.S. 37:1270(A)(5).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 22:197 (March 1996).

#### **§11119. Motions for Continuance of Hearing**

A. A motion for continuance of hearing shall be filed within the delay prescribed by §11117 of these rules, provided that the committee may accept the filing of a motion for continuance at any time prior to hearing upon a showing of good cause not discoverable within the time otherwise provided for the filing of prehearing motions.

B. A scheduled hearing may be continued by the committee only upon a showing by respondent or complaint counsel that there are substantial legitimate grounds that the hearing should be continued balancing the right of the respondent to a reasonable opportunity to prepare and present a defense to the complaint and the committee's responsibility to protect the public health, welfare and safety. Except in extraordinary circumstances evidenced by verified motion or accompanying affidavit, the committee will not ordinarily

grant a motion to continue a hearing that has been previously continued upon motion of the same party.

C. If an initial motion for continuance is not opposed, it may be granted by the investigating officers.

**AUTHORITY NOTE:** Promulgated in accordance with R.S. 37:1311-1329 and R.S. 37:1270(A)(5).

**HISTORICAL NOTE:** Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 22:197 (March 1996).

#### **§11121. Disposition of Prehearing Motions**

A. Any prehearing motion, other than an unopposed initial motion for continuance of hearing which may be granted by the investigating officers, shall be referred for decision to the presiding officer of the hearing panel designated with respect to the proceeding for ruling. The presiding officer, in his discretion, may refer any prehearing motion to the entire panel for disposition, and any party aggrieved by the decision of a presiding officer on a prehearing motion may request that the motion be reconsidered by the entire panel.

B. Prehearing motions shall ordinarily be ruled upon by the presiding officer or the hearing panel, as the case may be, on the papers filed, without hearing. On the written request of respondent or of complaint counsel, however, and on demonstration that there are good grounds therefor, the presiding officer may grant opportunity for hearing, by oral argument, on any prehearing motion.

**AUTHORITY NOTE:** Promulgated in accordance with R.S. 37:1311-1329 and R.S. 37:1270(A)(5).

**HISTORICAL NOTE:** Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 22:198 (March 1996).

#### **§11123. Subpoenas for Hearing**

A. Upon request of the respondent or complaint counsel and compliance with the requirements of this section, the executive director of the board shall sign and issue subpoenas in the name of the board requiring the attendance and giving of testimony by witnesses and the production of books, papers, and other documentary evidence at an adjudication hearing.

B. No subpoena shall be issued unless and until the party who wishes to subpoena the witness first deposits with the board a sum of money sufficient to pay all fees and expenses to which a witness in a civil case is entitled pursuant to R.S. 13:3661 and R.S. 13:3671. Witnesses subpoenaed to testify before the committee only to an opinion founded on special study or experience in any branch of science, or to make scientific or professional examinations, and to state the results thereof, shall receive such additional compensation from the party who wishes to subpoena such witnesses as may be fixed by the committee with reference to the value of the time employed and the degree of learning or skill required.

**AUTHORITY NOTE:** Promulgated in accordance with R.S. 37:1311-1329 and R.S. 37:1270(A)(5).

**HISTORICAL NOTE:** Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 22:198 (March 1996).

#### **§11125. Prehearing Conference**

A. In any case of adjudication noticed and docketed for hearing, counsel for respondent and complaint counsel may

agree, or the presiding officer may require, that a prehearing conference be held among such counsel, or together with the committee's independent counsel appointed pursuant to §11127.D hereof, for the purpose of simplifying the issues for hearing and promoting stipulations as to facts and proposed evidentiary offerings which will not be disputed at hearing.

B. Following such prehearing conference the parties shall, and without such conference the parties may by agreement, agree in writing on a prehearing stipulation which should include:

1. a brief statement by complaint counsel as to what such counsel expects the evidence to be presented against respondent to show;

2. a brief statement by respondent as to what the evidence and arguments in defense are expected to show;

3. a list of the witnesses to be called by complaint counsel and by respondent, together with a brief general statement of the nature of testimony each such witness is expected to give;

4. any stipulations which the parties may be able to agree upon concerning undisputed claims, facts, testimony, documents, or issues; and

5. an estimate of the time required for the hearing.

**AUTHORITY NOTE:** Promulgated in accordance with R.S. 37:1311-1329 and R.S. 37:1270(A)(5).

**HISTORICAL NOTE:** Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 22:198 (March 1996).

#### **§11127. Conduct of Hearing; Record**

A. Unless requested by the respondent, adjudication hearings shall be conducted in closed session.

B. At an adjudication hearing, opportunity shall be afforded to complaint counsel and respondent to present evidence on all issues of fact and argument on all issues of law and policy involved, to call, examine and cross-examine witnesses, and to offer and introduce documentary evidence and exhibits as may be required for a full and true disclosure of the facts and disposition of the complaint.

C. Unless stipulation is made between the parties, and approved by the hearing panel, providing for other means of recordation, all testimony and other proceedings of an adjudication shall be recorded by a certified stenographer who shall be retained by the board to prepare a written transcript of such proceedings.

D. During evidentiary hearing, the presiding officer shall rule upon all evidentiary objections and other procedural questions, but in his discretion may consult with the entire panel in executive session. At any such hearing, the committee may be assisted by legal counsel, retained by the committee for such purpose, who is independent of complaint counsel and who has not participated in the investigation or prosecution of the case. If the committee or panel is attended by such counsel, the presiding officer may delegate to such counsel ruling on evidentiary objections and other procedural issues raised during the hearing.

E. The record in a case of adjudication shall include:

1. the administrative complaint and notice of hearing, respondent's response to the complaint, if any, subpoenas issued in connection with discovery in the case or hearing of

the adjudication, and all pleadings, motions, and intermediate rulings;

2. evidence received or considered at the hearing;
3. statement of matters officially noticed except matters so obvious that statement of them would serve no useful purpose;
4. offers of proof, objections, and rulings thereon;
5. proposed findings and exceptions, if any;
6. the decision, opinion, report or other disposition of the case made by the committee.

E. Findings of fact shall be based exclusively on the evidence of record and on matters officially noticed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1311-1329 and R.S. 37:1270(A)(5).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 22:198 (March 1996).

#### **§11129. Evidence**

A. In an adjudication hearing, the committee, or the designated hearing panel thereof, may give probative effect to evidence which possesses probative value commonly accepted by reasonably prudent men in the conduct of their affairs. Effect shall be given to the rules of privilege recognized by law. The committee or panel may exclude incompetent, irrelevant, immaterial, and unduly repetitious evidence. Objections to evidentiary offers may be made and shall be noted in the record. Subject to these requirements, when a hearing will be expedited and the interests of the parties will not be prejudiced substantially, any part of the evidence may be received in written form

B. All evidence, including records and documents in the possession of the committee which complaint counsel desires the committee to consider, shall be offered and made a part of the record, and all such documentary evidence may be received in the form of copies or excerpts, or by incorporation by reference. In case of incorporation by reference, the materials so incorporated shall be available for examination by the respondent before being received in evidence.

C. Notice may be taken of judicially cognizable facts and of generally recognized technical or scientific facts within the committee's professional knowledge. Parties shall be notified either before or during the hearing of the material noticed or sought by a party to be noticed, and they shall be afforded an opportunity to contest the material so noticed. The committee's professional experience, technical competence and knowledge may be utilized in the evaluation of the evidence.

D. Any member of the committee serving as presiding officer in an adjudication hearing shall have the power to and shall administer oaths or affirmations to all witnesses appearing to give testimony, shall regulate the course of the hearing, set the time and place for continued hearings, fix the time for the filing of briefs and other documents, if any are required or requested, and may direct the parties to appear and confer to consider simplification of the issues.

E. Except as otherwise governed by the provisions of these rules, adjudication hearings before the committee shall be governed by the Louisiana Code of Evidence, insofar as the same may be applied.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1311-1329 and R.S. 37:1270(A)(5).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 22:199 (March 1996).

#### **§11131. Informal Disposition**

The committee may recommend to the board an informal disposition, by default, consent order, agreement, settlement, or otherwise of any adjudication pending before it. A consent order shall be considered by the committee only upon the recommendation of the investigating officers.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1311-1329 and R.S. 37:1270(A)(5).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 22:199 (March 1996).

#### **§11133. Recommended Decisions; Notice**

A. The recommended decision of the committee in an adjudication proceeding shall be set forth in writing, shall include findings of fact and conclusions of law, and shall be signed by the presiding officer of the hearing panel on behalf and in the name of the committee.

B. Upon issuance of a recommended decision, a certified copy thereof shall promptly be served upon respondent's counsel of record, or upon respondent personally in the absence of counsel, in the same manner of service prescribed with respect to service of complaints.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1311-1329 and R.S. 37:1270(A)(5).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 22:199 (March 1996).

#### **§11135. Rehearings**

A. A recommended decision by the committee in a case of adjudication shall be subject to rehearing, reopening, or reconsideration by the committee pursuant to written motion filed with the committee within 10 days from service of the recommended decision on respondent. A motion for rehearing, reopening, or reconsideration shall be made and served in the form and manner prescribed by §11115 and shall set forth the grounds upon which such motion is based, as provided by Subsection B of this Section.

B. The committee may grant rehearing, reopening, or reconsideration if it is shown that:

1. the recommended decision is clearly contrary to the law and the evidence;
2. the respondent has discovered since the hearing evidence important to the issues which he or she could not have with due diligence obtained before or during the hearing;
3. other issues not previously considered ought to be examined in order properly to dispose of the matter; or
4. there exists other good grounds for further consideration of the issues and the evidence in the public interest.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1311-1329 and R.S. 37:1270(A)(5).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 22:199 (March 1996).

**§11137. Effect of Recommended Decision; Appeal to Board**

A. A recommended decision of the committee shall be adopted by the board and become final and effective, subject to appeal as hereinafter provided, 20 days after the date of its service on the respondent if no rehearing has been sought or 20 days after the committee issues its decision following a timely request for rehearing or reconsideration, whichever is later.

B. A recommended decision of the committee which is timely appealed shall not become effective as to the respondent until such recommended decision is adopted by the board.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1311-1329 and R.S. 37:1270(A)(5).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 22:200(March 1996).

**§11139. Appeal of Recommended Decision**

A. A respondent may appeal a recommended decision of the committee by giving written notice of intent to appeal to the board, the committee and the investigating officers prior to the date on which such recommended decision would become final pursuant to §11137.A.

B. Upon receipt of a notice of appeal, the committee shall promptly transmit to the board the entire hearing record.

C. Following service of notice of appeal, on such date as may be designated by the board, the respondent and the investigating officers shall appear before the board, in person or through legal counsel and/or other representative, and shall be entitled to make such relevant representations and arguments as they deem appropriate.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1311-1329 and R.S. 37:1270(A)(5).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 22:200(March 1996).

**§11141. Conduct of Appeal Before Board**

A. A respondent who fails without good cause, as determined by the board, to appear and proceed at appeal proceedings shall be deemed to have waived his right to appeal.

B. Appeal of a recommended decision of the committee shall be confined to the record of the hearing and the issues addressed and determined therein.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1311-1329 and R.S. 37:1270(A)(5).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 22:200(March 1996).

**§11143. Decision by Board**

A. The board shall adopt the recommended decision of the committee as its own if the respondent has not appealed such decision.

B. Upon appeal of a recommended decision of the committee, the board shall consider the entire hearing record together with the representations and arguments made before it by the respondent and the investigating officers and render

its decision thereon as soon as practicable following conclusion of the appeal proceedings.

C. The board may affirm and adopt, reverse, or modify and adopt the recommended decision of the committee.

D. The decision of the board shall be given in writing, including a statement of the basis and reasons for the decision, dated and subscribed by the president of the board or other presiding officer. A copy of the decision shall be served on the respondent by certified mail, return-receipt-requested, and delivered to the investigating officers and the committee.

E. The decision of the board shall become final and effective 10 days after the date of its service on the respondent, subject to reconsideration by the board as hereinafter provided.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1311-1329 and R.S. 37:1270(A)(5).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 22:200(March 1996).

**§11145. Reconsideration on Appeal**

A. A decision by the board pursuant to a recommended decision by the committee in a case of adjudication shall be subject to reconsideration by the board pursuant to written motion filed with the board within 10 days from service of the board's decision on respondent. A motion for reconsideration shall be made and served in the form and manner prescribed by §11115 and shall set forth the grounds upon which such motion is based, as provided by Subsection B of this Section.

B. The board may grant reconsideration if it is shown that:

1. the decision is clearly contrary to the law and the evidence;
2. other issues not previously considered ought to be examined in order properly to dispose of the matter; or
3. there exists other good grounds for further consideration of the issues and the evidence in the public interest.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1311-1329 and R.S. 37:1270(A)(5).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 22:200(March 1996).

Delmar Rorison  
Executive Director

9603#011

**RULE**

**Department of Health and Hospitals  
Board of Medical Examiners**

Physician Assistants Licensing, Certification and Practice  
(LAC 46:XLV.Chapters 15 and 45)

The Board of Medical Examiners, pursuant to the authority vested in the board by R.S. 37:1270(B)(6) and 37:1360.23(D), (F), and in accordance with applicable provisions of the Administrative Procedure Act, has amended to its rules governing the certification and practice of physician

assistants, LAC 46:XLV, Subpart 2, Chapter 15, §§1501-1519, Subpart 3, Chapter 45, §§4501-4515, to conform such rules to the statutory law providing for the licensing and regulation of practice of physician assistants, as amended by Acts 1993, No. 662, and Acts 1995, No. 879, R.S. 37:1360.21-1360.38. The rule amendments were proposed for by Notice of Intent published in the *Louisiana Register*, Volume 21, Number 11, November 20, 1995, pages 1283-84. In consideration of public comments on the rules, the board has made revisions to the proposed amendments. The text of the final rules, as amended by the board, is set forth below.

## Title 46

### PROFESSIONAL AND OCCUPATIONAL STANDARDS

#### Part XLV. Medical Profession

#### Subpart 2. Licensing and Certification

#### Chapter 15. Physician Assistants

#### §1501. Scope of Chapter

These rules govern the licensure of physician assistants in the state of Louisiana.

**AUTHORITY NOTE:** Promulgated in accordance with R.S. 37:1270(B)(6), R.S. 37:1360.23(D), (F).

**HISTORICAL NOTE:** Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 4:109 (April 1978), amended LR 17:1102 (November 1991), LR 22:201 (March 1996).

#### §1503. Definitions

As used in this Chapter, the following terms shall have the meanings specified:

*Advisory Committee*—the Louisiana State Board of Medical Examiners Physician Assistants Advisory Committee constituted under R.S. 37:1270.1.

*Applicant*—a person on whose behalf the board has received an application for licensure as a physician assistant.

*Approved Application*—all of the information, representations, terms, restrictions, and documents contained in or submitted with an application upon which the Board has issued a physician assistant license.

*Board*—the Louisiana State Board of Medical Examiners.

*Independent Medical Judgment*—the implementation or effectuation of any medical determination, where such determination is made without the informed concurrence of a physician responsible to the patient for such determination.

*Locum Tenens Physician*—a qualified physician who will assume the obligations and responsibilities of the supervising physician when the supervising physician is absent or unavailable as a result of illness, medical emergency or other causes.

*Physician*—a person possessing a current license to practice medicine in the state of Louisiana.

*Physician Assistant*—a person possessing a current physician assistant license issued under this Chapter.

*Physician Assistant—Certified (PA-C)*—a physician assistant who is currently certified by the National Commission on Certification of Physicians' Assistants (NCCPA) or its successors.

*Supervising Group of Physicians or Supervising Group*—a professional partnership, professional corporation, or other professional, physician-owned entity approved by and

registered with the board under this Chapter to supervise one or more physician assistants.

*Supervising Physician*—a person approved by and registered with the board under this Chapter to supervise a physician assistant.

**AUTHORITY NOTE:** Promulgated in accordance with R.S. 37:1270(B)(6), R.S. 37:1360.23(D), (F).

**HISTORICAL NOTE:** Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 4:109 (April 1978), amended LR 17:1102 (November 1991), LR 22:201 (March 1996).

#### §1505. Necessity for License

A. No person may act as or undertake to perform the functions of a physician assistant unless he has in his personal possession a current physician assistant license issued to him under this Chapter.

B. Any person who acts or undertakes to perform the functions of a physician assistant without a current physician assistant license issued under this Chapter shall be deemed to be engaging in the practice of medicine; provided, however, that none of the provisions of this Chapter shall apply to:

1. any person employed by, and acting under the supervision and direction of, any commissioned physician or surgeon of the United States Armed Services, or Public Health Services, practicing in the discharge of his official duties;
2. practitioners of allied health fields, duly licensed, certified, or registered under other laws of this State, when practicing within the scope of such license, certificate or registration.

**AUTHORITY NOTE:** Promulgated in accordance with R.S. 37:1270(B)(6), R.S. 37:1360.23(D), (F).

**HISTORICAL NOTE:** Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 4:109 (April 1978), amended LR 17:1102 (November 1991), LR 22:201 (March 1996).

#### §1507. Qualifications for Licensure

A. To be eligible for licensure under this Chapter, an applicant shall:

1. be at least 20 years of age;
2. be of good moral character;
3. demonstrate his competence to provide patient services under the supervision and direction of a supervising physician by:

a. presenting to the board a valid diploma certifying that the applicant is a graduate of a physician assistant training program accredited by the Committee on Allied Health Education and Accreditation (CAHEA), or its successors, and by presenting or causing to be presented to the board satisfactory evidence that the applicant has successfully passed the national certificate examination administered by the National Commission on Certification of Physicians' Assistants (NCCPA) or its successors, together with satisfactory documentation of current certification or recertification by said Commission; or

b. presenting to the board a valid, current physician assistant license, certificate or permit issued by any other state of the United States; provided, however, that the board is satisfied that the certificate, license or permit presented was issued upon qualifications and other requirements substantially equivalent to the qualifications and other requirements set forth in this Chapter;

4. certifying that he is mentally and physically able to engage in practice as a physician assistant;

5. not, as of the date of application or the date on which it is considered by the board, being subject to discipline, revocation, suspension, or probation of certification or licensure in any jurisdiction for cause resulting from the applicant's practice as a physician assistant; provided, however, that this qualification may be waived by the board in its sole discretion.

B. The burden of satisfying the board as to the eligibility of the applicant for licensure shall be upon the applicant.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270(B)(6), R.S. 37:1360.23(D), (F).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 4:109 (April 1978), amended LR 17:1102 (November 1991), LR 22:201 (March 1996).

#### **§1508. Qualifications for Registration as Supervising Physician**

A. To be eligible for approval and registration under this Chapter, a proposed supervising physician shall, as of the date of the application:

1. hold an unrestricted license to practice medicine in the state of Louisiana; and

2. have been in the active practice of medicine for not less than five years following the date on which the physician was awarded a doctor of medicine or doctor of osteopathy degree;

3. have been in active practice for at least two years following the completion of any postgraduate medical residency program; or

4. hold current certification by a member board of the American Board of Medical Specialties or hold current status as a Candidate for Certification, as defined by such boards, having completed all required education and credentials approval and having passed the qualifying examination therefor, with such status being confirmed in writing by an American Specialty Board.

B. The burden of satisfying the board as to the eligibility of the proposed supervising physician for approval and registration shall be upon the proposed supervising physician.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270(b)(6), R.S. 37:1360.23(D), (F).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 22:202 (March 1996).

#### **§1509. Application for Licensure; Procedure**

A. Application for licensure as a physician assistant must be made upon forms supplied by the board and must include:

1. proof, documented in a form satisfactory to the board that the applicant possesses the qualifications set forth in §1507 of this Chapter;

2. an affidavit, notarized and properly executed by the applicant, certifying the truthfulness and authenticity of all information, representations and documents contained in or submitted with the completed application;

3. payment of a fee of \$155.00, of which the sum of \$20.00 will represent a nonrefundable processing fee; and

4. such other information and documentation as the board may require.

B. A personal interview of a physician assistant applicant

by a member of the board or its designee may be required by the board, as a condition of licensure, with respect to:

1. an initial application for licensure where discrepancies exist in the application; or

2. an applicant who has been the subject of prior adverse licensure, certification or registration action in any jurisdiction.

C. All documents required to be submitted to the board must be the original or certified copy thereof. For good cause shown, the board may waive or modify this requirement.

D. The board may reject or refuse to consider any application which is not complete in every detail, including submission of every document required by the application form. The board may in its discretion require a more detailed or complete response to any request for information set forth in the application form as a condition to consideration of an application.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270(B)(6), R.S. 37:1360.23(D), (F).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 4:110 (April 1978), amended LR 17:1103 (November 1991), LR 22:202 (March 1996).

#### **§1510. Application for Registration as Supervising Physician; Procedure**

A. Application for approval and registration as a supervising physician must be made upon forms supplied by the board and must include:

1. a detailed description of the proposed supervising physician's professional background and specialty, if any; the nature and scope of his medical practice; the geographic and demographic characteristics of his medical practice; the address or location of the primary office where the physician assistant is to practice and be supervised;

2. a description of the way in which the physician assistant will be utilized as a physician assistant, and the methods to be used by the proposed supervising physician to insure responsible direction and control of the activities of the physician assistant;

3. a statement that the physician will exercise supervision over the physician assistant in accordance with any rules and regulations adopted by the board and that the physician will retain professional and legal responsibility for the care rendered by the physician assistant;

4. an affidavit, notarized and properly executed by the proposed supervising physician, certifying the truthfulness and authenticity of all information, representations and documents contained in or submitted with the completed application;

5. payment of a fee of \$75, of which the sum of \$20 will represent a nonrefundable processing fee; and

6. such other information and documentation as the board may require.

B. A physician seeking to supervise a physician assistant shall be required to appear before the board upon his notification to the board of his intention to supervise a physician assistant:

1. upon a first notification to the board of the physician's intention to supervise a physician's assistant if the board finds discrepancies in the physician's application; or

2. if the physician has been the subject of prior adverse licensure, certification or registration action in any jurisdiction.

C. All documents required to be submitted to the board must be the original or certified copy thereof. For good cause shown, the board may waive or modify this requirement.

D. The board may reject or refuse to consider any application which is not complete in every detail, including submission of every document required by the application form. The board may in its discretion require a more detailed or complete response to any request for information set forth in the application form as a condition to consideration of an application.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270(B)(6), R.S. 37:1360.23(D), (F).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 22:202 (March 1996).

#### **§1511. Physician Assistant Advisory Committee**

A. The Advisory Committee shall be authorized to advise the board on all matters specifically dealing with licensing or disciplining of physician assistants or the drafting and promulgating of regulations relating to physician assistants. The Advisory Committee shall also review and make recommendations to the board on applications for licensure as physician assistants.

B. The Advisory Committee shall meet not less than twice each calendar year, or more frequently as may be deemed necessary or appropriate and as approved by the board, at the call of and at such time and place as may be noticed by its chairman.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270(B)(6), R.S. 37:1360.23(D), (F).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 4:110 (April 1978), amended LR 17:1103 (November 1991), LR 22:203 (March 1996).

#### **§1513. Issuance of License; Working Permit**

A. If the qualifications, requirements and procedures of §§1507 and 1509 are met to the satisfaction of the board, the board shall license the applicant as a physician assistant.

B. The board may grant a working permit (temporary license), valid and effective for one year but renewable for one additional year, to an applicant who otherwise meets the qualifications for licensure, except that the applicant has not yet taken or is awaiting the results of the national certification examination.

C. A working permit shall expire and become null and void on the date on which:

1. the results of the applicant's national certifying examination are available and the applicant has failed to pass such examination; or

2. the board takes final action on the applicant's application for licensure.

D. Every license or permit issued under this Chapter is expressly subject to the terms, restrictions and limitations set forth in the approved application.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270(B)(6), R.S. 37:1360.23(D), (F).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 4:110 (April 1978), amended LR 17:1103 (November 1991), LR 22:203 (March 1996).

#### **§1514. Issuance of Approval as Supervising Physician**

If all the qualifications, requirements and procedures of §§1508 and 1510 are met to the satisfaction of the board, the board shall approve and register a physician as a supervising physician.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270(B)(6), R.S. 37:1360.23(D), (F).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 22:203 (March 1996).

#### **§1515. Consent to Examination; Waiver of Privileges; Examining Committee of Physicians**

A. An applicant or physician assistant shall, by applying for or accepting licensure under this Chapter, be deemed to have given his consent to submit to physical or mental examinations when so directed by the board and to waive all objections as to the disclosure or admissibility of findings, reports, or recommendations pertaining thereto on the grounds of privileged communication or other personal privileges provided by law.

B. The board may appoint or designate an examining committee of physicians, possessing appropriate qualifications, to conduct physical and mental examinations of a physician assistant, to otherwise inquire into the physician assistant's fitness ability to provide services with reasonable skill and safety patients, and to submit advisory reports and recommendations the board, when the board has reasonable cause to believe that the fitness and ability of such physician assistant is affected by mental illness or deficiency or physical illness, including but not limited to deterioration through the aging process or the loss of motor skills, and/or excessive use or abuse of drugs, including alcohol.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270(B)(6), R.S. 37:1360.23(D), (F).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 4:111 (April 1978), amended LR 17:1104 (November 1991), LR 22:203 (March 1996).

#### **§1517. Expiration of Licensure; Renewals; Modification; Notification of Intent to Practice**

A. Initial licensure shall expire as of the last day of the year in which such license was issued.

B. Every license issued under this Chapter shall be renewed annually on or before January 1 by submitting to the board an application for renewal upon forms supplied by the board, together with satisfactory documentation of current certification or recertification by the National Commission on Certification of Physicians' Assistants. Each application for renewal shall be accompanied by a fee of \$100.

C. A physician assistant licensed in this state, prior to initiating practice, shall submit, on forms approved by the board, notification of such intent to practice. Such notification shall include:

1. the name, business address, and telephone number of the supervising physician; and

2. the name, business address, and telephone number of the physician assistant.

D. Licensure shall not terminate upon termination of a relationship between a physician assistant and a supervising physician provided that:

1. the physician assistant ceases to practice as a physician assistant until such time as he enters into a supervision relationship with a supervising physician or supervising group of physicians registered with the board; and

2. the physician assistant notifies the board of any changes in or additions to his supervising physicians within 15 days of the date of such change or addition.

E. The board may, in its discretion, at the time of and upon application for renewal of licensure, require a review of the current accuracy of the information provided in the approved application and of the physician assistant's performance thereunder and may modify or restrict any licensure in accordance with the findings of such review.

F. A physician assistant may elect to have his license placed on inactive status by the board by giving notice to the board in writing, on forms prescribed by the board, of his election of inactive status. A physician assistant whose license is on inactive status shall be excused from payment of renewal fees and shall not practice as a physician assistant in the state of Louisiana. Any licensee who engages in practice while his or her license is on inactive status shall be deemed to be engaged in practice without a license and shall be subject to administrative sanction under R.S. 37:1360.34 or to judicial injunction pursuant to R.S. 37:1360.37. A physician assistant on inactive status may be reinstated to active status upon payment of the current renewal fees and satisfaction of other applicable qualifications for renewal prescribed by Subsection B of this Section.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270(B)(6), R.S. 37:1360.23(D), (F).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 4:111 (April 1978), amended LR 17:1104 (November 1991), LR 22:203 (March 1996).

### Subpart 3. Practice

#### Chapter 45. Physician Assistants

##### §4501. Supervision by Supervising Group of Physicians

A. A physician assistant may be supervised by a supervising group of physicians provided that, a member, partner or employee of the supervising group is designated as the supervising physician, and such supervising physician meets and satisfies all of the qualifications, procedures and other requirements of this Chapter to the same extent as if the physician assistant were supervised individually by the supervising physician.

B. With respect to any physician assistant supervised by a supervising group of physicians, all duties, obligations, and responsibilities imposed by statute or by the rules of this Chapter on the supervising physician shall be equally and independently assumed and borne by the designated supervising physician and the supervising group.

C. When a physician assistant is supervised by a supervising group of physicians, the supervising physician may designate any other member, partner or employee of the supervising group as *locum tenens* physician, provided that such designee meets the qualifications of §1508 of these Rules and the designation otherwise complies with said Section. A registered supervising physician shall not be required to pay additional fees to the board to act as *locum tenens* physician.

D. A physician may obtain approval from the board to be the primary supervising physician for up to two physician assistants; however, nothing shall prohibit a qualified supervising physician from acting as supervising physician on a *locum tenens* basis for any physician assistants in addition to the two physician assistants for whom he is the primary supervising physician.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270(B)(6), R.S. 37:1360.23(D), (F).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 4:111 (April 1978), amended LR 17:1105 (November 1991), LR 22:204 (March 1996).

##### §4503. Compensation

A. A physician assistant may receive compensation, salary or wages only from his or her employer and may neither render a statement for service directly to any patient nor receive any payment, compensation or fee for services directly from any patient.

B. Nothing in this Section shall prohibit charges from being submitted to any governmental or private payor for services rendered by a physician assistant.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270(B)(6), R.S. 37:1360.23(D), (F).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 4:111 (April 1978), amended LR 17:1105 (November 1991), LR 22:204 (March 1996).

##### §4505. Services Performed by Physician Assistants

A. The practice of a physician assistant shall include the performance of medical services that are delegated by the supervising physician and are within the scope of the physician assistant's education, training, and licensure.

B. Medical services rendered by a physician assistant may include: screening patients to determine need for medical attention; eliciting patient histories; reviewing patient records to determine health status; performing routine physical examinations; recording pertinent patient data; performing developmental screening examinations on children; making preliminary decisions regarding data gathering and appropriate management and treatment of patients being seen for initial evaluation of a problem or follow-up evaluation of a previously diagnosed and stabilized condition; making appropriate referrals; preparing patient summaries; requesting initial laboratory studies; collecting specimens for blood, urine and stool analyses; performing urine analyses, blood counts and other laboratory procedures; identifying normal and abnormal findings on history, physical examinations and laboratory studies; initiating appropriate evaluation and emergency management for emergency situations such as cardiac arrest, respiratory distress, burns and hemorrhage; performing clinical procedures such as venipuncture, intradermal testing, electrocardiography, care and suturing of wounds and lacerations, casting and splinting, control of external hemorrhage, application of dressings and bandages, administration of medications, intravenous fluids, and transfusion of blood or blood components, removal of superficial foreign bodies, cardio-pulmonary resuscitation, audiometry screening, visual screening, aseptic and isolation techniques; providing counseling and instruction regarding common patient problems; monitoring the effectiveness of therapeutic intervention; assisting in surgery; and signing for



receipt of medical supplies or devices that are delivered to the supervising physician or supervising physician group. This list is illustrative only, and by no means constitutes the limits or parameters of the physician assistant's practice.

C. Medical services rendered by a physician assistant in the event of the temporary absence of the supervising physician shall be limited to:

1. obtaining patient histories and performing physical examinations;

2. ordering or performing diagnostic procedures approved by the board;

3. implementing a treatment plan prescribed by the supervising physician with respect to an individual, identified patient;

4. monitoring the effectiveness of therapeutic intervention;

5. suturing wounds in accordance with Subsection D of this Section;

6. offering counseling and education to meet patient needs; and

7. making appropriate referrals.

D. A physician assistant who performs the suturing of lacerations, may undertake to do so with respect to a particular patient, only when the patient's laceration has been previously examined in person by the supervising physician and the supervising physician provides specific directions as to the appropriate manner of and procedure for suturing the laceration.

E. A physician assistant may administer medication to a patient, or transmit orally, or in writing on a patient's record, a prescription from his or her supervising physician to a person who may lawfully furnish such medication or medical device. The supervising physician's prescription, transmitted by the physician assistant, for any patient cared for by the physician assistant, shall be based on a patient-specific order by the supervising physician. At the direction and under the supervision of the supervising physician, a physician assistant may hand to a patient of the supervising physician a properly labeled prescription drug prepackaged by a physician, a manufacturer or a pharmacist. In any case, the medical record of any patient cared for by the physician assistant for whom the physician's prescription has been transmitted or carried out shall be reviewed, countersigned and dated by a supervising physician within 24 hours.

F. A physician assistant shall not:

1. exercise independent medical judgment, as defined by §1503, except in life-threatening emergencies;

2. issue prescriptions for any medication and/or complete and issue prescription blanks previously signed by any physician;

3. order for administration or administer any medication to any patient except pursuant to the specific order or direction of his or her supervising physician;

4. suture any laceration with respect to any patient until and unless the patient has been previously examined in person by the supervising physician and the supervising physician has provided specific directions as to the appropriate manner of and procedure for suturing the laceration;

5. act as or engage in the functions of a physician

assistant other than on the direction and under the supervision of his supervising physician at the location or locations specified in physician assistant's notice of practice location to the board, where the supervising physician is present, except in the following situations:

a. if the physician assistant is acting as assistant in life-threatening emergencies and in situations such as man-made and natural disaster or a physician emergency relief efforts;

b. if the physician assistant is volunteering his services to a non-profit charitable organization, receives no compensation for such services, and is performing such services under the direction and supervision and in the presence of a licensed physician.

6. act as or engage in the functions of a physician assistant when the supervising physician and the physician assistant do not have the capability to be in contact with each other by telephone or other telecommunication device; or

7. identify himself, or permit any other person to identify him, as "doctor" or render any service to a patient unless the physician assistant has clearly identified himself as a physician assistant by any method reasonably calculated to advise the patient that the physician assistant is not a licensed physician.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270(B)(6), R.S. 37:1360.23(D), (F).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 4:111 (April 1978), amended LR 17:1105 (November 1991), LR 22:204 (March 1996).

#### **§4507. Authority and Limitations of Supervising Physician**

A. The supervising physician is responsible for the responsible supervision, control, and direction of the physician assistant and retains responsibility to the patient for the competence and performance of the physician assistant.

B. A supervising physician may not supervise more than two physician assistants at the same time; provided, however, that a physician may be approved to act as a supervising physician on a *locum tenens* basis for physician assistants in addition to the physician assistants for whom he or she is the primary supervising physician, provided that such physician shall not act as supervising physician for more than four physician assistants at any one time.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270(B)(6), R.S. 37:1360.23(D), (F).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 4:112 (April 1978), amended LR 22:205 (March 1996).

#### **§4509. Designation of *Locum Tenens***

A. Notwithstanding other provisions of this Chapter, the board may permit a supervising Physician to designate as *locum tenens* a physician who will assume the obligations and responsibilities of the supervising physician when the supervising physician is absent or unavailable as a result of illness, medical emergency or other causes.

B. To be eligible for designation as *locum tenens*, a physician shall:

1. meet the qualifications of §1508 of this Chapter; and

2. actively practice in the same specialty as the supervising physician or in a reasonably related field of medicine.

C. Designation of a *locum tenens* must include:

1. a description of the *locum tenens*' professional background and specialty, if any;

2. the address of all office locations used by the;

3. a detailed description of the specific circumstances under which the *locum tenens* will act for and in place of the supervising physician and the manner in which the *locum tenens* will supervise, direct and control the physician assistant; and

4. a certificate, signed by the designated *locum tenens*, acknowledging that he has read and understands the rules of this Chapter and that he will assume the duties, obligations and responsibilities of the supervising physician under the circumstances specified in the application.

D. The board may, in its discretion, refuse to approve the use of a *locum tenens*, or it may restrict or otherwise modify the specified circumstances under which the *locum tenens* would be authorized to act for and in place of the supervising physician.

E. A physician assistant shall not, while acting under the direction and supervision of an approved *locum tenens* designated by the supervising physician, attend or otherwise provide any services for or with respect to any patient other than a patient of the supervising physician or supervising group.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270(B)(6), R.S. 37:1360.23(D), (F).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 4:112 (April 1978), amended LR 17:1106 (November 1991), LR 22:205 (March 1996).

#### §4511. Mutual Obligations and Responsibilities

A. The physician assistant and supervising physician shall:

1. within 15 days notify the board, in writing, of:

a. the termination of the physician assistant's supervision relationship with a supervising physician or supervising group of physicians;

b. the retirement or withdrawal from active practice by the supervising physician; and

c. any other change in the employment, functions, activities or services of the physician assistant or the manner or location of their performance;

2. comply with reasonable requests by the Board for personal appearances and/or information relative to the functions, activities and performance of the physician assistant and supervising physician;

3. insure that each individual to whom the physician assistant provides patient services is expressly advised and understands that the physician assistant is not a licensed physician;

4. insure that, with respect to each direct patient encounter, all activities, functions, services and treatment measures of the physician assistant are properly documented in written form by the physician assistant and that each such entry is countersigned by the supervising physician within 24 hours with respect to inpatients in an acute care setting and patients in a hospital emergency department; within 48 hours

with respect to patients of nursing homes and other sub-acute settings and within 72 hours in all other cases.

B. The physician assistant and the supervising physician shall bear equal and reciprocal obligations to insure strict compliance with the obligations, responsibilities and provisions set forth in the rules of this Chapter.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270(B)(6), R.S. 37:1360.23(D), (F).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 4:112 (April 1978), amended LR 17:1106 (November 1991), LR 22:206 (March 1996).

#### §4513. Causes for Nonissuance, Suspension, Revocation of Restrictions; Fines, Reinstatement

A. The board may refuse to issue, or may suspend, revoke or impose probationary or other restrictions on, any license issued under this Chapter, or issue a private or public reprimand, for the following causes:

1. conviction of or entry of a plea of guilty or *nolo contendere* to a criminal charge constituting a felony under the laws of the United States or of any state;

2. conviction of or entry of a plea of guilty or *nolo contendere* to any criminal charge arising out of or in connection with practice as a physician assistant;

3. fraud, deceit, or perjury in obtaining any license or permit issued under this Chapter;

4. providing false testimony before the board;

5. habitual or recurring drunkenness;

6. habitual or recurring use of morphine, opium, cocaine, drugs having a similar effect, or other substances which may induce physiological or psychological dependence;

7. aiding, abetting, or assisting any physician in any act or course of conduct enumerated in Louisiana Revised Statutes, Title 37, Section 1285;

8. efforts to deceive or defraud the public;

9. incompetency;

10. immoral conduct in exercising the privileges provided for by licensure under this Chapter;

11. persistent violation of federal or state laws relative to control of social diseases;

12. interdiction or commitment by due process of law;

13. inability to perform or function as a physician assistant with reasonable skill or safety to patients because of medical illness or deficiency; physical illness, including but not limited to deterioration through the aging process or loss of motor skills; and/or excessive use or abuse of drugs, including alcohol;

14. refusing to submit to the examination and inquiry of an examining committee of physicians appointed or designated by the board to inquire into the physician assistant's physical and mental fitness and ability to provide patient services with reasonable skill and safety;

15. the refusal of the licensing authority of another state to issue or renew a license, permit or certificate to act as a physician assistant in that state, or the revocation, suspension or other restriction imposed on a license, permit or certificate issued by such licensing authority which prevents or restricts the functions, activities or services of the physician assistant in that state; or

16. violation of any provision of this Chapter, or of rules or regulations of the board or statute pertaining to physician assistants.

B. The board may, as a probationary condition, or as a condition of the reinstatement of any license suspended or revoked hereunder, require the physician assistant and/or the supervising physician group to pay all costs of the board proceedings, including investigators', stenographers', and attorneys' fees, and to pay a fine not to exceed the sum of \$5,000.

C. Any license suspended, revoked or otherwise restricted by the board may be reinstated by the board.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270(B)(6), R.S. 37:1360.23(D), (F).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 4:112 (April 1978), amended LR 17:1107 (November 1991), LR 22:206 (March 1996).

Delmar Rorison  
Executive Director

9603#015

## RULE

### Department of Health and Hospitals Board of Medical Examiners

#### Physicians and Surgeons—Licensing (LAC 46:XLV.301-431)

The Board of Medical Examiners (board), pursuant to the authority vested in the board by the Louisiana Medical Practice Act, R.S. 37:1261-1292, and the provisions of the Administrative Procedure Act, has amended its rules governing the licensure of physicians and surgeons. LAC 46:XLV.301-431. The amendments were proposed by notice of intent published in the *Louisiana Register*, Volume 21 (November 1995), Number 11, pages 1284-85. In consideration of public comments on the amendments, the board has made a single technical amendment to a cross-reference appearing at §311.A.6 of the proposed amendments. The text of the final rules, as so amended by the board, is set forth below.

#### Title 46

### PROFESSIONAL AND OCCUPATIONAL STANDARDS

#### Part XLV. Medical Professions

#### Subpart 2. Licensure and Certification

#### Chapter 3. Physicians and Surgeons

#### Subchapter B. Graduates of American and Canadian Medical School and Colleges

#### §311. Qualifications for License

A. To be eligible for a license, an applicant shall:

1. be at least 21 years of age;
2. be of good moral character as defined by §303.A;
3. be a citizen of the United States or possess valid and current legal authority to reside and work in the United States duly issued by the Commissioner of the Immigration and Naturalization Service of the United States under and pursuant

to the Immigration and Nationality Act (66 Stat. 163) and the Commissioner's regulations thereunder (8 C.F.R.);

4. possess:

a. a doctor of medicine or equivalent degree duly issued and conferred by a medical school or college approved by the board; or

b. a doctor of osteopathy degree issued and conferred on or after June 1, 1971 by a school or college of osteopathy approved by the board;

5. have completed at least one year of postgraduate clinical training in a medical internship or equivalent program accredited by the American Council on Graduate Medical Education (ACGME) of the American Medical Association, or by the Royal College of Physicians and Surgeons (RCPS) of Canada, and approved by the board; and

6. have, within the prior 10 years, in conformity with the restrictions and limitations prescribed by §381 of these rules, and subject to the exception provided for certain applicants for licensure by reciprocity provided by §353.A, taken and successfully passed:

a. all three steps of the United States Medical Licensing Examination (USMLE) of the Federation of State Medical Board of the United States, Inc. (FSMB);

b. both components of the Federation Licensing Examination (FLEX) of the FSMB; or

c. all three parts of the examinations of the National Board of Medical Examiners (NBME);

d. Step 1 of the USMLE or Part I of the NBME, Step 2 of the USMLE or Part II of the NBME, and Step 3 of the USMLE or Part III of the NBME;

e. Component 1 of the FLEX and Step 3 of the USMLE; or

f. Step 1 of the USMLE or Part I of the NBME and Step 2 of the USMLE or Part II of the NBME and Component 2 of the FLEX.

B. The burden of satisfying the board as to the qualifications and eligibility of the applicant for licensure shall be upon the applicant. An applicant shall not be deemed to possess such qualifications unless the applicant demonstrates and evidences such qualifications in the manner prescribed by, and to the satisfaction of, the board.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270, R.S. 37:1271, R.S. 37:1272, R.S. 37:1274 and R.S. 37:1275.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 10:908 (November 1984), amended LR 16:513 (June 1990), LR 22:207 (March 1996).

#### §313. Procedural Requirements

In addition to the substantive qualifications specified in §311, to be eligible for a license, an applicant shall satisfy the procedures and requirements for application provided by §§359 to 365 of this Chapter and, if applicable, the procedures and requirements for examination administered by the board provided by §§371 to 385 of this Chapter.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270, R.S. 37:1271, R.S. 37:1272, R.S. 37:1274 and R.S. 37:1275.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 10:908 (November 1984), amended LR 22:207 (March 1996).

## Subchapter C. International Medical Graduates

### §321. Scope of Subchapter; Definition

A. The rules of this Subchapter specify additional qualifications, requirements and procedures for the licensing of physicians and surgeons who are graduates of foreign medical schools.

B. As used in this Subchapter, the term *International Medical Graduate* or *IMG*—a graduate of a medical school or college not located in any state or in Canada, recognized and officially listed by the World Health Organization and not affirmatively disapproved by the board.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270, R.S. 37:1272 and R.S. 37:1275.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 10:909 (November 1984), amended LR 12:212 (April 1986), LR 12:528 (August 1986), LR 22:208 (March 1996).

### §323. Qualifications for License

A. To be eligible for a license, an international medical graduate applicant shall:

1. possess all of the substantive qualifications for license specified by §311 of this Chapter;
2. possess a valid Standard ECFMG Certificate issued by the Educational Commission for Foreign Medical Graduates;
3. be competent and proficient in speaking, understanding, reading and writing the English language; and
4. have completed at least three years of postgraduate clinical training in the United States or in Canada in a medical residency or equivalent program accredited by the American Council on Graduate Medical Education (ACGME) of the American Medical Association, or by the Royal College of Physicians and Surgeons of Canada (RCPS), and approved by the board. To be approved by the board such program must be offered and taken in an institution offering not fewer than two residency or equivalent programs accredited by the ACGME or the RCPS; the program in which the applicant participates must evidence the applicant's progressive responsibility for patient care; and the three years of such a program must be in the same specialty or, alternatively, constitute the IMG, upon completion of such three years program, as eligible for specialty board certification or for postgraduate year four (PGY-4) training.

B. In addition to the qualifications specified in the preceding subsection, if an IMG applicant has participated in any clinical clerkship program within the United States as part of the academic training requisite to his doctor of medicine degree, such clinical clerkship program shall be subject to approval by the board as a condition of the applicant's eligibility for licensure. Such a clinical clerkship program may be approved by the board only if, at the time the applicant participated in such program, the clinical clerkship program was accredited or approved by the ACGME, the clinical clerkship was served in a hospital or other institution accredited by the Joint Commission on Accreditation of Health Care Organizations, and the applicant's supervising physician within such program held formal appointment as a professor or associate professor of the medical school or college sponsoring such program; provided, however, that notwithstanding a clinical clerkship program's satisfaction of

these standards, the board may decline to approve any such program upon a finding that it was not substantially equivalent to the clinical clerkships offered by medical schools and colleges accredited by the Liaison Committee on Medical Education of the American Medical Association and the Association of American Medical Colleges.

C. The burden of satisfying the board as to the qualifications and eligibility of the IMG applicant for licensure shall be upon the applicant. An applicant shall not be deemed to possess such qualifications unless the applicant demonstrates and evidences such qualifications in the manner prescribed by, and to the satisfaction of, the board.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270, R.S. 37:1272 and R.S. 37:1275.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 10:909 (November 1984), amended LR 12:213 (April 1986), LR 12:528 (August 1986), LR 22:208 (March 1996).

### §325. Procedural Requirements

In addition to the substantive qualifications specified in §323, to be eligible for a license, an IMG applicant shall satisfy the procedures and requirements for application provided by §§359 to 365 of this Chapter; if applicable, the procedures and requirements for examination administered by the board provided in §§371 to 391 of this Chapter; and shall provide notarized verification of his medical school transcript, reflecting the courses and hours taken and grades achieved.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270, R.S. 37:1272 and R.S. 37:1275.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 10:909 (November 1984), amended LR 22:208 (March 1996).

### §326. Alternative Qualification [Transitional Rule]

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270(b)(1)(6), R.S. 37:1272 and R.S. 37:1275.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 15:272 (April 1989), repealed LR 22:208 (March 1996).

### §327. Waiver of Qualifications

A. The waiver of qualifications provided by §315 of this Chapter shall be available to international medical graduate applicants.

B. Upon request by an applicant, the board may, in its discretion, waive the necessity of successfully passing the ECFMG examination, as otherwise required by §323.A.2, in favor of an applicant who is currently certified by a specialty board recognized by the American Board of Medical Specialties.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270, R.S. 37:1272 and R.S. 37:1275.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 10:909 (November 1984), amended LR 22:208 (March 1996).

## Subchapter D. Board Approval of Medical Schools and Colleges

### §335. Applicability of Approval

Graduation from an approved school is among the qualifications requisite to medical licensure as provided by §311.A.4 (American and Canadian graduates), §323.A.1 (international medical graduates), and §353.A (reciprocity

applicants). This qualification will be deemed to be satisfied if the school or college from which the applicant graduated was approved by the board as of the date the applicant's degree was issued.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270 and R.S. 37:1272.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 10:909 (November 1984), amended LR 22:208 (March 1996).

### **Subchapter E. Licensure by Reciprocity**

#### **§353. Qualifications for Licensure by Reciprocity**

A. An applicant who possesses and meets all of the qualifications and requirements specified by §§311 to 313 of this Chapter, save for successfully passing one of the examinations specified by §311.A.6 within the prior ten years, shall nonetheless be eligible for licensing if such applicant possesses, as of the time of the application is filed and at the time the board passes upon such application, a current, unrestricted license to practice medicine issued by the medical licensing authority of another state, and the applicant has, within 10 years prior to the date of application, taken and successfully passed:

1. a medical licensing examination developed and administered by the licensing authority of a state in which they hold an unrestricted license to practice medicine; or

2. a written certification or recertification examination administered and leading to certification or recertification by a specialty board recognized by the American Board of Medical Specialties.

B. An applicant who possesses all of the qualifications for licensure by reciprocity specified by Subsection A of this Section, save for having taken and passed a written medical competence examination within 10 years of the date of application, shall nonetheless be considered eligible for licensure by reciprocity if such applicant takes and successfully passes the Special Purpose Examination (SPEX) of the Federation of State Medical Boards of the United States, Inc., as administered by and under the auspices of the board, or a written certification or recertification examination by a specialty board recognized by the American Board of Medical Specialties.

C. An osteopathic physician qualified for medical licensure under §311.A.4.b shall be eligible for medical licensure by reciprocity only if he holds a medical license issued by the medical licensing authority of another state on the basis of successful USMLE, FLEX or National Board of Medical Examiners examination and is otherwise qualified for licensure by reciprocity under this Section. For purposes of medical licensure by reciprocity or otherwise, the examination of the National Board of Osteopathic Examiners does not qualify as a written medical competence examination acceptable to the board.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270 and R.S. 37:1276.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 10:910 (November 1984), amended LR 14:149 (March 1988), LR 16:516 (June 1990), LR 22:209 (March 1996).

### **Subchapter F. Application**

#### **§361. Application Procedure**

A. Application for unrestricted licensing shall be made upon forms supplied by the board.

B. If application is made for licensing subject to successful completion of Step 3 of the United States Medical Licensing Examination (USMLE), an initial application must be received by the Board not less than 120 days prior to the scheduled administration of USMLE Step 3 for which the applicant desires to sit (See Subchapter G of this Chapter respecting dates and places of examination). Applications must be completed and all supporting documentation must be received by the board not less than 90 days prior to the scheduled administration of USMLE Step 3 for which the applicant desires to sit.

C. Application for licensing by reciprocity under Subchapter E may be made at any time.

D. Application forms and instructions pertaining thereto may be obtained upon written request directed to the office of the board. Application forms will be mailed by the board within 30 days of the board's receipt of request therefor. To ensure timely filing and completion of application, forms must be requested not later than 40 days prior to the deadlines for initial application specified in the preceding subsection.

E. An application for licensing under this Chapter shall include:

1. proof, documented in a form satisfactory to the board as specified by the secretary, that the applicant possesses the qualifications set forth in this Chapter;

2. three recent photographs of the applicant; and

3. such other information and documentation as the board may require to evidence qualification for licensing.

F. All documents required to be submitted to the board must be the original thereof. For good cause shown, the board may waive or modify this requirement.

G. The board may refuse to consider any application which is not complete in every detail, including submission of every document required by the application form. The board may, in its discretion, require a more detailed or complete response to any request for information set forth in the application form as a condition to consideration of an application.

H. Each application submitted to the board shall be accompanied by the applicable fee, as provided in Chapter 1 of these rules.

I. Following submission of a completed application, an applicant shall, upon approval by the board office and by appointment, make a personal appearance before the board, a member of the board, or its designee, as a condition to the board's consideration of such application. At the time of such appearance, the applicant shall present the original of the documents required under this Chapter. The recommendation of the board, board member, or designee as to the applicant's fitness for licensure shall be made a part of the applicant's file.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270 and R.S. 37:1278.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 10:910 (November 1984), amended LR 16:516 (June 1990), LR 22:209 (March 1996).

### §363. Additional Requirements for International Medical Graduates

A. Any diploma or other document required to be submitted to the board by an IMG applicant which is not in the English language must be accompanied by a certified translation thereof into English.

B. In addition to the procedures and requirements set forth in §361, following submission of a completed application, an IMG applicant shall, upon approval by the Board office and by appointment, make a personal appearance before a member of the board as a condition to the board's consideration of such application.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270 and R.S. 37:1278.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 10:911 (November 1984), amended LR 22:210 (March 1996).

### Subchapter G. Examination

#### §371. Designation of Examination

The examination recognized by the board pursuant to R.S. 37:1272(5) is the United States Medical Licensing Examination (USMLE) of the Federation of State Medical Boards of the United States, Inc. Application for taking Step 3 of the USMLE is made to the board.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270, R.S. 37:1272 and R.S. 37:1273.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 10:911 (November 1984), amended LR 22:210 (March 1996).

#### §373. Subversion of Examination Process

A. An applicant-examinee who engages or attempts to engage in conduct which subverts or undermines the integrity of the examination process shall be subject to the sanctions specified in §385 of this Chapter.

B. Conduct which subverts or undermines the integrity of the examination process shall be deemed to include:

1. refusing or failing to fully and promptly comply with any rules, procedures, instructions, directions or requests made or prescribed by the Chief Proctor or an Assistant Proctor;

2. removing from the examination room or rooms any of the examination materials;

3. reproducing or reconstructing, by copying, duplication, written notes or electronic recording, any portion of the licensing examination;

4. selling, distributing, buying, receiving, obtaining or having unauthorized possession of a future, current or previously administered licensing examination;

5. communicating in any manner with any other examinee or any other person during the administration of the examination;

6. copying answers from another examinee or permitting one's answers to be copied by another examinee during the administration of the examination;

7. having in one's possession during the administration of the examination any materials or objects other than the examination materials distributed, including, without limitation, any books, notes, recording devices, or other written, printed or recorded materials or data of any kind;

8. impersonating an examinee by appearing for and as an applicant and taking the examination for, as and in the name of an applicant other than himself;

9. permitting another person to appear for and take the examination on one's behalf and in one's name; or

10. engaging in any conduct which disrupts the examination or the taking thereof by other examinees.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270, R.S. 37:1272 and R.S. 37:1273.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 10:911 (November 1984), amended LR 16:518 (June 1990), amended LR 22:210 (March 1996).

#### §375. Finding of Subversion

When the board has probable cause to believe that an applicant has engaged or attempted to engage in conduct which subverts or undermines the integrity of the examination process, the board shall so advise the applicant in writing, setting forth the grounds for its finding of probable cause, specifying the sanctions which are mandated or permitted for such conduct by §377 of this Subchapter and provide the applicant with an opportunity for hearing pursuant to R.S. 49:955-58 and applicable rules of the board governing administrative hearings. Unless waived by the applicant, the board's findings of fact, its conclusions of law under these rules, and its decision as to the sanctions, if any, to be imposed shall be made in writing and served upon the applicant.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270, R.S. 37:1272 and R.S. 37:1273.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 10:911 (November 1984), amended LR 16:518 (June 1990), amended LR 22:210 (March 1996).

#### §377. Sanctions for Subversion of Examination

A. An applicant who is found by the board, prior to the administration of the examination, to have engaged in conduct or to have attempted to engage in conduct which subverts or undermines the integrity of the examination process may be permanently disqualified from taking the examination and for medical licensure in the state of Louisiana.

B. An applicant-examinee who is found by the board to have engaged or to have attempted to engage in conduct which subverts or undermines the integrity of the examination process shall be deemed to have failed the examination. Such failure shall be recorded in the official records of the board.

C. In addition to the sanctions permitted or mandated by subsections A and B of this Section, as to an applicant-examinee found by the board to have engaged or to have attempted to engage in conduct which subverts or undermines the integrity of the examining process, the board may:

1. revoke, suspend or impose probationary conditions on any license or permit issued to such applicant;

2. disqualify the applicant, permanently or for a specified period of time, from eligibility for licensure in the state of Louisiana; or

3. disqualify the applicant, permanently or for a specified number of subsequent administrations of the examination, from eligibility for examination.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270, R.S. 37:1272 and R.S. 37:1273.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 10:912 (November 1984), amended LR 22:210 (March 1996).

### **§379. Passing Scores**

A. An applicant will be deemed to have successfully passed Step 3 of the USMLE examination if he attains a score of at least 75 in such examination.

B. An applicant for licensure on the basis of FLEX examination will be deemed to have successfully passed the FLEX examination if he attained a score of at least 75 in each component of the examination. or, having taken the FLEX when a weighted average was calculated and reported thereon, had attained a FLEX weighted average of at least 75.

C. A person who is required to and does take the SPEX examination will be deemed to have successfully passed the examination if he attains a score of at least 75.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270, R.S. 37:1272 and R.S. 37:1273.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 10:912 (November 1984), amended LR 16:519 (June 1990), LR 22:211 (March 1996).

### **§381. Restrictions, Limitations on Examinations**

An applicant who has failed to obtain a passing score upon taking Step 2 or Step 3 of the USMLE more than three times, or who has failed to obtain a passing score upon taking part 2 or part 3 of the NBME more than three times each, or who has failed to obtain a passing score upon taking any component of the FLEX more than three times shall thereafter be deemed ineligible for licensing.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270, R.S. 37:1272 and R.S. 37:1273.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 10:912 (November 1984), amended LR 16:519 (June 1990), LR 22:211 (March 1996).

### **§383. Examination In or For Another State**

A. Upon application to the board, an applicant for licensing under this Chapter may be permitted to take Step 3 of the USMLE in another state. The score attained by such applicant on such examination will be accepted by the board as if the applicant had taken the USMLE pursuant to application to the board provided that the examination is administered and taken consistently with the restrictions and limitations prescribed by §387 of this Subchapter.

B. A USMLE score attained by an applicant in a USMLE examination administered prior to the applicant's application to the board for licensing will be accepted by the board, provided that:

1. the applicant presents or causes to be presented to the board written certification of the date and place that the USMLE was taken and the score achieved;

2. the examination was administered and taken consistently with the rules, regulations, restrictions and limitations prescribed by §381 of this Subchapter and by the medical licensing authority of the state for which the examination was taken; and

3. the applicant provides the board with a satisfactory written explanation of the applicant's failure to obtain licensing in the state in which the examination was taken.

C. Upon application to the board and payment of the fee prescribed in Chapter 1 of these rules, an individual applying

for licensure in another state may sit for the FLEX examination administered by the board in Louisiana.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270, R.S. 37:1272 and R.S. 37:1273.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 10:912 (November 1984), amended LR 16:519 (June 1990), LR 22:211 (March 1996).

### **§385. Lost, Stolen or Destroyed Examinations**

The submission of an application for examination shall constitute and operate as an acknowledgment and agreement by the applicant that the liability of the board, its members, employees and agents, and the state of Louisiana to the applicant for the loss, theft or destruction of all or any portion of an examination taken by the applicant, prior to the reporting of scores thereon by the National Board of Medical Examiners, other than by intentional act, shall be limited exclusively to the refund of the fees paid for examination by the applicant.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270, R.S. 37:1272 and R.S. 37:1273.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 10:912 (November 1984), amended LR 16:520 (June 1990), amended LR 22:211 (March 1996).

## **Subchapter H. Restricted Licensure, Permits**

### **§405. Short-Term Residency Permit**

A. The board may issue an institutional temporary permit to an applicant who is a commissioned physician of the Armed Services of the United States for the purpose of receiving postgraduate clinical training in a medical program approved by the board and conducted by a Louisiana medical school or college, provided that such physician:

1. possesses the qualifications for licensing prescribed by §311.A.1-4;

2. possesses a current unrestricted license to practice medicine in, and duly issued by the medical licensing authority of any state, or has successfully passed either the USMLE examination, the FLEX examination or the examination of the National Board of Medical Examiners;

3. will participate in such postdoctoral medical training program pursuant to and within the course and scope of his orders and duties as a commissioned officer of the Armed Services;

4. within a reasonable time prior to the commencement of such training program, presents or causes to be presented to the board:

a. satisfactory documentation that he possesses the qualifications required by this section, including a certified copy of his military orders authorizing and directing his participation in the specified medical training program; and

b. written certification by the dean of the medical school or college in which the applicant is to receive such training that the applicant has been accepted for participation in such program subject to the issuance of a permit by the board; and

5. satisfies the application and processing fees prescribed in Chapter 1 of these rules.

B. The board may, in its discretion, issue a temporary permit for the purpose of serving a preceptorship or participating in a short-term residency program to an applicant

who possesses the qualifications for licensure prescribed by §311.A.1-4 and who possesses a current unrestricted license to practice medicine in, and duly issued by, any state; provided that:

1. the preceptorship or residency program is approved by the board;
2. the applicant presents, or causes to be presented, to the board:
  - a. a completed application for a short-term residency permit upon the form provided by the board, together with the fee prescribed by Chapter 1 of these rules;
  - b. satisfactory documentation that the applicant possesses the qualifications required by this section;
  - c. written certification of current unrestricted licensure by the state in which the applicant resides at the time of the application; and
  - d. a letter from the physician under whom he will be serving the preceptorship or short-term residency, describing the capacity in which the applicant will be serving and the inclusive dates of such service; and
3. the applicant appears in person before and presents to a member of the board his original doctor of medicine degree and original certificate of state medical licensure.

C. The holder of a permit issued under this section shall not engage in the practice of medicine in any respect in the state of Louisiana or receive medical educational training other than within the postdoctoral medical educational program, preceptorship or short-term residency program for which he is approved by the board.

D. A temporary permit issued under this section shall expire, and thereby become null and void and to no effect on the date specified by such permit.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270, R.S. 37:1285 and R.S. 37:1275.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 10:913 (November 1984), amended LR 16:521 (June 1990), LR 22:211 (March 1996).

#### **§407. Permit Pending Examination Results**

A. The board may issue a temporary permit to an applicant for licensure by reciprocity (§§351 to 353) who is required by §353.B to take the SPEX or a specialty board certification or recertification examination, but who has not yet taken such examination or whose scores have not yet been reported to the board, provided that the applicant possesses and meets all of the qualifications and requirements for licensure provided by this Chapter save for having successfully passed such an examination (§353.B), and provided further that the applicant has registered for the next available administration of such an examination which shall be given not more than six months following submission of application for reciprocity licensure, and the applicant has not previously taken and failed to achieve a passing score on the SPEX or a specialty board certification or recertification examination.

B. A permit issued under this Section shall expire, and thereby become null, void and to no effect on that date that:

1. the board gives written notice to the permit holder that he has failed to achieve a passing score on the SPEX, or the permit holder receives notice that he has failed to achieve a passing score on a specialty board certification or recertification examination;

2. the board gives written notice to the permit holder pursuant to §383.C that it has probable cause to believe that he has engaged or attempted to engage in conduct which subverted or undermined the integrity of the examination process;

3. the permit holder is issued a license pursuant to §413.A or another type of permit as provided by §397 to §405 of this Chapter; or

4. the holder of a permit issued under Subsection B fails to appear for and take the SPEX or specialty board certification or recertification examination for which he is registered.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270, R.S. 37:1272 and R.S. 37:1273.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 10:914 (November 1984), amended LR 16:521 (June 1990), LR 22:212 (March 1996).

#### **409. Visiting Foreign National Resident Permit**

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270, R.S. 37:1272 and R.S. 37:1273.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 16:522 (June 1990), repealed LR 22:212 (March 1996).

#### **Subchapter I. License Issuance, Termination, Renewal, Reinstatement**

##### **§413. Issuance of License**

A. If the qualifications, requirements and procedures prescribed or incorporated by §311 to §313, §323 to §325 or §353 are met to the satisfaction of the board, the board shall issue to the applicant a license to engage in the practice of medicine in the state of Louisiana.

B. A license issued under §311 of this Chapter shall be issued by the board within 30 days following the reporting of the applicant's USMLE scores to the board. A license issued under any other section of this Chapter shall be issued by the board within 15 days following the meeting of the board next following the date on which the applicant's application, evidencing all requisite qualifications, is completed in every respect.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270 and R.S. 37:1274.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 10:914 (November 1984), amended LR 16:523 (June 1990), LR 22:212 (March 1996).

##### **§415. Expiration of Licenses and Permits**

A. Every license or permit issued by the board under this Chapter, the expiration date of which is not stated thereon or provided by these rules, shall expire, and hereby become null, void and to no effect, on the last day of the year in which such license or permit was issued.

B. The timely submission of a properly completed application for renewal of a license, but not a permit, as provided by §417 of this Chapter, shall operate to continue the expiring licensing in full force and effect pending issuance of the renewal license.

C. Permits are not subject to renewal, except as expressly provided in these rules.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270 and R.S. 37:1280.



HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 10:914 (November 1984), amended LR 16:523 (June 1990), LR 22:212 (March 1996).

**§418. Reduced Renewal Fees for Certain Physicians**

A. The fee otherwise required for annual renewal of licensure will be reduced by one-half in favor of a physician who holds an unrestricted license to practice medicine issued by the board and who has, prior to the first day of the year for which such renewal will be effective:

1. attained the age of 70 years;
2. voluntarily surrendered to the issuing authorities his or her state license and federal registration to prescribe, dispense or administer controlled substances; and
3. made application to the board for such reduced licensure renewal fee, upon a form supplied by the board, verifying the conditions requisite to such reduced fee and consenting to revocation of any license renewed pursuant to this section upon a finding by the board that the licensee, following issuance of licensure renewal pursuant to this section, continued to hold, obtained, or sought to obtain state licensure or federal registration to prescribe, dispense or administer controlled substances.

B. The fee otherwise required for annual renewal of licensure will be reduced by one-half in favor of a physician who holds an unrestricted license to practice medicine issued by the board and who has, prior to the first day of the year for which such renewal will be effective:

1. ceased to engage in the practice of medicine in any form in this state as a consequence of physical or mental disability;
2. voluntarily surrendered to the issuing authorities his or her state license and federal registration to prescribe, dispense or administer controlled substances; and
3. made application to the board for such reduced licensure renewal fee, upon a form supplied by the board, verifying the conditions requisite to such reduced fee, including independent physician verification of the applicant's physical or mental disability, and consenting to revocation of any license renewed pursuant to this section upon a finding by the board that the licensee, following issuance of licensure renewal pursuant to this section, engaged or sought to engage in any manner in the practice of medicine in this state or continued to hold, obtained, or sought to obtain state licensure or federal registration to prescribe, dispense or administer controlled substances.

C. A physician whose medical license is renewed pursuant to this Section shall not thereafter engage or seek to engage in the active practice of medicine in this state or to prescribe, dispense or administer controlled substances or other prescription medications except upon prior application to and approval by the board, which, in its discretion, as a condition to reinstatement of full licensure, may require that:

1. that the physician take and successfully pass all or a designated portion of the USMLE or SPEX examination; and/or
2. that the physician provide medical documentation satisfactory to the board that the physician is then physically and mentally capable of practicing medicine with reasonable skill and safety to patients.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270, R.S. 37:1280 and R.S. 37:1281.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 16:523 (June 1990), LR 22:213 (March 1996).

**§419. Reinstatement of Expired License**

A. A license which has expired may be reinstated by the board subject to the conditions and procedures hereinafter provided, provided that application for reinstatement is made within four years of the date of expiration. A physician whose license has lapsed and expired for a period in excess of four years or who is otherwise ineligible for reinstatement under this Section may apply to the board for an initial original or reciprocal license pursuant to the applicable rules of this Chapter.

B. With respect to an application for reinstatement made more than one year from the date on which the license expired, as a condition of reinstatement, the board may require:

1. that the applicant complete a statistical affidavit, upon a form supplied by the board, and provide the board with a recent photograph;
2. that the applicant possess a current, unrestricted license issued by another state; and/or
3. if the applicant does not at the time of the application possess a current, unrestricted license issued by another state, that the applicant take and successfully pass all or a designated portion of the USMLE or SPEX examination.

C. An applicant whose medical license has been revoked, suspended or placed on probation by the licensing authority of another state or who has voluntarily or involuntarily surrendered his medical license in consideration of the dismissal or discontinuance of pending or threatened administrative or criminal charges, following the date on which his Louisiana medical license expired, shall be deemed ineligible for reinstatement of licensure.

D. An application for reinstatement of licensure meeting the requirements and conditions of this Section may nonetheless be denied for any of the causes for which an application for original licensure may be refused by the board as specified in R.S. 37:1285.

E. An application for reinstatement shall be made upon forms supplied by the board and accompanied by two letters of character recommendation from reputable physicians of the former licensee's last professional location, together with the applicable renewal fee plus a penalty computed as follows:

1. If the application for reinstatement is made less than two years from the date of license expiration, the penalty shall be equal to the renewal fee.
2. If the application for reinstatement is made more than two years but less than three years from the date of license expiration, the penalty shall be equal to twice the renewal fee.
3. If the application for reinstatement is made more than three years from the date of license expiration, the penalty shall be equal to three times the renewal fee.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 10:914 (November 1984), amended LR 14:86 (February 1988), LR 16:524 (June 1990), LR 22:213 (March 1996).

**Subchapter J. Postgraduate Education Registration**  
**§425. Necessity for Registration**

A. No person who does not possess a license or permit issued under this Chapter shall enroll or participate in any program of postgraduate medical education, unless he is duly registered with the board pursuant to this Subchapter.

B. Notwithstanding registration under this Subchapter, no person who does not possess a license or permit issued under this Chapter shall enroll or participate in any program of postgraduate medical educational program, howsoever designated or whenever taken, which permits or requires such person to exercise independent medical judgment, assume independent responsibility for patient care, or otherwise to engage in the practice of medicine.

C. Upon a finding that a person or registrant has violated the proscriptions of this section, the board may:

1. suspend or revoke such person's registration under this Subchapter or impose probationary conditions thereon;
2. consider and declare such person or registrant ineligible for a medical license or permit under this Chapter; or
3. cause institution of judicial proceedings against such person for injunctive relief, costs and attorneys fees, pursuant to R.S. 37:1286.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 10:914 (November 1984), amended LR 16:524 (June 1990), LR 22:214 (March 1996).  
**§431. Issuance and Term of Registration**

A. If the qualifications, requirements and procedures prescribed or incorporated by §429 to §431 are met to the satisfaction of the board, the board shall issue a certificate to the applicant evidencing his registration under this Subchapter for enrollment and participation in a program of postgraduate medical education in the state of Louisiana.

B. Registration issued under this Subchapter shall be effective on and as of the date on which an applicant's postgraduate medical education program is to commence.

C. A certificate of registration shall expire, and become null and void, on the earliest of the following dates:

1. the date of the administration of Step 3 of the next USMLE preceding the expiration of 24 months from the effective date of registration, if the registrant has failed to sit for such administration;
2. the date on which the National Board of Medical Examiners reports to the board that the registrant has failed to attain a passing score on the next USMLE examination preceding the expiration of 24 months from the effective date of the registration; or
3. the date on which the registrant is issued a license to practice medicine in the state of Louisiana.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 10:915 (November 1984), LR 22:214 (March 1996).

Delmar Rorison  
Executive Director

9603#013

**RULE**

**Department of Health and Hospitals**  
**Office of the Secretary**

**Annual Service Agreement**

The Louisiana Health Care Authority and the Department of Health and Hospitals, Office of the Secretary, hereby adopt the following rule in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

The purpose of this rule is to assure continuing coverage of the operations of the hospitals under the jurisdiction of the Louisiana Health Care Authority by the completion of an annual service agreement required by Act 390 of 1991.

**Annual Service Agreement**

**Introduction**

This Service Agreement for State Fiscal Year 1995-96 is entered into by the Department of Health and Hospitals (DHH) and the Louisiana Health Care Authority (LHCA) in compliance with R.S. 46:701 et seq., as amended and reenacted by Act 390 of 1991.

**I. Definitions**

A. *Medically Indigent*—any bona fide resident of the state of Louisiana whose family unit size and gross income is less than or equal to 200 percent of the Federal Poverty Income Guidelines for that size family unit, rounded up to the nearest thousand dollars.

B. *Overcollections*—any monies from Medicare, Medicaid or other third party payor, or from direct patient payments, collected by or on behalf of the medical centers operated by the LHCA in excess of the amounts budgeted in the General Appropriations Bill for FY 1995-96, as enacted, for operating expenses, as certified by the commissioner of administration and the Joint Legislative Committee on the Budget.

C. *Licensed Beds*—the number of beds in each medical center licensed by the Bureau of Health Services Financing and certified for participation in the Medicaid and Medicare programs.

**II. General Agreement**

The Department of Health and Hospitals is authorized by law to provide health and medical services for the uninsured and medically indigent citizens of Louisiana directly, through the operation of health care facilities, or indirectly by agreement with the Louisiana Health Care Authority.

The LHCA agrees to provide inpatient and outpatient hospital services on behalf of the Department of Health and Hospitals. The LHCA acknowledges that the provision of services to the medically indigent, to the uninsured and to others with problems of access to health care is its highest priority.

DHH agrees to work cooperatively with the authority to provide acute mental health services at authority facilities.

### III. Provision of Adequate Health Care Services

In accordance with the intent of Act 390 of 1991, the Louisiana Health Care Authority will strive to provide health services of sufficient quality and volume to meet the needs of the uninsured and medically indigent citizens of Louisiana. The LHCA and DHH agree that for FY 1995-96, adequate services shall be considered to consist of the following:

A. Those major services that are available at the medical centers on June 30, 1995 to any bona fide resident and taxpayer of the state of Louisiana determined to be uninsured, underinsured, or medically indigent and that are funded in the General Appropriation bill for FY 1995-96, provided that such appropriated funds are made available to the medical centers.

B. Adequate service provision shall also require that the medical centers maintain policies of access to services governed by the following:

1. The medically indigent or uninsured shall be afforded first priority for admission for any form of treatment available at the particular medical center.

2. Those persons who are determined not to be medically indigent or uninsured shall be admitted on a space available basis and shall be reasonably charged for treatment or service received.

3. Emergency treatment shall not be denied to anyone.

### IV. Elimination or Relocation of Services

A. The LHCA shall notify the secretary of DHH at least 60 days in advance of any elimination or relocation to another medical center of any major programs or services, or establishment of Centers of Excellence that require shifting of major services provided on the date of this agreement.

B. DHH shall notify the chief executive officer of LHCA at least 60 days in advance of any elimination or relocation of its psychiatric units or other DHH programs or services provided in the LHCA Medical Centers.

C. The LHCA agrees not to construct, operate or fund a health care facility, or substantial portion thereof, which primarily treats insured patients other than those covered by Medicare and Medicaid.

### V. Service Improvement and Development

A. The LHCA recognizes the need to improve and expand services in the medical centers in order to more fully meet the health care needs of the uninsured and medically indigent citizens of Louisiana. The authority will work to improve access to care, placing highest priority on the following:

1. reduced waiting times for all outpatient services for which there exist medically inappropriate delays in scheduling appointments;

2. improved access to emergency services;

3. improved access to prenatal and HIV clinics.

B. LHCA shall not develop new programs or major program expansions in the areas of public health, substance abuse, mental health, or mental retardation without the concurrence of DHH.

C. In accordance with recognized primary care needs, as identified by state and federal criteria, the DHH Primary Care Access Plan, the State Rural Health Care Plan, the LHCA

Strategic Plan and other mutually agreed upon priorities, DHH and LHCA will work together to meet those needs. This shall be accomplished by a joint DHH/LHCA Planning Task Force.

### VI. Financing Arrangements

A. DHH agrees not to adjust interim Medicaid payment rates, target rates, disproportionate share formulas, or to amend the Medicaid State Plan as it relates to inpatient and outpatient hospital services, without timely notice to the LHCA CEO.

B. LHCA agrees not to submit any Budget Adjustment (BA-7) request to DOA which increase the expenditure authority of its facilities without prior notice to the secretary of DHH.

C. DHH agrees not to submit any BA-7's to DOA where the means of financing would reflect use of unbudgeted overcollections from the LHCA without prior notice to the LHCA chief executive officer.

D. DHH and LHCA agree that prior to the March meeting of the Joint Legislative Committee on the Budget a meeting will be held to determine the amount of funds to be transferred from the Louisiana Health Care Authority to the Department of Health and Hospitals, as required by law.

E. LHCA agrees to adhere to DHH Policy No. 4600-77 (DHH Liability Limitation Policy), with regard to the liability for payment for services by those inpatients who are classified as self pay, until such time as a revised policy may be promulgated by the authority through the Administrative Procedure Act.

F. LHCA is to provide a 90-day notice if they intend to cancel any operational service agreement with DHH facilities that could adversely affect the LHCA facilities budget.

G. DHH is to provide a 90-day notice if they intend to cancel any operational service agreement with DHH facilities that could adversely affect the LHCA facilities budget.

### VII. Annual Revision of Service Agreement

DHH and the LHCA agree to revise this service agreement on an annual basis, as required by law, and to promulgate the agreement through the Administrative Procedure Act. The draft annual agreement shall be published in the *Louisiana Register* each year, in order for significant changes to be considered in the budget process for the ensuing fiscal year.

Bobby P. Jindal	Carey Doherty
Secretary	Acting Chief Executive Officer
Health and Hospitals	Health Care Authority
9603#048	

### RULE

#### Department of Health and Hospitals Office of the Secretary

Ephedrine Marketing, Advertising, or Labeling  
(LAC 48:I.3945)

In accordance with R.S. 49:950 et seq., and pursuant to R.S. 40:962(1) (as enacted by Act 1253 of the 1995 Regular Session of the Louisiana Legislature), the Department of

Health and Hospitals, Office of the Secretary hereby adopts rules relative to products containing ephedrine. The statute sets forth the general rule that ephedrine products may be dispensed only by prescription, then enumerates certain exceptions to the general rule.

**Title 48**

**PUBLIC HEALTH—GENERAL**

**Part I. General Administration**

**Subpart 1. General**

**Chapter 39. Controlled Dangerous Substances**

**§3945. Ephedrine Marketing, Advertising, or Labeling**

A. General Rule. Pursuant to the statute, product containing ephedrine may be dispensed only by prescription unless: (a) it is enumerated as an exemption per R.S. 40:962(1)(B) or by the Department of Health and Hospitals review committee, (b) it may be lawfully sold over the counter per the federal Food, Drug and Cosmetic Act, (c) it is labeled and marketed in a manner consistent with OTC Tentative Final or Final Monograph, and (d) is manufactured and distributed for legitimate medicinal use in a manner that reduces or eliminates the likelihood of abuse. The marketing, advertising, or labeling of any nonprescription product containing ephedrine, a salt of ephedrine, an optical isomer of ephedrine, or a salt of an optical isomer of ephedrine for the indication of stimulation, mental alertness, weight loss, appetite control, or energy is prohibited unless the distributor or manufacturer is granted an exemption by the Department of Health and Hospitals.

B. Procedures for Seeking an Exemption

1. Distributors or manufacturers seeking an exemption from the prohibition set forth in Subsection A above must submit documentation which clearly demonstrates the following:

a. the nonprescription product is intended for use for a valid medicinal purpose, and

b. the marketing of the product does not encourage, promote, or abet the abuse or misuse of ephedrine.

2. A review committee composed of representatives from the following groups shall conduct a review of the documentation submitted by the distributor or manufacturer:

a. a pharmacist designated by the Board of Pharmacy,

b. a representative designated by the Board of Wholesale Drug Distributors,

c. a representative designated by the state health officer,

d. a representative designated by the Department of Health and Hospitals, Office of Alcohol and Drug Abuse,

e. a physician designated by the Board of Medical Examiners.

3. The following factors shall be considered by the review committee in determining whether an exemption should be granted, and information related to the factors shall be submitted by the distributor or manufacturer:

a. packaging of the product;

b. name and labeling of the product;

c. manner of distribution, advertising, and promotion of the product;

d. verbal representations made concerning the product; and

e. duration, scope, and significance of abuse or misuse of the particular product.

4. Following a review of the materials submitted by the manufacturer or distributor, the review committee shall report findings and recommendations to the secretary of the Department of Health and Hospitals, who will provide for written notification of the findings and recommendations to the applicant.

AUTHORITY NOTE: Act 1253 of the 1995 Louisiana Regular Legislative Session, enacting R.S. 40:962(1).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, LR 22:216 (March 1996).

Bobby P. Jindal  
Secretary

9603#047

**RULE**

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

**Chiropractic Care**

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing has adopted the following rule in the Medical Assistance Program to comply with Louisiana Constitution Article 7, Section 10, R.S. 39:73 and R.S. 77, which requires that the secretary not incur obligations or expenditures in excess of the funds appropriated.

Act 16, Schedule 9, of the 1995 Louisiana Regular Legislative Session directs: "The secretary shall implement reductions in the Medicaid Program as necessary to control expenditures to the level approved in this schedule. The secretary is hereby directed to utilize various cost containment measures to accomplish these reductions, including but not limited to precertification, pre-admission screening, and utilization review, and other measures as allowed by federal law".

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

**Rule**

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing adopts the following provisions governing chiropractic care under the Professional Services Program of the Medicaid Program.

I. Effective for dates of service December 1, 1995 and after, coverage for chiropractic services under the State Plan is suspended.

II. Effective for dates of service December 1, 1995 and after recipients of the Early Periodic, Screening, Diagnostic Treatment Program (EPSDT) are eligible to receive only mandatory medically necessary manual manipulations of the spine, specifically procedure codes 97260 and 97261. Also, these services may be reimbursed by the Medicaid Program only if provided on the basis of a referral of a medical

screening provider of the Early Periodic, Screening, Diagnostic Treatment Program.

III. Effective November 9, 1995 reimbursement for chiropractic dates of service prior to December 1, 1995 is provided in accordance with the following requirements.

A. General Provisions

1. Chiropractors' services consist of diagnostic and treatment services which are within the scope of practice for chiropractors under state law and regulations.

2. An encounter is defined as any visit in which any of the services listed in the Professional Services Program Manual are rendered which are included under the selected CPT treatment codes.

3. All chiropractic treatment services for recipients under the age of 21 shall be prior authorized.

B. Service Limits

1. One diagnostic evaluation per 180 days per recipient not to exceed two diagnostic evaluations per calendar year per recipient will be allowed.

2. Radiology services are limited to \$50 per recipient per 180 days not to exceed \$100 per calendar year per recipient.

3. Recipients 21 years of age and older are allowed 18 chiropractic encounters or treatment services per calendar year. No extension of this number shall be granted.

C. Reimbursement

1. Reimbursement is provided to chiropractors who are licensed by the state to provide chiropractic care and services and who are enrolled in the Medicaid Program as an enrolled provider.

2. Reimbursement is made in accordance with the following designated CPT codes under a maximum fee schedule for billable codes established by the Professional Services Program for each chiropractic service rendered to a Medicaid eligible individual.

Procedure Code	Proposed Rate
97010	\$ 7.41
97012	\$ 5.31
97014	\$ 7.41
97020	\$ 4.88
97022	\$ 6.65
97024	\$ 4.88
97026	\$ 4.88
97028	\$ 1.66
97039	\$ 6.65
97110	\$ 8.08
97112	\$ 8.08
97032	\$ 8.08
97122	\$ 3.85
97124	\$ 5.05
97034	\$ 6.65
97035	\$ 3.85
97139	\$ 6.65
97036	\$11.09
97250	\$12.94
97260	\$ 8.00
97261	\$ 3.54

IV. The Bureau of Health Services Financing will reimburse claims for chiropractic services up to the extent that funds are authorized by legislative appropriation for these services.

Bobby P. Jindal  
Secretary

9603#049

RULE

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

Durable Medical Equipment

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing has adopted 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 and as directed by the 1995-96 General Appropriations Act which states: "The Secretary shall implement reductions in the Medicaid program as necessary to control expenditures to the level approved in this schedule.

The secretary is hereby directed to utilize various cost containment measures to accomplish these reductions, including but not limited to pre-certification, pre-admission screening, and utilization review, and other measures as allowed federal law." This rule is in accordance with the provisions of the Administrative Procedure Act, R. S. 49:950 et seq.

Rule

The Department of Health and Hospitals, Bureau of Health Services Financing adopts the following provisions governing the reimbursement of durable medical equipment in the Medicaid Program.

1. The flat fee component of the reimbursement methodology for durable medical equipment is revised at a rate of 80 percent of the Medicare durable medical equipment fee schedule or at the lowest cost at which a needed item has been determined to be widely available.

2. If the item is not available at 80 percent of the Medicare DME fee schedule, the flat fee to be utilized will be 100 percent of the Medicare durable medical equipment fee schedule or at the lowest cost at which these items have been determined to be widely available.

3. Wound care supplies and dressings, and other medically necessary supply items exclusively designated for home health care are reimbursable under the Durable Medical Equipment Program, and are not reimbursable under the Home Health Program. Durable medical equipment providers must obtain prior authorization through the prior authorization process required under the Durable Medical Equipment Program in order to provide and be reimbursed for these home health care supplies. These supplies must be used by home health agencies in the home.

4. Diapers and blue pads are not reimbursable supply items under the Durable Medical Equipment Program.

Bobby Jindal  
Secretary

9603#043

## RULE

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

### Home Health Services-Homebound Criteria

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 in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

#### Rule

The Bureau of Health Services Financing provides reimbursement for approved home health services for Medicaid recipients based upon the certification of a licensed physician that the recipient is homebound and upon the determination of the Medicaid Program that the recipient meets the bureau's homebound criteria under the Medicaid Program.

#### Homebound Criteria for Medicaid Recipients

Homebound status is determined by the recipient's illness and functional limitations. A recipient is considered to be homebound if the individual:

- 1) experiences a normal inability to leave home; or
- 2) is unable to leave home without expending a considerable and taxing effort; and
- 3) whose absences from the home are infrequent, of short duration, or to receive medical services which may be unavailable in the home setting, such as ongoing treatment of outpatient kidney dialysis or outpatient chemotherapy or radiation therapy.

The bureau allows an exception to the third requirement of being unable to leave home for EPSDT recipients, up to age 21, who attend school. However, the services may only be provided in the home. These recipients may be considered to meet the homebound criteria while attending school if prior authorization has approved the individual for multiple daily home visits and/or extended skilled nursing visits in accordance with the certifying physician's orders which must document and meet the following criteria:

- 1) the medical condition of the child meets the medical necessity requirement for the skilled nursing services in the home and that the provision of these services in the home is the most appropriate level of medical care;
- 2) that the failure to receive skilled nursing services in the home would place the recipient at risk of developing additional medical problems or could cause further debilitation; and
- 3) that the recipient/student requires skilled nursing services on a regular basis and that these services cannot be obtained in an outpatient setting before or after normal school hours.

In addition the following conditions must be met.

- 1) The recipient/student is determined to be medically fragile. A medically fragile individual is one who has a

medically complex condition characterized by multiple, significant medical problems, which require extended care. Examples of medically fragile patients are patients whose care requires most or all of the following services/aides: use of home monitoring equipment, IV therapy, ventilator or tracheostomy care, feeding tube and nutritional support, frequent respiratory care or medication administration, catheter care, frequent positioning needs, etc.

- 2) Special accommodations such as specially equipped vehicles or medical devices and/or personal care attendants are needed to accompany the patient/student to and from school and/or to assist the patient/student at school.

The responsibilities of the home health agency:

The home health agency must provide to the bureau upon request the supporting documentation used to determine the recipient's homebound status.

The home health agency must report a complaint of abuse or neglect of home health recipient(s) to the appropriate authorities if the agency has knowledge that a minor child, or a nonconsenting adult or mentally incompetent adult, has been abused or not receiving the proper medical care due to neglect or lack of cooperation on the part of the legal guardians or caretakers. This includes knowledge that a patient is routinely being taken out of the home by a legal guardian or caretaker against medical advise, or when it is obviously medically contraindicated.

Bobby P. Jindal  
Secretary

9603#046

## RULE

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

### Home Health Services-Reimbursement

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing has adopted 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 and as directed by the 1995-96 General Appropriation Act, which states: "The Secretary shall implement reductions in the Medicaid program as necessary to control expenditures to the level approved in this schedule. The Secretary is hereby directed to utilize various cost containment measures to accomplish these reductions, including but not limited to precertification, preadmission screening, and utilization review, and other measures as allowed by federal law." This rule is adopted in accordance with the Administrative Procedure Act, R.S. 49:950 et seq.

#### Rule

The Department of Health and Hospitals, Bureau of Health Services Financing, adopts the following provisions governing home health services under the Medicaid Program.

1. The bureau reimburses home health agencies for allowable services by establishing the following prospective rates: 1) skilled nursing visits (procedure code X9900) - \$68.65; 2) health aide visits (procedure code X9901) - \$24.38; and 3) physical therapy (procedure code X9926) - \$70.46.

2. The Home Health Agency is required to insure that the families are instructed on a home maintenance exercise program which has been established by the treating physical therapist.

3. The bureau reimburses home health agencies for medically necessary supplies through the Durable Medical Equipment Program which requires prior authorization for the item. Items may be authorized to an existing durable medical equipment provider or to home health agencies which enroll as durable medical equipment providers.

a) Diapers and blue pads are not reimbursable as a durable medical equipment item.

b) Certain supplies for wound care and dressing will be covered under the Durable Medical Equipment Program but will be authorized exclusively for the use of home health agencies when delivering a home health service.

Bobby P. Jindal  
Secretary

9603#042

**RULE**

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

**Hospital Program—Inpatient Psychiatric Services**

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing has adopted the following rule as authorized by R.S. 46:153 and pursuant to Title XIX of the Social Security Act and as directed by the 1995-96 General Appropriation Act, which states: "The Secretary shall implement reductions in the Medicaid program and as necessary to control expenditures to the level approved in this schedule. The Secretary is hereby directed to utilize various cost containment measures to accomplish these reductions, including but not limited to precertification, pre-admission screening, utilization review, and other measures as allowed by federal law." This rule is in accordance with the provision 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, limits inpatient psychiatric services to a maximum of 30 days per calendar year per recipient. This limitation applies to Medicaid recipients who are under 21 years of age and 65 years of age and over and to inpatient psychiatric services provided other than in a distinct part psychiatric unit. Persons under 21 years of age may receive additional days if medically necessary. The fiscal intermediary shall continue to review each inpatient psychiatric admission to determine

the recipient's eligibility for these services in accordance with the above as well as the previously established regulations for inpatient psychiatric services.

Bobby P. Jindal  
Secretary

9603#045

**RULE**

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

**Laboratory and X-Ray Services**

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing adopts the following rule under the Medical Assistance Program as authorized by R.S. 46:153 and pursuant to Title XIX of the Social Security Act and as directed by the 1995-96 General Appropriations Act, which states: "The Secretary shall implement reductions in the Medicaid program as necessary to control expenditures to the level approved in this schedule. The Secretary is hereby directed to utilize various cost containment measures to accomplish these reductions, including but not limited to precertification, preadmission screening, and utilization review, and other measures as allowed by federal law." 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 adopts the following requirements for the reimbursement of clinical laboratory services.

**I. Automated, Multichannel Tests and Panels**

A. Procedure code 84478 (Triglycerides) is included in the list of automated, multichannel tests enumerated under the heading "Automated, Multichannel Tests" in the 1995 issuance of the Physicians' Current Procedural Terminology.

B. A panel code (80002 - 80019) must be billed after the performance of the first, rather than the second, automated, multichannel test.

C. If more than one of the codes listed below is billed by the same billing provider for the same recipient for the same date of service, the first billing will be paid and the second will be denied with the message "Multi blood tests billed; to be combined to panel."

82040	82250	82251	82310	82315	82320
82325	82330	82374	82435	82465	82565
82947	83615	83620	84060	84075	84100
84132	84155	84295	84450	84455	84460
84465	84520	84525	84550	83624	83610
82555	84478	82550	84160		

**II. Hepatic Function Panel and General Health Panel**

A. If individual tests and panel codes are billed for the same recipient for the same date of service by the same billing provider, the first billing will be paid and the second billing

will be denied with the message "Blood component billed with panel code."

B. The panel codes begin with 80002 and extend through 80019 and include panel codes 80050 and 80058. The individual codes included in this edit are the ones listed under I.C above.

### III. Hematology

A. Incorrect billings of hematology components, indices and profiles will be denied with the message "Hematology components/indices/profiles billed incorrectly."

B. Only one of codes 85021 - 85027 shall be paid to the same billing provider for the same recipient for the same date of service. A second billing of any of these codes on the same date of service for the same recipient by the same billing provider will be denied. Code 85021 should be billed by itself or one of 85022, 85023, 85024, 85025 or 85027 should be billed.

C. The billing of more than two of the hematology component codes (85007, 85014, 85018, 85041, 85048, 85595) by the same billing provider for the same recipient for the same date of service will result in denial of the third code in this group as a profile code should be billed if more than two tests in this group are performed.

D. The billing of one of the above profile codes (85021 - 85027) and one or more of the component codes 85014, 85018, 85041 or 85048 by the same billing provider for the same recipient for the same date of service will result in payment of the first billing and denial of the second as the component codes are included in the profile codes.

E. The billing of code 85007 and codes 85022 and/or 85023 on the same date of service for the same recipient by the same billing provider will result in payment of the first claim and denial of the second. Procedure code 85007 is included in codes 85022 and 85023.

F. A billing of code 85595 and codes 85023, 85024, 85025 and/or 85027 by the same billing provider for the same recipient for the same date of service will result in payment of the first claim and denial of the second claim. Procedure code 85595 is included in codes 85023, 85024, 85025 and 85027.

### IV. Panel Codes

A billing of more than one panel code (80002 - 80019, 80050 and 80058) on the same date of service for the same recipient by the same billing provider will result in denial of the second billing with the message "Max allowed. One panel per day per billing provider."

### V. Prenatal Lab Panels

A. A billing of more than one prenatal lab panel code (Z9001, Z9002, Z9003) on the same date of service for the same recipient by the same billing provider will result in denial of the second billing with the message "One prenatal panel per pregnancy payable."

B. Only one prenatal lab panel code is to be paid per pregnancy. Therefore, a second billing of Z9001, Z9002 or Z9003 within a 270-day period by the same billing provider for the same recipient will be denied with the message "Max allowed. Only one payable per pregnancy."

C. Procedure code 80055 (Obstetric Panel) will be placed in nonpay status as the Louisiana Medicaid Program has locally-assigned codes for prenatal lab panels.

D. Providers who have been reimbursed for a Z9001, Z9002 or Z9003 on a recipient will not be reimbursed also for codes 85018, 85022, 85025, 86592, 86762, 86900, 86901 or 86850 on that same recipient.

E. Only one claim for code 81000 will be reimbursed per recipient per pregnancy (270 days) per billing provider.

### VI. Urinalysis

A. A billing of code 81000 and one or more of 81002, 81003, or 81015 by the same billing provider for the same recipient for the same date of service will result in denial of the second billing with the message "Urinalysis billed incorrectly" because 81002, 81003 and 81015 are inappropriate with 81000.

B. A billing of code 81002 and 81003 on the same date of service for the same recipient by the same billing provider will result in denial of the second claim with the same message because the descriptions of the two codes are contradictory.

C. A billing of code 81001 and 81002, 81003 or 81015 on the same date of service for the same recipient by the same billing provider will result in denial of the second claim as the descriptions of the latter three codes are contradictory to that of code 81001.

D. A billing of code 81000 and 81001 on the same date of service for the same recipient by the same billing provider will result in denial of the second claim as the two codes have contradictory descriptions.

### VII. Panels and Component Codes within Panels

A. A billing of panel code 80050 and component codes 80012 - 80019, 85022, 85025 and/or 84443 by the same billing provider on the same date of service for the same recipient will result in denial of the second claim with the message "Billed panel and individual code within panel."

B. A billing of panel code 80058 and component codes 82040, 82250, 84075, 84450 and/or 84460 by the same billing provider on the same date of service for the same recipient will result in denial of the second billing with the same message.

C. If panel code 80059 is paid, component codes 86287, 86291, 86289, 86296, and 86302 will not also be paid on the same date of service for the same recipient to the same billing provider.

D. The above rule also applies to panel codes 80061, 80072, 80090, 80091, 80092 and their components.

Bobby P. Jindall  
Secretary

9603#044

### RULE

Department of Labor  
Office of Workers' Compensation

Compliance Penalty (LAC 40:I.109)

Under the authority of the Workers' Compensation Act, particularly R.S. 23:1021 et seq., and in accordance with the provision of the Administrative Procedure Act, R.S. 49:950 et



seq., the Department of Labor, Office of Workers' Compensation hereby amends the Office of Workers' Compensation Rules, LAC 40:I.109, General and Administrative; Compliance Penalties.

The provisions of this rule are contained in Act 246 of the 1995 Regular Session and will provide for a penalty not to exceed \$500 for failing to comply with any rule or regulation adopted under the Office of Workers' Compensation Act. Penalties may be imposed after a contradictory hearing before the director or his designee and any penalty may be appealed by filing a Disputed Claims Form, LDOL-WC-1008.

#### **Title 40**

### **LABOR AND EMPLOYMENT**

#### **Part I. Workers' Compensation Administration**

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

###### **§109. Compliance Penalty**

A. Unless otherwise provided for in the rules of the Office of Workers' Compensation, a person or entity that fails to comply with any rule or regulation adopted under the provisions of the Workers' Compensation Act may be penalized with a fine not to exceed \$500.

B. Penalties may be imposed pursuant to this rule after a investigatory hearing before the director or his designee.

C. A person or entity may appeal any penalty imposed pursuant to this rule by filing a Disputed Claim Form, LDOL-WC-1008, in the district where the person or entity is located or in Baton Rouge, Louisiana. All such appeals shall be de novo. Any penalty imposed pursuant to this rule becomes final and may be pursued for collection unless such an appeal is filed within 30 days of the notice of the penalty.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1291(B)(13).

HISTORICAL NOTE: Promulgated by the Department of Labor, Office of Workers' Compensation Administration, LR 11:775 (August 1985), repealed and repromulgated by the Department of Employment and Training, Office of Workers' Compensation, LR 17:357 (April 1991), amended by the Department of Labor, Office of Workers' Compensation, LR 22:221 (March 1996).

O. Larry Wilson  
Director

9603#018

#### **RULE**

##### **Department of Labor Office of Workers' Compensation**

###### **Forms (LAC 40:I.105)**

Under the authority of the Workers' Compensation Act, R.S. 23:1021 et seq., and in accordance with the Administrative Procedure Act, R.S. 49:950 et seq., the Department of Labor, Office of Workers' Compensation has amended the Office of Workers' Compensation rules, LAC 40:I.105, Chapter 1, General Provisions.

This rule provides for the forms prescribed for use as required by the Workers' Compensation Act and the Workers' Compensation rules.

In addition to the above rule amendment, existing rule text

in §§105, 107, and 109 is being repromulgated in new §§1733, 1735, and 1737, respectively.

#### **Title 40**

### **LABOR AND EMPLOYMENT**

#### **Part I. Workers' Compensation Administration**

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

###### **§105. Forms (formerly "Annual Reports")**

The following forms are prescribed for use as required by the Workers' Compensation Act and these Rules:

1. Form LDOL-WC-1007, Employer's Report of Occupational Injury or Disease, shall be filed with the Office of Workers' Compensation and with the employer's insurer when required by R.S. 23:1306, or within seven days of the first mediation conference of a disputed claim for benefits, whichever comes first. Failure to file this form as required may be penalized pursuant to LAC 40:I.109.

2. Form LDOL-WC-1020, Employee's Monthly Report of Earnings, shall be filed with the employer's insurer by employees who receive workers' compensation indemnity disability benefits within 30 days of their job-related injury, and every 30 days thereafter as long as they receive workers' compensation indemnity disability benefits. This form does not have to be filed by employees who only have received medical benefits. Failure to file this form as required may result in a suspension of benefits.

3. a. Form LDOL-WC-1025, Employee and Employer Certificate of Compliance, shall be filed with the employer's insurer after form LDOL-WC-1007 has been filed with the Office of Workers' Compensation. Employers who fail to file this form as required are subject to a penalty of \$500, payable to the insurer.

b. Form LDOL-WC-1025, Employee and Employer Certificate of Compliance, shall be filed with the employer's insurer by employees within 14 days of their receipt of the form, after form LDOL-WC-1007 has been filed with the Office of Workers' Compensation. Employees who fail to file this form as required may have their benefits suspended; after this form is filed, employees are entitled to all suspended benefits, if otherwise eligible for benefits.

4. Form LDOL-WC-1026, Employee's Quarterly Report of Earnings, shall be filed with the employer's insurer by employees within 14 days of receipt of the form. This form does not have to be filed by employees who only have received medical benefits, or by employees who have timely filed all necessary LDOL-WC-1020 forms. Employees who fail to file this form as required may have their benefits suspended; after this form is filed, employees are entitled to all suspended benefits, if otherwise eligible for benefits.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1291.

HISTORICAL NOTE: Promulgated by Louisiana Department of Labor, Office of Workers' Compensation Administration, LR 11:776 (August, 1985), repealed and repromulgated by the Department of Employment and Training, LR 17:358 (April, 1991), amended by Department of Labor, Office of Workers' Compensation, LR 22:221 (March 1996).

###### **§107. Assessments (see new §1735)**

Repealed. (Reserved.)

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1291.

HISTORICAL NOTE: Promulgated by Louisiana Department of Labor, Office of Workers' Compensation Administration, LR 11:776 (August, 1985), repealed and repromulgated by the Department of Employment and Training, LR 17:358 (April, 1991), repealed by Department of Labor, Office of Workers' Compensation, LR 22:221 (March 1996).

**§109. Compliance Penalty (see new §1737)**

Repealed. (See Emergency Rule Section, December, 1995 issue of the *Louisiana Register*.)

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1291.

HISTORICAL NOTE: Promulgated by Louisiana Department of Labor, Office of Workers' Compensation Administration, LR 11:776 (August, 1985), repealed and repromulgated by the Department of Employment and Training, LR 17:358 (April, 1991), repealed by Department of Labor, Office of Workers' Compensation, LR 22:222 (March 1996).

*NOTE: The following Chapter number is new and the new sections in it contain existing rule text previously located in Chapter 1.*

**Chapter 17. Fiscal Responsibility Unit**

**§1733. Annual Reports (formerly promulgated in Part I, §105)**

All carriers writing workers' compensation insurance and all self-insured employers shall submit to the office, by April 30 of each year, an annual report on Form LDOL-WC-1000 showing the amount of workers' compensation benefits paid in the previous calendar year.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1291.

HISTORICAL NOTE: Promulgated by the Department of Labor, Office of Workers' Compensation, LR 22:222 (March 1996).

**§1735. Assessments (formerly promulgated in Part I, §107)**

The annual report will be used by the director in determining an assessment for the administration of workers' compensation. The assessment shall be paid into the Office of Workers' Compensation Administrative Fund within 30 days from the date notice is served upon such carrier. If such amount is not paid within such period there may be assessed, for each 30 days the amount assessed remains unpaid, a civil penalty equal to 20 percent of the amount unpaid, which shall be due and collected at the same time as the unpaid part of the amount assessed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1291.

HISTORICAL NOTE: Promulgated by the Department of Labor, Office of Workers' Compensation, LR 22:222 (March 1996).

**§1737. Compliance Penalty (formerly promulgated in Part I, §109)**

If any carrier fails to pay the amount assessed against it within 60 days from the time such notice is served upon it, the commissioner of insurance, upon being advised by the director, may suspend or revoke the authorization to insure compensation in accordance with the procedures of the insurance code.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1291.

HISTORICAL NOTE: Promulgated by the Department of Labor, Office of Workers' Compensation, LR 22:222 (March 1996).

O. Larry Wilson  
Assistant Secretary

9603#008

**RULE**

**Department of Labor  
Office of Workers' Compensation**

**Fraud (LAC 40:I.Chapter 19)**

Under the authority of the Workers' Compensation Act, particularly R.S. 23:1021 et seq., and in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., the Department of Labor, Office of Workers' Compensation amends the Office of Workers' Compensation rules, LAC 40:I.Chapter 19.

The changes to these rules replace the current fraud section of the Office of Workers' Compensation rules in their entirety. These rules are being amended in order to implement the provisions of Act 368 of 1995.

**Title 40**

**LABOR AND EMPLOYMENT**

**Part I. Workers' Compensation Administration**

**Chapter 19. Fraud**

**§1901. Forms**

The following forms are prescribed for use pursuant to R.S. 23:1208:

1. LDOL-WC-1025 Employee's and Employer's Certificate of Compliance;
2. LDOL-WC-1026 Employee's Quarterly Report of Earnings.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1208 and 23:1291.

HISTORICAL NOTE: Promulgated by the Department of Employment and Training, Office of Workers' Compensation, LR 17:359 (April, 1991), amended by the Department of Labor, Office of Workers' Compensation, LR 22:222 (March 1996).

**§1903. Certification; Report**

A. For an accident occurring on or after April 1, 1996, the employee and employer shall certify their compliance with the Louisiana Workers' Compensation Act by filing with their insurer form LDOL-WC-1025, Employee's and Employer's Certificate of Compliance.

B.1. Whenever an employee receives workers' compensation indemnity disability benefits for more than 30 days, the employee shall report his other earnings to his employer's insurer quarterly on form LDOL-WC-1026, Employee's Quarterly Report of Earnings.

2. The requirements of paragraph B.1 of this rule are waived whenever an employee has timely filed all necessary LDOL-WC-1020 forms, or only has received medical benefits.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1208 and 23:1291.

HISTORICAL NOTE: Promulgated by the Department of Employment and Training, Office of Workers' Compensation, LR 17:359 (April, 1991), amended by the Department of Labor, Office of Workers' Compensation, LR 22:222 (March 1996).

**§1905. Penalty; Hearing; Appeal**

A. Any person violating the provisions of R.S. 23:1208 may be assessed civil penalties by the director of not less than \$500 nor more than \$5000.

B. Penalties may be imposed pursuant to this rule after a investigatory hearing before the director or his designee.

C. A person may appeal any penalty imposed pursuant to this rule by filing form LDOL-WC-1008, Disputed Claim for Compensation, in the district where the person is located or in Baton Rouge, Louisiana. All such appeals shall be de novo.

Any penalty imposed pursuant to this rule becomes final and may be pursued for collection unless such an appeal is filed within 30 days of the notice of penalty.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1208 and 23:1291(1)(5).

HISTORICAL NOTE: Promulgated by the Department of Employment and Training, Office of Workers' Compensation, LR 17:359 (April, 1991), amended by the Department of Labor, Office of Workers' Compensation, LR 22:223 (March 1996).

**§1907. Notice of Penalty; Filing**

The director shall notify the employee and employer of any civil penalty imposed for violation of R.S. 23:1208. In addition, the director shall file the notice of penalty in the record of the disputed claim for benefits.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1208 and 23:1291.

HISTORICAL NOTE: Promulgated by the Department of Employment and Training, Office of Workers' Compensation, LR 17:359 (April, 1991), amended by the Department of Labor, Office of Workers' Compensation, LR 22:223 (March 1996).

**§1909. Commencement of Hearing**

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1208 and 23:1291.

HISTORICAL NOTE: Promulgated by the Department of Employment and Training, Office of Workers' Compensation, LR 17:359 (April, 1991), repealed by the Department of Labor, Office of Workers' Compensation, LR 22:223 (March 1996).

**§1911. Fact Finding Determination**

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1208 and 23:1291.

HISTORICAL NOTE: Promulgated by the Department of Employment and Training, Office of Workers' Compensation, LR 17:359 (April, 1991), repealed by the Department of Labor, Office of Workers' Compensation, LR 22:223 (March 1996).

O. Larry Wilson  
Assistant Secretary

9603#017

**RULE**

**Department of Social Services  
Office of Family Support**

**Delinquent Child Support Collection by Revenue and  
Taxation Department (LAC 67:III.2543)**

The Department of Social Services, Office of Family Support, has amended the Louisiana Administrative Code, Title 67, Part III, Subpart 4, Support Enforcement Services (SES), the child support enforcement program.

Pursuant to Act 894 of the Regular Session of the 1995 Louisiana Legislature and to further improve enforcement of child support orders, SES will refer certain delinquent claims to the Department of Revenue and Taxation for assistance in collection. In particular, the rule may assist SES with regard to delinquent obligors who are self-employed. The rule will establish the agency's role in this referral process.

**Title 67**

**SOCIAL SERVICES**

**Part III. Office of Family Support**

**Subpart 4. Support Enforcement Services**

**Chapter 25. Support Enforcement**

**Subchapter M. Cooperation with Other State Agency**

**§2543. Department of Revenue and Taxation**

A. Support Enforcement Services may refer support cases to the Department of Revenue and Taxation which can use any means available under law to collect delinquent court-ordered child support payments. SES will provide to the obligor a 30-day advance notice prior to referral.

B. Criteria for referral include cases in which the obligor is not making regular child support payments at least equal to the monthly obligation; income assignment cannot be used; the obligor is delinquent \$1,000 or more; and there is an indication that the obligor may have assets which could be seized to pay the delinquency.

C. The Department of Revenue will refer information to SES when an obligor indicates that collection would result in undue hardship to the health and welfare of his family. SES will review the case and render a decision on continuance within 45 days.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:236.9.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Family Support, LR 22:223 (March 1996).

Madlyn B. Bagneris  
Secretary

9603#028

**RULE**

**Department of Social Services  
Office of Family Support**

**Uniform Interstate Family Support Act  
(LAC 67:III.2524)**

The Department of Social Services, Office of Family Support, has adopted LAC 67:III.2524, Support Enforcement Services (SES), the child support enforcement program.

Chapter III of 45 CFR requires that states have laws for the interstate establishment and enforcement of child support obligations. Since its inception SES has operated under the judicial rules of the Uniform Reciprocal Enforcement of Support Act (URESA) as recommended by the governing federal agency. An improved version of this interstate agreement has been developed, and it is the Uniform Interstate Family Support Act.

Therefore, pursuant to Chapter I of Title XIII of the Children's Code, Articles 1301.1 through 1308.2 as amended by Act 251 of the Regular Session of the 1995 Louisiana Legislature, the agency has adopted the Uniform Interstate Family Support Act.

**Title 67**

**SOCIAL SERVICES**

**Part III. Office of Family Support**

**Subpart 4. Support Enforcement Services**

**Chapter 25. Support Enforcement**

**Subchapter F. Cooperation with Other States**

**§2524. Uniform Interstate Family Support Act**

Support Enforcement Services will establish, modify and enforce interstate child support obligations under the provisions of the Uniform Interstate Family Support Act (UIFSA).

**AUTHORITY NOTE:** Promulgated in accordance with 45 CFR 302.36, 303.7, and LSA-Ch.C. art. 1301-1308.

**HISTORICAL NOTE:** Promulgated by the Department of Social Services, Office of Family Support, LR 22:224 (March 1996).

Madlyn B. Bagneris  
Secretary

9603#027

**RULE**

**Department of Transportation and Development  
Highways/Engineering**

**Specific Services (LOGO) Signing  
(LAC 70:I.101-113)  
(LAC 70:III.301-313)**

In accordance with the applicable provisions of the Administrative Procedure Act, R.S. 49:950 et seq., the Department of Transportation and Development has amended

LAC 70:I.101-113 entitled "Installation of Specific Services (LOGO) Signing", in accordance with R.S. 48:274.1 and Act 490 of the 1995 Regular Session of the Louisiana Legislature.

LAC 70:III.301-307 pertaining to Specific Services (LOGO) Signing is being repealed to recodify in LAC 70:I.101-113.

**Title 70**

**TRANSPORTATION**

**Part I. Office of the General Counsel**

**Chapter 1. Outdoor Advertisement**

**Subchapter A. Outdoor Advertising Signs**

**§101. Purpose**

The purpose of this directive is to establish policies for the installation of Specific Services (LOGO) Signing within state highway rights-of-way.

**AUTHORITY NOTE:** Promulgated in accordance with R.S. 48:461.

**HISTORICAL NOTE:** Promulgated by the Department of Transportation and Development, Office of Highways, LR 11:782 (August 1985), amended LR 18:784 (July 1992), LR 19:352 (March 1993), LR 22:224 (March 1996).

**§103. Definitions**

Except as defined in this Paragraph, the terms used in this directive shall be defined in accordance with the definitions and usage of the Louisiana Manual on Uniform Traffic Control Devices (MUTCD).

**Business Sign**— a separately attached sign mounted on the specific information sign panel to show the brand, symbol, trademark, or name, or combination of these, for a motorist service available on or near a crossroad or frontage road at or near an interchange.

**Department**—the Louisiana Department of Transportation and Development.

**Specific Information Sign**—a ground mounted rectangular sign panel with:

- a. the words "FUEL", "FOOD", "LODGING", "CAMPING" or "ATTRACTIONS";
- b. directional information;
- c. one or more business signs.

**Specific Services (LOGO) Signing**—the Specific Services (LOGO) Signing Program consists of the various components including business signs, specific information signs (Mainline and Ramp) and trailblazing signs. The term "LOGO Program" shall refer to the overall Specific Services Signing Program.

**AUTHORITY NOTE:** Promulgated in accordance with R.S. 48:461.

**HISTORICAL NOTE:** Promulgated by the Department of Transportation and Development, Office of Highways, LR 11:782 (August 1985), amended LR 18:784 (July 1992), LR 19:352 (March 1993), LR 22:224 (March 1996).

**§105. Location**

A. Eligible Highways. Specific information signs shall be allowed only on interstates and other fully controlled access facilities. Signs shall not be installed on elevated roadways and bridges.

B. Rural Areas. Specific information signs are intended for use primarily in rural areas.

C. Urban Areas. Specific information signs may be installed within urban areas where there is sufficient room for the installation of two or more specific services signs. Separate distance criteria have been established for

interchanges in urban and rural areas. Increased congestion and travel time dictate the use of shorter distance criteria for interchanges in urban areas. The department shall determine which interchanges are urban based on political boundaries, commercial development, and other appropriate factors.

D. Lateral Location. The specific information signs should be located to take advantage of natural terrain, to have the least impact on the scenic environment, and to avoid visual conflict with other signs within the highway right-of-way. Sign panel supports shall be of a breakaway or yielding design.

E. Relative Location. In the direction of travel, successive specific information signs shall be those for "ATTRACTIONS", "CAMPING", "LODGING", "FOOD", and "FUEL" in that order.

F. Convenient Reentry Required. Specific Information signs will not be installed at an interchange where the motorist cannot conveniently reenter the highway and continue in the same direction of travel.

G. Number of Signs Permitted. There shall be no more than one specific information sign for each type of service along an approach to an interchange or intersection. There shall be no more than six business signs displayed on a specific information sign.

H. Ramp Signing. Specific Information signs with directional and distance information shall be installed along the ramp approaching the crossroad when the business(es) are not visible from that approach. These signs will be similar to the corresponding specific information signs along the main highway but reduced in size.

I. Trailblazing. Trailblazing to a business shall be determined by the department in accordance with the following provisions:

1. Trailblazing shall be done with an assembly (or series of assemblies) consisting of a ramp size business sign, an appropriate white on blue arrow, and if required a mileage plaque. The business shall furnish all business sign(s) required. Preference will always be given to the erection of standard traffic signs (e.g., regulatory, warning, and guide signs) which may preclude the installation of trailblazers in heavily congested areas.

2. Intersection trailblazers shall be required in advance of all intersections requiring the motorist to turn from one route to another. The intersection trailblazer shall be installed with the appropriate left or right arrows.

3. When the distance between the interchange and the intersection trailblazers is greater than five miles verification trailblazers shall be required. The verification trailblazers shall be installed with a straight ahead arrow.

4. When the total distance from the interchange is greater than five miles a verification trailblazer shall be installed within 1,000 feet of the interchange. The verification trailblazers shall be installed with a straight ahead arrow and a mileage plaque.

AUTHORITY NOTE: Promulgated in accordance with R.S. 48:461.

HISTORICAL NOTE: Promulgated by the Department of Transportation and Development, Office of Highways, LR 11:782 (August 1985), amended LR 18:785 (July 1992), LR 19:352 (March 1993), LR 22:224 (March 1996).

## §107. Criteria for Specific Information Permitted

A. General Criteria. Each business identified on a specific information sign shall meet the following general criteria:

1. Give written assurance to the department of its conformity with all applicable laws concerning the provision of public accommodations without regard to race, religion, color, sex, age, disability, or national origin, and not be in breach of that assurance.

2. In rural areas businesses shall be located no more than 10 miles in either direction for "FUEL", "FOOD" and "LODGING" or 25 miles in either direction for "CAMPING" and "ATTRACTIONS" from the terminal of the nearest off ramp. In urban areas businesses shall be located no more than two miles in either direction for "FUEL", "FOOD" and "LODGING" or five miles in either direction for "CAMPING" and "ATTRACTIONS" from the terminal of the nearest off ramp. Measurements shall be made from the beginning of the curves connecting the ramp to the crossroad or the nosepoint of a loop along the normal edge of the pavement of the crossroad as a vehicle must travel to reach a point opposite the main entrance to the business.

3. Have appropriate licensing and/or permitting as required by federal, state, parish, and local laws or regulations.

4. Provide a telephone for public use.

B. Types of Services Permitted. The types of services permitted shall be limited to "FUEL", "FOOD", "LODGING", "CAMPING", and "ATTRACTIONS." At the discretion of the department, Camping business signs may be displayed on an "ATTRACTIONS" specific information sign using the provisions of §109.C.2 to differentiate the two services.

C. Specific Criteria for "FUEL"

1. Vehicle services of fuel (unleaded, diesel, or alternative fuels intended for use in motor vehicles for highway travel), oil, and water for batteries and/or radiators.

2. Clean modern restroom facilities for each sex and drinking water suitable for public use.

3. Year-round operation at least 16 continuous hours per day, seven days a week.

4. An on-premise attendant to collect monies, and/or make change.

D. Specific Criteria for "FOOD"

1. Indoor seating for at least 16 persons.

2. Clean modern restroom facilities for each sex.

3. Year-round operation at least 12 continuous hours per day.

E. Specific Criteria for "LODGING"

1. Adequate sleeping accommodations consisting of a minimum of 20 units with private baths.

2. Off-street vehicle parking spaces for each lodging room for rent.

3. Year-round operation.

F. Specific Criteria for "CAMPING"

1. Adequate off-street vehicle parking

2. Clean modern restroom facilities for each sex, drinking water suitable for public use, modern sanitary and bath facilities (for each sex) which are adequate for the number of campers that can be accommodated.

3. Year-round operation seven days per week.

4. At least 10 campsites with water and electrical outlets for all types of travel-trailers and camping vehicles. A tent camping area must also be provided.

G. Specific Criteria for "ATTRACTIONS"

1. Fall under one of the following categories:

- Arena/Stadium\*
- Bed and Breakfast
- Cultural Center\*
- Historical Society\*
- Historic District
- Historic Structure/Museum\*
- Industrial Facility\*
- Museum/Art Gallery
- Scenic/Natural Attraction  
(forest, garden, nature preserve, park, etc.)
- Tour Boat
- Winery/Brewery\*
- Zoo/Aquarium

\* providing visitor tours

2. Adequate off-street vehicle parking
3. Clean modern restroom facilities for each sex and drinking water suitable for public use.
4. Year-round operation at least five continuous days per week.

5. Bed and Breakfast shall have adequate sleeping accommodations consisting of a minimum of two units with private baths, and shall serve complementary breakfast (included as part of the room rate). In addition the Bed and Breakfast shall be a member of the Louisiana Bed and Breakfast Association OR shall meet additional specific criteria established by the department.

AUTHORITY NOTE: Promulgated in accordance with R.S. 48:461.

HISTORICAL NOTE: Promulgated by the Department of Transportation and Development, Office of Highways, LR 11:782 (August 1985), amended LR 18:785 (July 1992), LR 19:353 (March 1993), LR 22:225 (March 1996).

**§109. Sign Composition**

A. Specific Information Sign. The Specific Information sign shall be a blue background with a white reflectorized border and legend.

B. Business Signs. Business signs shall consist of either graphic symbols or text used to identify the business. A business identification graphic symbol or trademark shall be reproduced in the colors and general shape consistent with customary use, and any integral legend shall be in proportionate size. Businesses advertising on the "FUEL" specific information panel shall be required to use the trademark of the brand of fuel offered rather than a unique graphic symbol. Graphic symbols and trademarks that resemble any official traffic control device are prohibited. Business identification text shall consist of block letters no smaller than FHWA 6" Series C Lettering. No products, goods and services, accessory activities or descriptive advertising words, phrases or slogans shall be displayed on a business sign. The word "Diesel" shall be permitted on the "FUEL" business sign of a facility that provides Diesel motor fuel.

C. Supplemental Information on Business Signs (Flashes). Flashes consist of a solid color 6" stripe with a contrasting

legend along the bottom edge of a business sign. Flashes may be used to convey the following information:

1. Twenty-four Hours. A business that is open 24 hours per day may use a highway red flash with the legend "24 HOURS" in white 4" block lettering.

2. Attractions. A business that qualifies under camping, but is placed on the "ATTRACTIONS" specific information sign may use a highway yellow flash with the legend "CAMPING" in black 4" block letters. A business that qualifies as an attraction, but is not open seven days a week, must use a highway yellow flash with the continuous days of operation in black 4" letters. (ex: "MON - FRI" or "TUE - SUN")

D. Single-Exit Interchanges. The name of the specific service followed by the exit number shall be displayed in one line above the business signs. At unnumbered interchanges the directional legend "NEXT RIGHT (LEFT)" shall be substituted for the exit number.

E. Double-Exit Interchanges. The specific information signs shall consist of two sections, one for each exit. The top section shall display the business signs for the first exit and the lower section shall display signs for the second exit. The name of the specific service followed by the exit number shall be displayed in one line above the business signs in each section. At unnumbered interchanges the directional legends "NEXT RIGHT (LEFT)" and "SECOND RIGHT (LEFT)" shall be substituted for the exit numbers. Where a specific service is to be signed for at only one exit, one section of the specific information sign may be omitted, or a single-exit interchange sign may be used.

F. Split Signs. In remote rural areas where not more than three qualified facilities are available for each of two or more specific services or urban areas where space is not available for more than two signs, business signs for two specific services may be displayed on the same specific information sign. The specific information sign shall consist of two sections, one for each service. The top section shall display the business signs for the first service and the lower section shall display signs for the second service. The name of the specific service followed by the exit number shall be displayed in one line above the business signs in each section. Business signs should not be combined on a specific information sign when it is anticipated that additional service facilities will become available in the near future.

G. Priority. If space is limited, when an interchange is brought into the Specific Services Program, priority for signs will be given to FUEL, FOOD, LODGING, CAMPING and ATTRACTIONS in that order. Combined specific information signs shall be used to provide signing for all services with qualifying businesses, even if there are more than three qualifying businesses in a particular service.

H. Size

1. Specific Information Signs. The allowed sizes and layouts shall be as shown in the "DETAILS FOR SPECIFIC INFORMATION SIGNS."

2. Business Signs. Signs displayed on a mainline specific information panel shall be 48" x 36". Signs displayed on a ramp specific information panel or trailblazer shall be 24" x 18". The legend on ramp or trailblazer business signs

shall be the same as on the mainline sign only proportionately smaller.

AUTHORITY NOTE: Promulgated in accordance with R.S. 48:461.

HISTORICAL NOTE: Promulgated by the Department of Transportation and Development, Office of Highways, LR 11:782 (August 1985), amended LR 18:785 (July 1992), LR 19:353 (March 1993), LR 22:226 (March 1996).

### §111. Special Requirements

A. Business sign applications will be accepted on a "first-come" basis. Businesses must meet the distance requirements from each approach independently in order to be signed on each approach. All distance criteria are to be determined in accordance with the provisions stated in §107.A.2.

B. The specific information signs shall be fabricated and installed by the department. All business signs shall be furnished by the businesses at no cost to the department and shall be manufactured in accordance with the department's standards or special specifications and/or supplements thereto, for both materials and construction. Signs not meeting these requirements shall not be installed.

C. No business shall be eligible to participate in the Specific Services (LOGO) Signing program while advertising on an illegal outdoor advertising sign.

D. When one or more businesses at an interchange meeting the requirements of §107.A.2 agree to participate in the Specific Services (LOGO) Signing program, the general motorist service sign at that interchange shall be removed. General services other than FUEL, FOOD, LODGING, CAMPING and ATTRACTIONS shall be signed for using an independently mounted symbolic service sign.

AUTHORITY NOTE: Promulgated in accordance with R.S. 48:461.

HISTORICAL NOTE: Promulgated by the Department of Transportation and Development, Office of Highways, LR 11:782 (August 1985), amended LR 18:786 (July 1992), LR 19:354 (March 1993), LR 22:227 (March 1996).

### §113. Fees and Agreements

The fees and renewal dates shall be established by the department. Notification will be given 30 days prior to changes in fees.

1. Businesses will be invoiced for renewal 30 days before the renewal date. The fee shall be remitted by check or money order payable to the LOUISIANA DEPARTMENT OF TRANSPORTATION AND DEVELOPMENT. Failure of a business to submit the renewal fee(s) by the annual renewal date shall be cause for removal and disposal of the business signs by the department. The initial fee shall be prorated by the department to the annual renewal date to cover the period beginning with the month following the installation of the business signs.

2. When requested by a business, the department, at its convenience may perform additional services in connection with changes of the business sign. A service charge shall be assessed for each business sign changed, and any new or renovated business sign required for such purposes shall be provided by the applicant.

3. The department shall not be responsible for damages to business signs caused by acts of vandalism, accidents, natural causes (including natural deterioration), etc. requiring repair or replacement. In such events the business shall

provide a new or renovated business sign together with payment of a service charge fee per sign to the department to replace such damaged business sign(s).

4. Individual businesses requesting placement of business signs on a specific information sign shall submit to the department a completed application form provided by the department.

5. Businesses must submit a layout of professional quality or other satisfactory evidence indicating design of the proposed business sign for approval by the department before the sign is fabricated.

6. No business sign shall be displayed which, in the opinion of the department, does not conform to the department's standards, is unsightly, badly faded, or in a substantial state of dilapidation. The department shall remove, replace, or mask any such business signs as appropriate. Ordinary initial installation and maintenance service shall be performed by the department and removal shall be performed upon failure to pay any fee or for violation of any provision of these rules. The business (applicant) shall provide all business signs.

7. When a business sign is removed, it will be taken to the business during normal business hours. If the sign cannot be left with the business (closed, new owners, etc.), it will be taken to the district office of the district in which the business is located. The business will be notified of such removal and given 30 days in which to retrieve their business sign(s). After 30 days the business sign will become the property of the department and will be disposed of as the department shall see fit.

8. Should a business qualify for business signs at two or more interchanges, the business sign will be installed at the nearest interchange. If the business wants signing at the other interchanges, it may be so signed provided it does not prevent another business from being signed. Should a business qualify for two or more services at one business location, it may do so provided the secondary business does not prevent another primary business from participating in the program. The primary business will be determined by the department.

9. When it comes to the attention of the department that a participating business does not meet the minimum criteria, the business will be notified that it has a maximum of 30 days to correct any deficiencies or its signs will be removed. If the business later applies for reinstatement, this request shall be handled in the same manner as a request from a new applicant with a service charge per sign for reinstallation.

10. The department reserves the right to cover or remove any or all business signs in the conduct of its operation or whenever deemed to be in the best interest of the department or the traveling public without advance notice thereof. The department reserves the right to terminate this program or any portion thereof by furnishing the business written notice of such intent not less than 30 calendar days prior thereto.

AUTHORITY NOTE: Promulgated in accordance with R.S. 48:461.

HISTORICAL NOTE: Promulgated by the Department of Transportation and Development, Office of Highways, LR 11:782 (August 1985), amended LR 18:784 (July 1992), LR 19:352 (March 1993), LR 22:227 (March 1996).

**Part III. Office of Highways**

**Chapter 3. Installation of Specific Services (LOGO)  
Signing**

**§§301—313.**

Repeal to recodify in LAC 70:I.Chapter 1, Subchapter A.

AUTHORITY NOTE: Promulgated in accordance with R.S. 48:461.

HISTORICAL NOTE: Promulgated by the Department of Transportation and Development, Office of Highways, LR 11:782 (August 1985), amended LR 18:784 (July 1992), LR 19:352 (March 1993), repealed LR 22:228 (March 1996).

Frank M. Denton  
Secretary

9603#030

**RULE**

**Department of Transportation and Development  
Highways/Engineering**

**Rural Water District Permits  
(LAC 70:III.Chapter 21)**

In accordance with the applicable provisions of the Administrative Procedure Act, R.S. 49:950 et seq., the Department of Transportation and Development hereby adopts regulations pertaining to rural water district permits in accordance with Act 1075 of the 1995 Session of the Louisiana Legislature.

**Title 70**

**TRANSPORTATION**

**Part III. Highways/Engineering**

**Chapter 21. Permits for Rural Water Districts**

**§2101. Exemptions**

All parish and municipal facilities are exempt from payment of annual permit fees.

AUTHORITY NOTE: Promulgated in accordance with R.S. 48:381 (E).

HISTORICAL NOTE: Promulgated by the Department of Transportation and Development, LR 22:228 (March 1996).

**§2103. Expense Reimbursement**

The Department of Transportation and Development shall reimburse any reasonable expenses incurred by the rural water districts during an inspection and issue permits insofar as funding for such expense is available.

AUTHORITY NOTE: Promulgated in accordance with R.S. 48:381(E).

HISTORICAL NOTE: Promulgated by the Department of Transportation and Development, LR 22:228 (March 1996).

**§2105. Inspection Fee Reimbursement**

Rural water districts shall comply with the following regulations if inspection fees are to be reimbursed:

1. A cost estimate per unit break-down shall accompany each permit request. The minimum cost reimbursable estimate shall be one inspector-hour.

2. The rural water district shall notify DOTD within 72 hours of completing work, and DOTD shall arrange for a final inspection. Failure to notify DOTD within the time limit specified shall relieve DOTD of any responsibility for reimbursement of inspection fees.

3. The rural water district shall submit the detailed invoice to DOTD within one week of the final inspection.

4. Upon receipt of the above information, DOTD shall schedule an audit of the rural water district's records. Upon completion of audit, all verifiable inspection expenses shall be paid by DOTD. Any expenses which cannot be verified by the DOTD auditor will not be approved for reimbursement.

AUTHORITY NOTE: Promulgated in accordance with R.S. 48:381(E).

HISTORICAL NOTE: Promulgated by the Department of Transportation and Development, LR 22:228 (March 1996).

**§2107. Fees Covering Expenses**

Reasonable inspection fees include one rural water district representative for the on-site inspection by DOTD, and other expenses incurred as a result of DOTD requests, such as surveying, excavating, probing, etc.

AUTHORITY NOTE: Promulgated in accordance with R.S. 48:381 (E).

HISTORICAL NOTE: Promulgated by the Department of Transportation and Development, LR 22:228 (March 1996).

**§2109. Expenses not Reimbursed**

A. DOTD shall not reimburse expenses associated with highway relocation projects or expenses incurred after the permitted work has been completed.

B. Rural water districts that have received or requested Utility Relocation Assistance Funds (URAF) shall not be eligible for reimbursement.

AUTHORITY NOTE: Promulgated in accordance with R.S. 48:381(E).

HISTORICAL NOTE: Promulgated by the Department of Transportation and Development, LR 22:228 (March 1996).

Frank M. Denton  
Secretary

9603#031

**RULE**

**Department of Transportation and Development  
Highways/Engineering**

**Tourist Oriented Directional Signs (TODS)  
(LAC 70:I.Chapter 2)**

In accordance with the applicable provision of the Administrative Procedure Act, R.S. 49:950 et seq., the Department of Transportation and Development adopted a rule in accordance with R.S. 48:461.2.

**Title 70**

**TRANSPORTATION**

**Part III. Highways/Engineering**

**Chapter 2. Installation of Tourist Oriented Directional  
Signs (TODS)**

**§201. Purpose**

The purpose of this directive is to establish policies for the installation of Tourist Oriented Directional Signs (TODS) within state highway rights-of-way.

AUTHORITY NOTE: Promulgated in accordance with R. S. 48:461.2.



HISTORICAL NOTE: Promulgated by the Department of Transportation and Development, LR 12:1596 (December, 1993), amended LR 22:228 (March 1996).

## §202. Definitions

Except as defined in this paragraph, the terms used in this directive shall be defined in accordance with the definitions and usage of the Louisiana Manual on Uniform Traffic Control Devices (MUTCD).

*Conventional Highway*—any state maintained highway other than interstate.

*Department*—all references to "department" shall be interpreted to mean Louisiana Department of Transportation and Development.

*Local Road*—any roadway which is not part of the state maintained system.

*Tourist Activities*—publicly or privately owned or operated; natural phenomena, historic, cultural, scientific, educational, or religious sites, and areas of national beauty or areas naturally suited for outdoor recreation, as well as all associated business services, deemed to be in the interest of the traveling public, "the major portion of whose income or visitors are derived during the normal business season from motorists not residing in the immediate area of the activity."

*Tourist Oriented Directional Signs (TODS)*—official signing located within the state rights-of-way giving specific directional information regarding tourist activities.

AUTHORITY NOTE: Promulgated in accordance with R. S. 48:461.2.

HISTORICAL NOTE: Promulgated by the Department of Transportation and Development, LR 12:1596 (December, 1993), amended LR 22:229 (March 1996).

## §203. General Eligibility Requirements

A. General. Tourist activities shall be open to all persons regardless of race, color, religion, ancestry, national origin, sex, age or handicap; be neat, clean and pleasing in appearance; maintained in good repair; and comply with all federal, state, and local regulations for public accommodations concerning health, sanitation, safety, and access.

B. Types of attractions may include, but will not be limited to the following:

1. national historical sites, parks, cemeteries, monuments;
2. state historical sites, parks, monuments, cultural attractions;
3. aquariums, museums, zoos planetariums, and arboretums;
4. lakes and dams, recreational areas, beaches;
5. Indian sites, historical homes/buildings, gift/souvenir shops.

C. Admission Charges. If general admission is charged, charges shall be clearly displayed so as to be apparent to prospective visitors at the place of entry.

D. Parking. Off-street parking adequate to handle the demand.

E. Hours. Tourist activities shall maintain regular hours and schedules and be open to the public at least five days each week and a minimum of eight months of the year.

F. Illegal Signs. TOD sign applications will not be accepted if the tourist activity has any illegal advertising signs on or along any state highway.

G. Insufficient Space. Preference will always be given to the erection of standard traffic signs (e.g., regulatory, warning, and guide signs) which may preclude the authorization of TODS since a space of 200 feet is required between all signs on conventional roads.

H. On-Premise Sign. The tourist activity shall have on-premise sign identifying the name of the facility. If the attraction's on-premise sign is readily visible from the highway, a TOD sign is not normally required in front of the attraction.

I. Trailblazing. Trailblazing needs will be determined by the department. The activity must provide all trailblazing signs on local roads.

J. Return in Same Direction of Travel. TOD signs will not be authorized for facilities if motorists cannot readily return to the highway in the same direction of travel.

K. Onto Freeways. TOD signs will not be authorized to direct traffic onto a freeway or expressway.

M. Sign Design. TOD signs will be designed as follows:

1. Each sign should have one or two lines of legend. All signs shall have directional arrow with mileage. If the distance to the attraction is over ½ mile, the distance to the attraction to the nearest whole mile shall be included below the arrow. The content of the legend shall be limited to the name of the attraction and the directional information. If space exists on the second line, additional directional information may be indicated, e.g., ¼ mile on left, left on second street, etc. The maximum number of letters and spaces on a given line will be about 18. Legends shall not include promotional advertising.

2. The standard sign will be 72 inches x 18 inches for conventional roads and 48 inches x 12 inches for trailblazers. Letters, numbers, and arrows are to conform to the provisions in the Louisiana Manual on Uniform Traffic Control Devices and detailed drawings in the *Standard Highway Signs* book.

3. TODS shall have white reflectorized legend and borders on a blue reflectorized background, except that a brown reflectorized background may be used for attraction signs for state and national parks or recreational areas, and for historical sites.

AUTHORITY NOTE: Promulgated in accordance with R. S. 48:461.2.

HISTORICAL NOTE: Promulgated by the Department of Transportation and Development, LR 12:1596 (December, 1993), amended LR 22:229 (March 1996).

## §204. Location and Number of TODS on Conventional Highways

A. General. On conventional highways, TODS may be authorized for eligible attractions, directing motorists from the nearest arterial highway from each approach to the attraction for a distance not to exceed 15 road miles.

B. Sign Location. Sign assemblies should be placed far enough in advance of the intersection to allow time for the necessary maneuver. A minimum of 200 feet should be maintained between all signs.

C. Maximum Number of Signs. A maximum of six attractions will be authorized for signs on any approach to an intersection.

D. Sign Assemblies. TOD signs should normally be installed as independent sign assemblies as follows:

1. Signs shall be installed on one sign assembly with the signs with arrows pointing to the left above those pointing to the right. If any straight ahead arrows are authorized, as in the case where the road turns and the attraction's access is straight ahead, the sign for that attraction shall be installed above any signs for attractions to the left or right.

2. If more than six attractions qualify at a given location priority will be given to the closest attraction. Once an attraction has been signed it has priority over subsequent attractions which are closer.

3. If more than one attraction exists in a given direction, the signs for the closer attraction should be above the more distant attractions.

AUTHORITY NOTE: Promulgated in accordance with R.S. 48:461.2.

HISTORICAL NOTE: Promulgated by the Department of Transportation and Development, LR 12:1596 (December, 1993), amended LR 22:229 (March 1996).

### §205. Application Procedure

A. Application for TODS shall be submitted to LA DOTD Traffic Engineering and Safety Section or one of the district traffic operations engineers.

B. Personnel assigned to the Office of DOTD Traffic Engineering and Safety Section will review the application and a field check will be made by the district traffic operations engineer to verify information provided and to collect additional data on existing conditions, including whether a location for a TODS exist at the requested intersection and what trailblazing will be necessary.

C. The department shall forward the application with information to the assistant secretary of the Louisiana Office of Tourism.

D. The assistant secretary of the Louisiana Office of Tourism will determine if the applicant qualifies as a tourist activity and make a report of its finding to the department.

E. TODS applications will accepted on a "first-come" basis.

F. All TODS signs shall be furnished by the businesses at no costs to the department and shall be manufactured in accordance with the department's standards or special specifications and/or supplements thereto, for both materials and construction. Signs not meeting these requirements shall not be installed.

G. Applicants must submit a layout of professional quality or other satisfactory evidence indicating design of the proposed TODS sign for approval by the department before the sign is fabricated.

AUTHORITY NOTE: Promulgated in accordance with R.S. 48:461.2.

HISTORICAL NOTE: Promulgated by the Department of Transportation and Development, LR 12:1596 (December, 1993), amended LR 22:230 (March 1996).

### §206. Fees and Agreements

The fees and renewal dates shall be established by the department. Notification will be given 30 days prior to changes in fees.

1. The permittee will be invoiced for renewal, 30 days prior to the renewal date. The fee shall be remitted by check or money order payable to the Louisiana Department of Transportation and Development. Failure of a business to submit the renewal fee(s) by the annual renewal date shall be cause for removal and disposal of the TOD signs by the department. The initial fee shall be prorated by the department to the annual renewal date to cover the period beginning with the month following the installation of the TOD signs. Service fees will be charged for the removal and reinstallation of delinquent applicants.

2. When requested by the applicant, the department at its convenience may perform additional requested services in connection with changes of the TOD sign, with a service charge per sign. A service fee will be charged for removal and reinstallation of seasonal signs.

3. The department shall not be responsible for damages to TOD signs caused by acts of vandalism, accidents, natural causes (including natural deterioration), etc., requiring repair or replacement. In such events the business shall provide a new or renovated business sign together with payment of a service charge fee per sign to the department to replace such damaged business sign(s).

4. Tourist attractions requesting placement of TOD signs shall submit to the department a completed application form provided by the department. The required service charges for installation must be submitted prior to commencing work.

5. No TOD sign shall be displayed which, in the opinion of the department, does not conform to department standards, is unsightly, badly faded, or in a substantial state of dilapidation. The department shall remove or replace any such TOD signs as appropriate. Removal shall be performed upon failure to pay any fee or for violation of any provision of these rules.

6. When a TOD sign is removed, it will be taken to the district office of the district in which the activity is located. The applicant will be notified of such removal and given 30 days in which to pay the fees.

7. Should the department determine that trailblazing to a tourist attraction is desirable, it shall be done with an assembly (or series of assemblies) consisting of trailblazing signs or an acceptable alternate. The attraction will be responsible for installing the signs on all local roads.

8. Should an attraction qualify for TOD signs at two locations, the TOD sign(s) will be erected at the nearest location. If the applicant desires signing at the other location also, it may be so signed provided it does not prevent another attraction from being signed.

9. When it comes to the attention of the department that a participating activity is not in compliance with the minimum criteria, the applicant will be notified that it has a maximum

of 30 days to correct any deficiencies or its signs will be removed. If the applicant applies for reinstatement, this request will be handled in the same manner as a request from a new applicant.

10. The department reserves the right to cover or remove any or all TOD signs in the conduct of its operations or whenever deemed to be in the best interest of the department or the traveling public without advance notice thereof. The department reserves the right to terminate this program or any portion thereof by furnishing the applicant, a written notice of such intent not less than 30 calendar days prior thereof.

AUTHORITY NOTE: Promulgated in accordance with R.S. 48:461.2.

HISTORICAL NOTE: Promulgated by the Department of Transportation and Development, LR 12:1596 (December, 1993), amended LR 22:230 (March 1996).

#### **§207. Other Issuances Affected**

All directives, memoranda or instructions issued heretofore that conflict with this rule are hereby rescinded. All existing supplemental guide signs which qualify under this rule, but are not TODS, shall be removed by the department within two years, and may be replaced with TODS in accordance with these procedures.

AUTHORITY NOTE: Promulgated in accordance with R.S. 48:461.2.

HISTORICAL NOTE: Promulgated by the Department of Transportation and Development, LR 12:1596 (December, 1993), amended LR 22:231 (March 1996).

Frank M. Denton  
Secretary

9603#029

### **RULE**

#### **Department of Wildlife and Fisheries Office of Fisheries**

Gill and Trammel Nets Marking System (LAC 76:VII.181)

The secretary of the Department of Wildlife and Fisheries hereby adopts a rule for marking gill and trammel nets used to take freshwater commercial fish.

#### **Title 76**

#### **WILDLIFE AND FISHERIES**

#### **Part VII. Fish and Other Aquatic Life**

#### **Chapter 1. Freshwater Sport and Commercial Fishing**

#### **§181. Marking System for Freshwater Gill Nets and Trammel Nets**

Each gill net or trammel net used to take freshwater commercial fish shall be marked with a waterproof tag attached to the corkline at each end of the net, no more than 3 feet from the edge of the webbing. Said tags shall be supplied by the commercial fisherman and shall be completely waterproof. Each tag shall have the fisherman's full name (no initials) and commercial fisherman's license number (not the net license number) printed thereon in the English language, so as to be clearly legible.

AUTHORITY NOTE: Promulgated in accordance with R.S. 56:320(F).

HISTORICAL NOTE: Promulgated by the Department of Wildlife and Fisheries, Office of Fisheries, LR 22:231 (March 1996).

James H. Jenkins, Jr.  
Secretary

9603#036

### **RULE**

#### **Department of Wildlife and Fisheries Office of Management and Finance**

Net Buy-Back Program (LAC 76:XVII.301)

The Department of Wildlife and Fisheries does hereby establish a schedule showing the amount to be paid for each type and size of net to be purchased under the Net Buy-Back Program portion of the Commercial Fisherman's Economic Assistance Program and to establish procedures for application. This is in accordance with the Louisiana Marine Resources Conservation Act of 1995 (Act 1316).

#### **Title 76**

#### **WILDLIFE AND FISHERIES**

#### **Part XVII. Commercial Fisherman's Assistance Program**

#### **Chapter 3. Net Buy-Back Program**

#### **§301. Criteria for Qualification; Procedures**

A. Until January 1, 1996, the Department of Wildlife and Fisheries shall purchase from qualified persons those commercial fishing nets that have been rendered illegal or useless due to the enactment of the Louisiana Marine Resources Conservation Act of 1995 (Act 1316).

B. In order to qualify, persons must have applied for assistance under the Commercial Fisherman's Assistance Program on or before October 1, 1995, and must have met all of the following criteria:

1. must have purchased a saltwater gill net license in at least two of the years 1995, 1994, and 1993;
2. during two of those years shall have derived more than fifty percent of his earned income from the legal capture and sale of seafood species;
3. shall not have been convicted of any fishery-related offense that constitutes a class three or greater violation; and
4. must have been a bona fide resident of Louisiana on June 30, 1995.

C.1. Proof of income shall be provided by the applicant in the form of a copy of his federal tax return, including Schedule C of federal form 1040, which has been certified by the Internal Revenue Service. The Department of Wildlife and Fisheries can provide the applicant with the appropriate Internal Revenue Service form to request this. In the event that the certified copy of the tax return, including Schedule C, does not confirm the applicant's claim that more than 50 percent of the income was earned from the legal capture and sale of seafood species, the applicant shall provide a certified, audited return to that effect prepared and signed by a certified public accountant (CPA) which includes copies of all documents relied upon by the CPA in preparation of the audit. Said documentation shall be in the form of records which the

applicant would rely on to document his return to the Internal Revenue Service. Tax returns for at least two of the years 1995, 1994, and 1993 shall be provided by the applicant. Fishermen applying for fishing permits which require proof that 50 percent of his income was derived from the legal capture and sale of seafood species may also qualify using the following alternative method.

2. Alternative Method. Provided a fisherman meets all other qualifications for obtaining a commercial fishing permit except for having a tax return in one of the years 1994 or 1993, he will be allowed to provide proof that 50 percent of his income was derived from the legal capture and sale of seafood species for the current calendar year 1995 along with a 1040 and Schedule C from 1994 or 1993 which meets the qualifying standard. Said proof of the nature and amount of his 1995 income shall be as follows with no exceptions.

a. Applicant shall submit to the Department of Wildlife and Fisheries an affidavit signed by a certified public accountant (CPA) attesting to the audit of applicant's financial records and applicant's eligibility as defined by Act 1316.

b. The Department of Wildlife and Fisheries shall make available the affidavit referred to in C.2.a of this Section.

c. CPAs engaged by applicants to prepare financial data shall adhere to generally accepted accounting principals as recognized by the American Institute of Certified Public Accountants (AICPA).

d. The CPA shall require and accept documentation of applicant's financial transactions in the form normally acceptable to the I.R.S. The record keeping standards required by I.R.S. shall be adhered to in the evaluation of applicant's documentation.

e. The CPA shall prepare a financial statement depicting and listing separately applicant's total earned income as well as his earned income derived solely from the capture and sale of seafood species. This financial statement shall represent the period beginning January 1, 1995 through September 30, 1995.

f. The CPA shall provide an unqualified opinion attesting to the nature and amount of the applicant's earned income and whether said income complies with the requirement that more than 50 percent of the applicant's earned income was derived from the legal capture and sale of seafood species.

g. The CPA shall provide copies to the Department of Wildlife and Fisheries (Licensing Section) of all financial documents relied upon in support of his unqualified opinion.

h. The alternative method of fulfilling the earned income requirement shall become obsolete and discontinued on May 1, 1996. Applicants qualifying under the alternative method subsequent to December 31, 1995 shall be allowed to acquire a temporary permit which will be valid only through May 1, 1996. Those applicants receiving a temporary fishing permit valid from January 1, 1996 through May 1, 1996 may reapply for the usual permit at no additional cost, provided said applicant can provide proof of earned income as described in Act 1316 for two 12-month periods (calendar years) including the years 1993, 1994 and 1995 exclusively.

i. Irrespective of the method used by applicant

fishermen to qualify under the 50 percent earned income from the capture and sale of seafood species criteria, each applicant shall make available to the Department of Wildlife and Fisheries (Licensing Section) a certified copy of his Federal Income Tax return, including Schedule C of Federal Form 1040 prior to being issued any additional permits which require the 50 percent earned income test. Currently accepted 1040 and Schedule C Transcripts shall not be sufficient to qualify a permit applicant to renew or acquire a fishing permit beyond the period May 1, 1996. It is incumbent upon each permit applicant to obtain said 1040 and Schedule C information from the Internal Revenue Service.

D. Beginning September 1, 1995, qualified persons desiring to have their nets purchased by the Department of Wildlife and Fisheries may obtain an application form provided by the department from any departmental district office; the completed form shall include all information necessary to assist in the determination of the eligibility status of the applicant. All requested information regarding size, type and number of nets must be provided. The completed form, along with proof of income as described herein, a copy of the applicants Louisiana driver's license, and copies of appropriate saltwater gill net licenses, shall be submitted no later than October 1, 1995, to the Commercial License Section of Wildlife and Fisheries located at 2000 Quail Drive, Baton Rouge, LA or by mail to Box 98000, Baton Rouge, LA 70898. Applicants will be notified by mail as to the disposition of their application.

E. Only those nets that were legal for use in the saltwater areas of this state on June 1, 1995, and only those nets in usable condition, will be eligible for purchase under the provisions of Act 1316.

F. Applicants must have had a gear license issued in their name for at least one of the years 1995, 1994, or 1993, for the specific type of net(s) being presented for purchase. This is in addition to the requirements for having a saltwater gill net license for two of the three years.

G. Monetary reimbursement for nets to be purchased under this rule shall be determined based on the availability of funds collected from the issuance of the Louisiana Marine Resources Conservation Act Stamp. Funds collected through June 30, 1996, will be distributed as follows: 30 percent to the Enforcement Division of the department in accordance with the act; and the remaining 70 percent to be made available for the net buy-back portion of the Commercial Fisherman's Assistance Program. Subsequent to June 1996, 70 percent of the revenue collected from the LMRC Stamp will be used for the remainder of the Commercial Fisherman's Assistance Program as defined in Act 1316, R.S. 56:13(1)(C).

H. The disbursement of available funds for nets shall be calculated on a pro rata basis to accommodate the number of qualified applicants at a rate not to exceed 50 percent of the average cost of each qualifying net. The following is a schedule of the maximum amount to be paid for each type and size of net based upon 50 percent of the average standard 1995 catalog prices not including sales tax, shipping charges, or options. Actual prices to be paid will be limited by the number of qualifying nets and by the amount of revenue collected.

MESH DEPTH	GILL NETS	SEINES
	PRICE PER FOOT	PRICE PER FOOT
4' - 6'	\$ .25	\$ .76
over 6' - 8'	\$ .30	\$ .80
over 8' - 10'	\$ .38	\$ .87
over 10' - 12'	\$ .42	\$ .92
over 12' - 14'	\$ .44	\$ .96
over 14'	\$ .53	\$ 1.02

TRAMMEL NETS	
PRICE PER FOOT	
4' - 6'	\$ .38
over 6' - 8'	\$ .40
over 8' - 10'	\$ .43
over 10'	\$ .45

FISH TRAWLS	
Complete	\$ 11.22 per foot of trawl width
Trawl only	\$ 6.84 per foot of trawl width

AUTHORITY NOTE: Promulgated in accordance with R.S. 56:13.1.D.

HISTORICAL NOTE: Promulgated by the Department of Wildlife and Fisheries, Office of Management and Finance, LR 22:231 (March 1996).

James H. Jenkins, Jr.  
Secretary

9603#033

## RULE

### Department of Wildlife and Fisheries Wildlife and Fisheries Commission

#### Black Drum, Sheepshead, Flounder Harvest (LAC 76:VII.349)

The Wildlife and Fisheries Commission does hereby promulgate a rule (LAC 76:VII.349) to establish regulations governing the commercial harvest of black drum, flounder, sheepshead and other saltwater finfish (other than red drum, spotted seatrout, and mullet) with pompano strike nets. These regulations are required to effectuate the requirements of Act 1316 of the 1995 Regular Legislative Session. Authority for adoption of this rule is included in R.S. 56:6(10); 56:6(25)(a); 56:326.1; 56:326.3; and Act 1316 of the 1995 Regular Legislative Session, R.S. 56:325.4.

#### Title 76

### WILDLIFE AND FISHERIES

#### Part VII. Fish and Other Aquatic Life

#### Chapter 3. Saltwater Sport and Commercial Fishing

#### §349. Rules for Harvest of Black Drum, Sheepshead, Flounder and Other Saltwater Species using Pompano Strike Net

##### A. Restricted Species Strike Net Permit

1. The commercial taking of black drum, sheepshead, flounder and other saltwater finfish species (other than red drum, spotted seatrout and mullet which may not be taken with this gear, and other than pompano taken under R.S.

56:406 and LAC 76:VII.703 regulations) with a pompano strike net is prohibited except by special permit issued by the Department of Wildlife and Fisheries, hereby designated as a Restricted Species Strike Net Permit. This permit is required in addition to the Pompano Strike Net License required by law.

2. No person shall be issued a Drum/Sheepshead Strike Net Permit unless that person meets all of the following requirements:

a. The person shall provide proof that he purchased a valid Louisiana commercial saltwater gill net license in any two of the years 1995, 1994, and 1993.

b. The person shall show that he derived more than 50 percent of his earned income from the legal capture and sale of seafood species in any two of the years 1995, 1994, and 1993. Proof of such income shall be provided by the applicant in the form of a copy of his federal income tax return including Schedule C of federal form 1040, which has been certified by the Internal Revenue Service. In the event that the certified copy of the tax return, including Schedule C, does not confirm the applicant's claim that more than 50 percent of the income was earned from the legal capture and sale of seafood species, the applicant shall provide a certified, audited return to that effect which has been prepared and signed by a certified public accountant (CPA) which includes copies of all documents relied upon by the CPA in preparation of the audit. Tax returns for at least two of the years 1995, 1994 and 1993 shall be provided by the applicant. Fishermen applying for fishing permits which require proof that 50 percent of his income was derived from the legal capture and sale of seafood species may also qualify using the following Alternative Method.

c. Alternative Method. Provided a fisherman meets all other qualifications for obtaining a commercial fishing permit except for having a tax return in one of the years 1994 or 1993, he will be allowed to provide proof that 50 percent of his income was derived from the legal capture and sale of seafood species for the current calendar year 1995 along with a 1040 and Schedule C from 1994 or 1993 which meets the qualifying standard. Said proof of the nature and amount of his 1995 income shall be as follows with no exceptions.

i. Applicant shall submit to the Department of Wildlife and Fisheries an affidavit signed by a certified public accountant (CPA) attesting to the audit of applicant's financial records and applicant's eligibility as defined by Act 1316.

ii. The Department of Wildlife and Fisheries shall make available the affidavit referred to in number 1 and number 6.

iii. CPA's engaged by applicants to prepare financial data shall adhere to generally accepted accounting principals as recognized by the American Institute of Certified Public Accountants (AICPA).

iv. The CPA shall require and accept documentation of applicant's financial transactions in the form normally acceptable to the I.R.S. The record keeping standards required by I.R.S. shall be adhered to in the evaluation of applicant's documentation.

v. The CPA shall prepare a financial statement depicting and listing separately applicant's total earned

income as well as his earned income derived solely from the capture and sale of seafood species. This financial statement shall represent the period beginning January 1, 1995 through September 30, 1995.

vi. The CPA shall provide an unqualified opinion attesting to the nature and amount of the applicant's earned income and whether said income complies with the requirement that more than 50 percent of the applicant's earned income was derived from the legal capture and sale of seafood species.

vii. The CPA shall provide copies to the Department of Wildlife and Fisheries (Licensing Section) of all financial documents relied upon in support of his unqualified opinion.

viii. The alternative method of fulfilling the earned income requirement shall become obsolete and discontinued on May 1, 1996. Applicants qualifying under the alternative method subsequent to December 31, 1995 shall be allowed to acquire a temporary permit which will be valid only through May 1, 1996. Those applicants receiving a temporary fishing permit valid from January 1, 1996 through May 1, 1996 may reapply for the usual permit at no additional cost, provided said applicant can provide proof of earned income as described in Act 1316 for two 12-month periods (calendar years) including the years 1993, 1994 and 1995 exclusively.

ix. Irrespective of the method used by applicant fishermen to qualify under the 50 percent earned income from the capture and sale of seafood species criteria, each applicant shall make available to the Department of Wildlife and Fisheries (Licensing Section) a certified copy of his Federal Income Tax return, including Schedule C of Federal Form 1040 prior to being issued any additional permits which require the 50 percent earned income test. Currently accepted 1040 and Schedule C Transcripts shall not be sufficient to qualify a permit applicant to renew or acquire a fishing permit beyond the period May 1, 1996. It is incumbent upon each permit applicant to obtain said 1040 and Schedule C information from the Internal Revenue Service.

d. The person shall not have applied for or received any assistance pursuant to R.S. 56:13.1(C).

e. The applicant shall not have been convicted of any fishery-related violations that constitute a class three or greater violation.

3. Any person convicted of any offense involving fisheries laws or regulations shall forfeit any Restricted Species Strike Net Permit and shall be forever barred from receiving any such permit in the future.

#### B. Commercial Taking of Saltwater Finfish Using Pompano Strike Net

1. There shall be two seasons for the commercial harvest of all species of saltwater finfish (other than mullet, spotted seatrout and red drum) with a pompano strike net: the first season shall open on Monday, October 16, 1995, and end with the closure of the mullet strike net season, but no later than March 1, 1996; the second season shall open on Monday, October 21, 1996, and end with the closure of the mullet strike net season, but no later than March 1, 1997. A season for the taking of these species shall be closed prior to the dates listed in this Paragraph if the commercial quota for that species has

been taken, or on the date projected by the staff of the Department of Wildlife and Fisheries that a quota will be reached, whichever occurs first. The closure shall not take effect for at least 72 hours after notice to public.

2. During these two seasons the commercial harvest of these species with a pompano strike net shall not be allowed during the period from 5 a.m. on Saturday through 6 p.m. on Sunday. There shall be no commercial taking of these species with a pompano strike net during the period after sunset and before sunrise.

3. The commercial taking of these species by using a pompano strike net in excess of 1200 feet in length is prohibited. Furthermore, use of more than one pompano strike net from any vessel at any time is prohibited, and use of monofilament strike nets is also prohibited.

4. Each pompano strike net shall have attached to it a tag issued by the department which states the name, address, and social security number of the owner of the net and the Restricted Species Strike Net Permit number, if applicable. The department shall not issue any tag to a person who does not have a social security number.

5. Each Restricted Species Strike Net Permit holder shall on or before the 10th of each month file a return to the department on forms provided or approved for the purpose, the pounds of black drum from 16 to 27 inches, the number of black drum over 27 inches, the pounds of sheepshead and the pounds of flounder taken commercially during the preceding month, the gears used for harvest, and the commercial dealers to whom these were sold. Monthly reports shall be filed, even if catch or effort is zero.

C. General Provisions. Effective with the closure of a commercial season for black drum, sheepshead, flounder, or other saltwater finfish species harvested with a pompano strike net, there shall be a prohibition of the commercial take of that species with a pompano strike net from Louisiana waters, and the possession of that species on the waters of the state with a pompano strike net in possession. Nothing shall prohibit the possession, sale, barter or exchange off the water of fish legally taken during any open period provided that those who are required to do so shall maintain appropriate records in accordance with R.S. 56:306.4 and R.S. 56:345 and be properly licensed in accordance with R.S. 56:303 or 306.

AUTHORITY NOTE: Promulgated in accordance with 56:6(10), 56:6(25)(a); 56:326.1; 56:326.3; and Act 1316 of the 1995 Regular Legislative Session, R.S. 56:325.4.

HISTORICAL NOTE: Promulgated by the Department of Wildlife and Fisheries, Wildlife and Fisheries Commission, LR 16:698 (August 1990), amended LR 22:233

Glynn Carver  
Chairman

9603#039

**RULE**

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

**Commercial Fisherman's Assistance  
Program (LAC 76:XVII.101)**

The Wildlife and Fisheries Commission does hereby establish the procedures for determining proof of income of applicants for economic assistance under the Commercial Fisherman's Assistance Program established by the Louisiana Marine Resources Conservation Act of 1995 (Act 1316).

**Title 76**

**WILDLIFE AND FISHERIES**

**Part XVII. Commercial Fisherman's Assistance  
Program**

**Chapter 1. Proof of Income**

**§101. Criteria for Establishing Proof of Income and  
Procedures**

A. An applicant for economic assistance shall have derived more than 50 percent of his earned income from the legal capture and sale of seafood species in at least two of the years 1995, 1994, and 1993.

B. 1. Proof of such income shall be provided by the applicant in the form of a copy of his federal income tax return, including Schedule C of federal form 1040, which has been certified by the Internal Revenue Service. In the event that the certified copy of the tax return, including Schedule C, does not confirm the applicant's claim that more than 50 percent of the income was earned from the legal capture and sale of seafood species, the applicant shall provide a certified, audited return to that effect which has been prepared and signed by a certified public accountant (CPA) which includes copies of all documents relied upon by the CPA in preparation of the audit. Said documentation shall be in the form of records which the applicant would rely on to document his return to the Internal Revenue Service. Tax returns for at least two of the years 1995, 1994, and 1993 shall be provided by the applicant. Fishermen applying for fishing permits which require proof that 50 percent of his income was derived from the legal capture and sale of seafood species may also qualify using the following alternative method.

2. Alternative Method. Provided a fisherman meets all other qualifications for obtaining a commercial fishing permit except for having a tax return in one of the years 1994 or 1993, he will be allowed to provide proof that 50 percent of his income was derived from the legal capture and sale of seafood species for the current calendar year 1995 along with a 1040 and Schedule C from 1994 or 1993 which meets the qualifying standard. Said proof of the nature and amount of his 1995 income shall be as follows with no exceptions.

a. Applicant shall submit to the Department of Wildlife and Fisheries an affidavit signed by a Certified Public Accountant (CPA) attesting to the audit of applicant's financial records and applicant's eligibility as defined by Act 1316.

b. The Department of Wildlife and Fisheries shall make available the affidavit referred to in B.2.a of this Section.

c. CPAs engaged by applicants to prepare financial data shall adhere to generally accepted accounting principals as recognized by the American Institute of Certified Public Accountants (AICPA).

d. The CPA shall require and accept documentation of applicant's financial transactions in the form normally acceptable to the I.R.S. The record keeping standards required by I.R.S. shall be adhered to in the evaluation of applicant's documentation.

e. The CPA shall prepare a financial statement depicting and listing separately applicant's total earned income as well as his earned income derived solely from the capture and sale of seafood species. This financial statement shall represent the period beginning January 1, 1995 through September 30, 1995.

f. The CPA shall provide an unqualified opinion attesting to the nature and amount of the applicant's earned income and whether said income complies with the requirement that more than 50 percent of the applicant's earned income was derived from the legal capture and sale of seafood species.

g. The CPA shall provide copies to the Department of Wildlife and Fisheries (Licensing Section) of all financial documents relied upon in support of his unqualified opinion.

h. The alternative method of fulfilling the earned income requirement shall become obsolete and discontinued on May 1, 1996. Applicants qualifying under the alternative method subsequent to December 31, 1995 shall be allowed to acquire a temporary permit which will be valid only through May 1, 1996. Those applicants receiving a temporary fishing permit valid from January 1, 1996 through May 1, 1996 may reapply for the usual permit at no additional cost, provided said applicant can provide proof of earned income as described in Act 1316 for two 12-month periods (calendar years) including the years 1993, 1994 and 1995 exclusively.

i. Irrespective of the method used by applicant fishermen to qualify under the 50 percent earned income from the capture and sale of seafood species criteria, each applicant shall make available to the Department of Wildlife and Fisheries (Licensing Section) a certified copy of his Federal Income Tax return, including Schedule C of Federal Form 1040 prior to being issued any additional permits which require the 50 percent earned income test. Currently accepted 1040 and Schedule C Transcripts shall not be sufficient to qualify a permit applicant to renew or acquire a fishing permit beyond the period May 1, 1996. It is incumbent upon each permit applicant to obtain said 1040 and Schedule C information from the Internal Revenue Service.

AUTHORITY NOTE: Promulgated in accordance with R.S. 56:13.1.B(1).

HISTORICAL NOTE: Promulgated by the Department of Wildlife and Fisheries, Wildlife and Fisheries Commission, LR 22:235 (March 1996).

James H. Jenkins, Jr.  
Secretary

9603#032

## RULE

### Department of Wildlife and Fisheries Wildlife and Fisheries Commission

#### Mullet Harvest (LAC 76:VII.343)

The Wildlife and Fisheries Commission does hereby promulgate a rule (LAC 76:VII.343) to amend the regulations governing the commercial harvest of mullet. These regulations are required to effectuate the requirements of Act 1316 of the Regular Legislative Session. Authority for adoption of this rule is included R.S. 56:6(25)(a); 56:326.3; 56:333; and Act 1316 of the 1995 Regular Legislative Session, R.S. 56:333.

#### Title 76

#### WILDLIFE AND FISHERIES

#### Part VII. Fish and Other Aquatic Life

#### Chapter 3. Saltwater Sport and Commercial Fishing

#### §343. Rules for Harvest of Mullet

##### A. Seasons

1. The season for the commercial taking of mullet shall begin at sunrise of the third Monday in October of each year and close at sunset of the third Monday in January of the following year. Mullet may not be taken commercially at any time outside of this season.

2. Commercial harvest of mullet shall not be allowed during the period from 5 a.m. on Saturday through 6 p.m. on Sunday. There shall be no commercial taking of mullet during the period after sunset and before sunrise.

##### B. Commercial Taking

1. Mullet may only be taken commercially with a mullet strike net, which may not be constructed of monofilament. The commercial taking of mullet by using a mullet strike net in excess of 1,200 feet or by using more than one mullet strike net from any vessel at any time is prohibited.

2. Each mullet strike net shall have attached to it a tag issued by the department which states the name, address, and social security number of the owner of the net and the permit number of the permit issued to commercially take mullet. The department shall not issue any tag to a person who does not have a social security number.

C. Commercial Limits. During the season, there shall be no daily take or possession limit for the commercial harvest of mullet by properly licensed and permitted fishermen.

D. Recreational Limits. The daily take and possession limit for recreational harvest of mullet shall be 100 pounds per person per day.

##### E. Permits

1. The commercial taking of mullet is prohibited except by special permit issued by the Department of Wildlife and Fisheries at the cost of \$100 for residents of this state and \$400 for those who are nonresidents. This permit, along with other applicable licenses, authorizes the bearer to sell his mullet catch.

2. No person shall be issued a license or permit for the commercial taking of mullet unless that person meets all of the following requirements:

a. The person shall provide proof that he purchased

a valid Louisiana commercial saltwater gill net license in any two of the years 1995, 1994, and 1993.

b. The person shall show that he derived more than 50 percent of his earned income from the legal capture and sale of seafood species in any two of the years 1995, 1994, and 1993. Proof of such income shall be provided by the applicant in the form of a copy of his federal income tax return including Schedule C of federal form 1040, which has been certified by the Internal Revenue Service. In the event that the certified copy of the tax return, including Schedule C, does not confirm the applicant's claim that more than 50 percent of the income was earned from the legal capture and sale of seafood species, the applicant shall provide a certified, audited return to that effect which has been prepared and signed by a certified public accountant (CPA) which includes copies of all documents relied upon by the CPA in preparation of the audit. Tax returns for at least two of the years 1995, 1994 and 1993 shall be provided by the applicant. Fishermen applying for fishing permits which require proof that 50 percent of his income was derived from the legal capture and sale of seafood species may also qualify using the following alternative method.

c. Alternative Method. Provided a fisherman meets all other qualifications for obtaining a commercial fishing permit except for having a tax return in one of the years 1994 or 1993, he will be allowed to provide proof that 50 percent of his income was derived from the legal capture and sale of seafood species for the current calendar year 1995 along with a 1040 and Schedule C from 1994 or 1993 which meets the qualifying standard. Said proof of the nature and amount of his 1995 income shall be as follows with no exceptions.

i. Applicant shall submit to the Department of Wildlife and Fisheries an affidavit signed by a certified public accountant (CPA) attesting to the audit of applicant's financial records and applicant's eligibility as defined by Act 1316.

ii. The Department of Wildlife and Fisheries shall make available the affidavit referred to in §343.E.2.c.i., above.

iii. CPA's engaged by applicants to prepare financial data shall adhere to generally accepted accounting principals as recognized by the American Institute of Certified Public Accountants (AICPA).

iv. The CPA shall require and accept documentation of applicant's financial transactions in the form normally acceptable to the I.R.S. The record keeping standards required by I.R.S. shall be adhered to in the evaluation of applicant's documentation.

v. The CPA shall prepare a financial statement depicting and listing separately applicant's total earned income as well as his earned income derived solely from the capture and sale of seafood species. This financial statement shall represent the period beginning January 1, 1995 through September 30, 1995.

vi. The CPA shall provide an unqualified opinion attesting to the nature and amount of the applicant's earned income and whether said income complies with the requirement that more than 50 percent of the applicant's earned income was derived from the legal capture and sale of seafood species.



vii. The CPA shall provide copies to the Department of Wildlife and Fisheries (Licensing Section) of all financial documents relied upon in support of his unqualified opinion.

viii. The Alternative Method of fulfilling the earned income requirement shall become obsolete and discontinued on May 1, 1996. Applicants qualifying under the alternative method subsequent to December 31, 1995 shall be allowed to acquire a temporary permit which will be valid only through May 1, 1996. Those applicants receiving a temporary fishing permit valid from January 1, 1996 through May 1, 1996 may reapply for the usual permit at no additional cost, provided said applicant can provide proof of earned income as described in Act 1316 for two 12-month periods (calendar years) including the years 1993, 1994 and 1995 exclusively.

ix. Irrespective of the method used by applicant fishermen to qualify under the 50 percent earned income from the capture and sale of seafood species criteria, each applicant shall make available to the Department of Wildlife and Fisheries (Licensing Section) a certified copy of his Federal Income Tax return, including Schedule C of Federal Form 1040 prior to being issued any additional permits which require the 50 percent earned income test. Currently accepted 1040 and Schedule C Transcripts shall not be sufficient to qualify a permit applicant to renew or acquire a fishing permit beyond the period May 1, 1996. It is incumbent upon each permit applicant to obtain said 1040 and Schedule C information from the Internal Revenue Service.

d. The person shall not have applied for or received any assistance pursuant to R.S. 56:13.1(C).

3. No person shall receive more than one permit or license to commercially take mullet.

4. Any person convicted of any offense involving fisheries laws or regulations shall forfeit any permit or license issued to commercially take mullet and shall be forever barred from receiving any permit or license to commercially take mullet.

5. Each Mullet Permit holder shall, on or before the 10th of each month of the open season, submit an information return to the department on forms provided or approved for this purpose, including the pounds of mullet taken commercially during the preceding month, and the commercial dealers to whom these were sold. Monthly reports shall be filed, even if catch or effort is zero.

F. General Provisions. Effective with the closure of the commercial season for mullet, there shall be a prohibition of the commercial take from Louisiana waters, and the possession of mullet on the waters of the state with commercial gear in possession. Nothing shall prohibit the possession, sale, barter or exchange off the water of mullet legally taken during any open period provided that those who are required to do so shall maintain appropriate records in accordance with R.S. 56:306.4. and R.S. 56:345 and be properly licensed in accordance with R.S. 56:303 or 306. G

In addition, all provisions of R.S. 56:333(C) are hereby adopted and incorporated into this rule.

AUTHORITY NOTE: Promulgated in accordance with R.S. 56:6(25)(a), 56:325.1, 56:333 and Act 1316 of the 1995 Regular Legislative Session, R.S. 56:333.

HISTORICAL NOTE: Promulgated by the Department of Wildlife and Fisheries, Wildlife and Fisheries Commission, LR 18:1420 (December 1992), amended LR 21:37 (January 1995), LR 22:236 (March 1996).

Glynn Carver  
Chairman

96031#038

## RULE

### Department of Wildlife and Fisheries Wildlife and Fisheries Commission

#### Saltwater Commercial Rod and Reel License (LAC 76:VII.405)

The Wildlife and Fisheries Commission does hereby establish the procedures relative to the proof of income criteria for applicants for a saltwater commercial rod and reel license in accordance with the Louisiana Marine Resources Conservation Act of 1995 (Act 1316).

#### Title 76

#### WILDLIFE AND FISHERIES

#### Part VII. Fish and Other Aquatic Life

#### Chapter 4. License and License Fees

#### §405. Saltwater Commercial Rod and Reel License; Proof of Income.

A. Each applicant shall have derived more than 50 percent of his earned income from the legal capture and sale of seafood species in at least two of the three years, 1995, 1994, and 1993.

B.1. Proof of income shall be provided by the applicant in the form of a copy of his federal income tax return, including Schedule C of federal form 1040, which has been certified by the Internal Revenue Service and a copy of his state tax return which has been certified by the Louisiana Department of Revenue and Taxation. In the event that the certified copies of the tax returns, including Schedule C, do not confirm the applicant's claim that more than 50 percent of the income was earned from the legal capture and sale of seafood species, the applicant shall provide a certified, audited return to that effect which has been prepared and signed by a certified public accountant (CPA) which includes copies of all documents relied upon by the CPA in preparation of the audit. Said documentation shall be in the form of records which the applicant would rely on to document his return to the Internal Revenue Service. Tax returns for at least two of the years 1995, 1994, and 1993 shall be provided by the applicant. Fishermen applying for fishing permits which require proof that 50 percent of his income was derived from the legal capture and sale of seafood species may also qualify using the following alternative method.

2. Alternative Method. Provided a fisherman meets all other qualifications for obtaining a commercial fishing permit except for having a tax return in one of the years 1994 or 1993, he will be allowed to provide proof that 50 percent of his income was derived from the legal capture and sale of seafood species for the current calendar year 1995 along with a 1040 and Schedule C from 1994 or 1993 which meets the

qualifying standard. Said proof of the nature and amount of his 1995 income shall be as follows with no exceptions.

a. Applicant shall submit to the Department of Wildlife and Fisheries an affidavit signed by a certified public accountant (CPA) attesting to the audit of applicant's financial records and applicant's eligibility as defined by Act 1316.

b. The Department of Wildlife and Fisheries shall make available the affidavit referred to in B.2.a. of this Section.

c. CPAs engaged by applicants to prepare financial data shall adhere to generally accepted accounting principals as recognized by the American Institute of Certified Public Accountants (AICPA).

d. The CPA shall require and accept documentation of applicant's financial transactions in the form normally acceptable to the I.R.S. The record keeping standards required by I.R.S. shall be adhered to in the evaluation of applicant's documentation.

e. The CPA shall prepare a financial statement depicting and listing separately applicant's total earned income as well as his earned income derived solely from the capture and sale of seafood species. This financial statement shall represent the period beginning January 1, 1995 through September 30, 1995.

f. The CPA shall provide an unqualified opinion attesting to the nature and amount of the applicant's earned income and whether said income complies with the requirement that more than 50 percent of the applicant's earned income was derived from the legal capture and sale of seafood species.

g. The CPA shall provide copies to the Department of Wildlife and Fisheries (Licensing Section) of all financial documents relied upon in support of his unqualified opinion.

h. The alternative method of fulfilling the earned income requirement shall become obsolete and discontinued on May 1, 1996. Applicants qualifying under the alternative method subsequent to December 31, 1995 shall be allowed to acquire a temporary permit which will be valid only through May 1, 1996. Those applicants receiving a temporary fishing permit valid from January 1, 1996 through May 1, 1996 may reapply for the usual permit at no additional cost, provided said applicant can provide proof of earned income as described in Act 1316 for two 12-month periods (calendar years) including the years 1993, 1994 and 1995 exclusively.

i. Irrespective of the method used by applicant fishermen to qualify under the 50 percent earned income from the capture and sale of seafood species criteria, each applicant shall make available to the Department of Wildlife and Fisheries (Licensing Section) a certified copy of his Federal Income Tax return, including Schedule C of Federal Form 1040 prior to being issued any additional permits which require the 50 percent earned income test. Currently accepted 1040 and Schedule C Transcripts shall not be sufficient to qualify a permit applicant to renew or acquire a fishing permit beyond the period May 1, 1996. It is incumbent upon each permit applicant to obtain said 1040 and Schedule C information from the Internal Revenue Service.

AUTHORITY NOTE: Promulgated in accordance with R.S. 56:13.1.D.

HISTORICAL NOTE: Promulgated by the Department of Wildlife and Fisheries, Wildlife and Fisheries Commission, LR 22:237 (March 1996).

James H. Jenkins, Jr.  
Secretary

9603#034

## RULE

### Department of Wildlife and Fisheries Wildlife and Fisheries Commission

#### Spotted Seatrout Harvest (LAC 76:VII.341)

The Wildlife and Fisheries Commission does hereby promulgate a rule (LAC 76:VII.341) to amend the regulations governing the commercial harvest of spotted seatrout. These regulations are required to effectuate the requirements of Act 1316 of the Regular Legislative Session. Authority for adoption of this rule is included in Act Number 157 of the 1991 Regular Session of the Louisiana Legislature, R.S. 56:6(25)(a); 56:325.3; 56:326.3; and Act 1316 of the 1995 Regular Legislative Session, R.S. 56:325.3.

#### Title 76

#### WILDLIFE AND FISHERIES

#### Part VII. Fish and Other Aquatic Life

#### Chapter 3. Saltwater Sport and Commercial Fishing

#### §341. Spotted Seatrout Management Measures

##### A. Commercial Season; Quota; Permits

1. The season for the commercial taking of spotted seatrout shall begin at sunrise on the third Monday in November of each year, and close at sunset on April 30 the following year or when the quota has been reached or on the date projected by the staff of the Department of Wildlife and Fisheries that the quota will be reached, whichever occurs first.

2. There shall be no commercial taking of spotted seatrout during the period after sunset and before sunrise.

3. The commercial quota for spotted seatrout shall be 1,000,000 pounds for each fishing season.

##### 4. Permits

a. The commercial taking of spotted seatrout is prohibited except by special nontransferable Spotted Seatrout Permit issued by the Department of Wildlife and Fisheries at the cost of \$100 for residents of this state and \$400 for those who are nonresidents. This permit, along with other applicable licenses, authorizes the bearer to sell his spotted seatrout catch.

b. No person shall be issued a license or permit for the commercial taking of spotted seatrout unless that person meets all of the following requirements:

i. The person shall provide proof that he purchased a valid Louisiana commercial saltwater gill net license in any two of the years 1995, 1994, and 1993.

ii. The person shall show that he derived more than 50 percent of his earned income from the legal capture and sale of seafood species in any two of the years 1995, 1994, and 1993. Proof of such income shall be provided by the

applicant in the form of a copy of his federal income tax return including Schedule C of federal form 1040, which has been certified by the Internal Revenue Service. In the event that the certified copy of the tax return, including Schedule C, does not confirm the applicant's claim that more than 50 percent of the income was earned from the legal capture and sale of seafood species, the applicant shall provide a certified, audited return to that effect which has been prepared and signed by a certified public accountant (CPA) which includes copies of all documents relied upon by the CPA in preparation of the audit. Tax returns for at least two of the years 1995, 1994 and 1993 shall be provided by the applicant. Fishermen applying for fishing permits which require proof that 50 percent of his income was derived from the legal capture and sale of seafood species may also qualify using the following alternative method.

iii. Alternative Method. Provided a fisherman meets all other qualifications for obtaining a commercial fishing permit except for having a tax return in one of the years 1994 or 1993, he will be allowed to provide proof that 50 percent of his income was derived from the legal capture and sale of seafood species for the current calendar year 1995 along with a 1040 and Schedule C from 1994 or 1993 which meets the qualifying standard. Said proof of the nature and amount of his 1995 income shall be as follows with no exceptions.

(a). Applicant shall submit to the Department of Wildlife and Fisheries an affidavit signed by a certified public accountant (CPA) attesting to the audit of applicant's financial records and applicant's eligibility as defined by Act 1316.

(b). The Department of Wildlife and Fisheries shall make available the affidavit referred to in A.4.b.iii.(a) of this Section.

(c). CPA's engaged by applicants to prepare financial data shall adhere to generally accepted accounting principals as recognized by the American Institute of Certified Public Accountants (AICPA).

(d). The CPA shall require and accept documentation of applicant's financial transactions in the form normally acceptable to the I.R.S. The record keeping standards required by I.R.S. shall be adhered to in the evaluation of applicant's documentation.

(e). The CPA shall prepare a financial statement depicting and listing separately applicant's total earned income as well as his earned income derived solely from the capture and sale of seafood species. This financial statement shall represent the period beginning January 1, 1995 through September 30, 1995.

(f). The CPA shall provide an unqualified opinion attesting to the nature and amount of the applicant's earned income and whether said income complies with the requirement that more than 50 percent of the applicant's earned income was derived from the legal capture and sale of seafood species.

(g). The CPA shall provide copies to the Department of Wildlife and Fisheries (Licensing Section) of all financial documents relied upon in support of his unqualified opinion.

(h). The alternative method of fulfilling the earned income requirement shall become obsolete and discontinued

on May 1, 1996. Applicants qualifying under the alternative method subsequent to December 31, 1995 shall be allowed to acquire a temporary permit which will be valid only through May 1, 1996. Those applicants receiving a temporary fishing permit valid from January 1, 1996 through May 1, 1996 may reapply for the usual permit at no additional cost, provided said applicant can provide proof of earned income as described in Act 1316 for two 12-month periods (calendar years) including the years 1993, 1994 and 1995 exclusively.

(i). Irrespective of the method used by applicant fishermen to qualify under the 50 percent earned income from the capture and sale of seafood species criteria, each applicant shall make available to the Department of Wildlife and Fisheries (Licensing Section) a certified copy of his Federal Income Tax return, including Schedule C of Federal Form 1040 prior to being issued any additional permits which require the 50 percent earned income test. Currently accepted 1040 and Schedule C Transcripts shall not be sufficient to qualify a permit applicant to renew or acquire a fishing permit beyond the period May 1, 1996. It is incumbent upon each permit applicant to obtain said 1040 and Schedule C information from the Internal Revenue Service.

iv. The person shall not have applied for or received any assistance pursuant to R.S. 56:13.1(C).

v. The applicant shall not have been convicted of any fishery-related violations that constitute a class three or greater violation.

c. No person shall receive more than one permit or license to commercially take spotted seatrout.

d. Any person convicted of any offense involving fisheries laws or regulations shall forfeit any permit or license issued to commercially take spotted seatrout and shall be forever barred from receiving any permit or license to commercially take spotted seatrout.

5. Each Spotted Seatrout Permit holder shall, on or before the 10th of each month of the open season, submit an information return to the department on forms provided or approved for this purpose, including the pounds of spotted seatrout taken commercially during the preceding month, and the commercial dealers to whom these were sold, if sold. Monthly reports shall be filed, even if catch or effort is zero.

B. Commercial Taking of Spotted Seatrout Using Mullet Strike Nets, Seasons

1. There shall be two seasons for the commercial harvest of spotted seatrout with a mullet strike net: the first season shall open on Monday, November 20, 1995, and end no later than March 1, 1996; the second season shall open on Monday, November 18, 1996, and end no later than March 1, 1997. Such seasons shall be closed prior to the dates listed in this Paragraph if:

a. 1,000,000 pounds of spotted seatrout have been taken commercially during a fishing season; or

b. on the date projected by the staff of the Department of Wildlife and Fisheries that the quota will be reached, whichever occurs first. The closure shall not take effect for at least 72 hours after notice to the public.

2. During these two seasons the commercial harvest of spotted seatrout with mullet strike nets shall not be allowed during the period from 5 a.m. on Saturday through 6 p.m. on

Sunday. There shall be no commercial taking of spotted seatrout during the period after sunset and before sunrise.

3. The commercial taking of spotted seatrout by using a mullet strike net in excess of 1200 feet in length is prohibited. Furthermore, use of more than one mullet strike net from any vessel at any time is prohibited, and use of monofilament strike nets is also prohibited.

4. Each mullet strike net shall have attached to it a tag issued by the department which states the name, address, and social security number of the owner of the net and the permit number of the permit issued to commercially take spotted seatrout. The department shall not issue any tag to a person who does not have a social security number.

**C. Commercial Taking of Spotted Seatrout Using Other Commercial Gear**

1. There shall be no commercial taking of spotted seatrout during the period after sunset and before sunrise.

2. During the 1995-1996 season for harvest of spotted seatrout with a mullet strike net, all other legal methods of harvest may also be used until March 1, 1996. After that date, only commercial rod and reel may be used for the commercial harvest of spotted seatrout, provided that the commercial harvest of spotted seatrout does not exceed the commercial quota.

3. During the 1996-1997 season for commercial harvest of spotted seatrout with a mullet strike net, only a mullet strike net or a commercial rod and reel may be used for the commercial harvest of spotted seatrout provided the commercial harvest of spotted seatrout does not exceed the commercial quota.

4. Following the closure of the 1996-1997 season for the harvest of spotted seatrout with a mullet strike net, only a commercial rod and reel shall be used for the commercial harvest of spotted seatrout, provided the commercial harvest of spotted seatrout does not exceed the commercial quota.

D. General Provisions. Effective with the closure of the commercial season for spotted seatrout, there shall be a prohibition of the commercial take from Louisiana waters, and the possession of spotted seatrout on the waters of the state with commercial gear in possession. Nothing shall prohibit the possession, sale, barter or exchange off the water of spotted seatrout legally taken during any open period provided that those who are required to do so shall maintain appropriate records in accordance with R.S. 56:306.4. and R.S. 56:345 and be properly licensed in accordance with R.S. 56:303 or 306.

AUTHORITY NOTE: Promulgated in accordance with Act Number 157 of the 1991 Regular Session of the Louisiana Legislature, R.S. 56:6(25)(a); 56:325.3; 56:326.3; and Act 1316 of the 1995 Regular Legislative Session, R.S. 56:325.3.

HISTORICAL NOTE: Promulgated by the Department of Wildlife and Fisheries, Wildlife and Fisheries Commission, LR 18:199 (February 1992), amended LR 22:238 (March 1996).

Glynn Carver  
Chairman

9603#037

**RULE**

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

**Traversing Permit (LAC 76:VII.403)**

The Department of Wildlife and Fisheries and the Wildlife and Fisheries Commission does hereby promulgate a rule to establish the rules and regulations for the issuance of Traversing Permits to persons authorized to possess gill nets, trammel nets, strike nets, and seines within the territorial boundaries of the state while traversing state waters to and from the federal exclusive economic zone.

**Title 76**

**WILDLIFE AND FISHERIES**

**Part VII. Fish and Other Aquatic Life**

**Chapter 4. License and License Fees**

**§403. Traversing Permit**

A. The Department of Wildlife and Fisheries is authorized to issue a Traversing Permit upon application to its Commercial License Section at the Baton Rouge office for a fee of \$250 for each permit. Application for permits must be made in person.

B. The Traversing Permit shall be valid for the calendar year of issue (January 1 through December 31).

C. The captain or vessel owner shall only be required to have one Traversing Permit for any number of gill nets, trammel nets, strike nets, or seines. Each gear used in the waters of the federal exclusive economic zone (EEZ) shall be properly licensed. For licensing purposes, trammel nets, strike nets, and seines are required to be licensed as gill nets when used in the EEZ.

D. The possession of gill nets, trammel nets, strike nets, or seines on or aboard any vessel in the saltwater areas of the state is prohibited unless the captain or owner of the vessel has in his immediate possession upon the vessel a Traversing Permit as well as any other licenses as required by law.

E. While traversing state waters going to and from the waters of the federal exclusive economic zone, all gill nets, trammel nets, strike nets, and seines shall remain on board the vessel and shall not be used in state waters.

F. Harvest and possession of all fish pursuant to this permit is subject to all rules established by the Wildlife and Fisheries Commission relative to seasons, size limits, and quotas.

G. Vessels containing or transporting prohibited nets shall proceed as directly, continuously, and expeditiously as possible.

H. Permittees will be required to abide by the following conditions:

1. Possession of a permit does not exempt the permittee from laws or regulations except for those which may be specifically exempted by the permit. Any violation of a fish law shall constitute a violation of this permit.

2. Information gained by the department through the issuance of a Traversing Permit is not privileged and will be disseminated to the public upon request.

3. The permittee shall report monthly the catch and effort under the permit, even when catch and effort is zero. This

report shall contain total catch, total effort, and any other parameters which may be required by the department. The report shall be filed with the enforcement division of the Department of Wildlife and Fisheries no later than 30 days following the last day of each month.

4. When permitted gear is on board the permitted vessel or in possession of the permittee, the permittee and the vessel are assumed to be operating under authority of the permit. No gear other than gear allowed under the Traversing Permit may be on board the vessel or in possession of the permittee.

5. The vessel authorized for use under the Traversing Permit shall have distinguishing signs so that it may be identified as such. The signs shall have the letters "EEZ" and assigned numbers printed on them in at least 10-inch high letters and numbers on a contrasting background in block style so as to be visible and legible from low-flying aircraft and from any vessel in the immediate vicinity. The assigned numbers shall be situated on both sides and on top of the vessel.

6. The department reserves the right to observe the operations taking place under the Traversing Permit and, at its request, the department may assign aboard any permitted vessel an enforcement agent as an observer.

7. All permittees shall notify the department four hours prior to leaving port to traverse or fish under the conditions of the Traversing Permit and immediately upon returning from the permitted trip. The department shall be notified by calling a designated phone number.

8. The permittee must report to the department the name of the buyer who will purchase the fish product obtained under the Traversing Permit. This information shall be provided at the time that permittee notifies the department of his return.

9. When quotas have been met or seasons have been closed, no fish affected by such quotas or seasons may be possessed on board a vessel while having commercial gear on board traveling state waters.

10. Any violation of the conditions of the Traversing Permit and any violation of any fisheries regulation shall be punishable as defined by R.S. 56:320.2.D.(1) in accordance with Act 1316 of the 1995 Legislature.

**AUTHORITY NOTE:** Promulgated in accordance with 56:305.B and 56:320.2.E.

**HISTORICAL NOTE:** Promulgated by the Department of Wildlife and Fisheries, Wildlife and Fisheries Commission, LR 22:240 (March 1996).

James H. Jenkins, Jr.  
Secretary

# Notices of Intent

## NOTICE OF INTENT

### Department of Culture, Recreation and Tourism Office of the State Library

Name Change; Restructuring; Certification  
(LAC 25:VII.Subparts 1-6)

In accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., notice is hereby given that the Office of the State Library intends to amend rules and regulations contained in Title 25, Cultural Resources, Part VII, Subparts 1-6).

The change will have no economic impact on the budget of the state and no fees are involved.

This revision of rules is being submitted to reflect current policies and practices of the State Library. Major revisions and changes can be summarized as follows.

1. The library name is changed throughout from Louisiana State Library to State Library of Louisiana.

2. Subpart 2, Library Technical Services, Chapter 11, State Library Processing Center, is retitled, State Library Specialized Cataloging Assistance Center. Sections 1103, 1105, 1107, and 1109 are deleted and §1101 revised to reflect the restructuring of the Processing Center into the Specialized Cataloging Assistance Center.

3. Subpart 3, Library Development, Chapter 23, Regional Library Systems, is deleted in its entirety, as the State Library no longer establishes and/or supports library systems.

Subpart 3, Chapter 27, Auditorium and Conference Room—Use by the Public, is deleted in its entirety as these facilities can no longer be used by the public.

4. Subpart 6, Board of Library Examiners, Chapter 53, Examination, is recodified and amended. The revised text is incorporated into Subpart 6, Chapter 51, Certification, §§5105-5119.

These rules are promulgated in accordance with R.S. 25:1 et seq.

These proposed rule changes may be viewed in their entirety by contacting the State Library at (504) 342-4923 and at the Office of the State Register, 1051 North Third Street, Capitol Annex, Fifth Floor, Baton Rouge, LA 70802, telephone (504) 342-5015, please refer to document 9603#040 when inquiring about this proposed rule.

Persons interested may submit written comments on the proposed changes by May 31, 1996, to: Thomas F. Jaques, State Librarian, State Library of Louisiana, Box 131, Baton Rouge, LA 70821-0131.

Phillip Jones  
Secretary

9603#035

**FISCAL AND ECONOMIC IMPACT STATEMENT  
FOR ADMINISTRATIVE RULES**

**RULE TITLE: Name Change; Restructuring;  
Certification**

- I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENTAL UNITS (Summary)  
Neither costs nor savings to state or local governmental units are involved in these rule changes.
- II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)  
No effect on revenue collections of state or local governmental units is anticipated from these rule changes.
- III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)  
No costs or economic benefits to directly affected persons or nongovernmental groups are expected from these rule changes.
- IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)  
No effect on competition and employment is anticipated from these rule changes.

Thomas F. Jaques  
State Librarian  
9603#040

Richard W. England  
Assistant to the  
Legislative Fiscal Officer

**NOTICE OF INTENT**

**Board of Elementary and Secondary Education**

**Bulletin 1196—School Food Service Manager Certification**

In accordance with R.S. 49:950, et seq., the Administrative Procedure Act, notice is hereby given that the Board of Elementary and Secondary Education approved for advertisement an amendment to the School Food Service Manager Certification Program of Bulletin 1196, School Food Service Programs stated below:

**Section 5.09. Exam Administration Procedures**

Delete the following:

"A trainee failing any one of the exams three times will not be allowed to continue the Manager Certification Program."

Deletion of this policy will allow persons to continue to train and test for manager certification regardless of the number of times the person fails one of the three required tests. Further, the USDA has determined that this policy is overly restrictive.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:191.

Interested persons may submit comments in writing until 4:30 p.m., May 9, 1996 to: Eileen Bickham, State Board of Elementary and Secondary Education, Box 94064, Capitol Station, Baton Rouge, LA 70804-9064.

Carole Wallin  
Executive Director

**FISCAL AND ECONOMIC IMPACT STATEMENT  
FOR ADMINISTRATIVE RULES**

**RULE TITLE: School Food Service Manager Certification  
Program**

- I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENTAL UNITS (Summary)  
The costs for implementation of this proposed rule change will be approximately \$200 in the first year and \$100 per year thereafter. These costs involve printing and postage necessary for dissemination of the rule change and the cost of printing of additional test documents.  
BESE's estimated cost for printing this policy change and first page of fiscal and economic impact statement in the *Louisiana Register* is approximately \$75. Funds are available.
- II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)  
There will be no effect on revenue collections to the Department of Education.
- III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)  
There will be an economic benefit to those persons who ultimately become employed in school food service manager positions once certified.
- IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)  
There will be an increase in competition for the position of school food service manager. Based on current figures, it is anticipated that five to then more persons per year could compete for the manager positions across the state. An increase in employment may not be experienced since the persons competing for the manager position would most likely already be employed as technicians.

Marlyn Langley  
Deputy Superintendent  
Management and Finance  
9603#060

Richard W. England  
Assistant to the  
Legislative Fiscal Officer

**NOTICE OF INTENT**

**Board of Elementary and Secondary Education**

**Bulletin 1196—School Food Service Severe Need Breakfast  
Program**

In accordance with R.S. 49:950, et seq., the Administrative Procedure Act, notice is hereby given that the Board of Elementary and Secondary Education approved for advertisement an amendment to the Severe Need Breakfast Program, under Section 3.22-03.B (Labor Cost) of Bulletin 1196, School Food Service Programs stated below.

**Section 3.22-03.B - Labor Cost**

Delete the last sentence of paragraph four under this section as stated below:

"Individual schools failing to meet this minimum in breakfast expenses will not be eligible to receive severe need breakfast funding in the coming year."

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:191.

Deletion of this sentence will allow schools to receive severe need funding regardless of their eligibility in the prior year. Further, the USDA has determined that this policy is overly restrictive.

Interested persons may submit comments in writing until 4:30 p.m., May 9, 1996 to: Eileen Bickham, State Board of Elementary and Secondary Education, Box 94064, Capitol Station, Baton Rouge, LA 70804-9064.

Carole Wallin  
Executive Director

**FISCAL AND ECONOMIC IMPACT STATEMENT  
FOR ADMINISTRATIVE RULES  
RULE TITLE: School Food Services Severe Need Breakfast  
Program**

**I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO  
STATE OR LOCAL GOVERNMENTAL UNITS (Summary)**

The costs for implementation of this proposed rule change will be approximately \$150 in the first year for printing and postage necessary for dissemination of the rule change.

BESE's estimated cost for printing this policy change and first page of fiscal and economic impact statement in the *Louisiana Register* is approximately \$75. Funds are available.

**II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF  
STATE OR LOCAL GOVERNMENTAL UNITS (Summary)**

The potential estimated revenue collection for the Department of Education will be \$6,070,074 in additional federal reimbursement under the severe need breakfast program.

**III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS  
TO DIRECTLY AFFECTED PERSONS OR  
NINGOVERNMENTAL GROUPS (Summary)**

The potential estimated economic benefit to local education agencies in Louisiana will be \$6,070,074 in additional federal reimbursement under the severe need breakfast program.

**IV. ESTIMATED EFFECT ON COMPETITION AND  
EMPLOYMENT (Summary)**

There will be no effect on competition and employment as a result of this proposed rule change.

Marlyn Langley  
Deputy Superintendent  
Management and Finance  
9603#061

Richard W. England  
Assistant to the  
Legislative Fiscal Officer

**NOTICE OF INTENT**

**Firefighters' Pension and Relief Fund  
City of New Orleans and Vicinity**

**Direct Rollovers**

The Board of Trustees of the Firefighters' Pension and Relief Fund for the City of New Orleans and Vicinity (fund), pursuant to R.S. 11:3363(F), proposes to amend and restate its rules and regulations of direct rollovers.

**Direct Rollovers**

1. Notwithstanding any provision of the plan to the contrary, benefit distributions shall be made in accordance with the following direct rollover requirements and shall otherwise comply with Section 401(a)(31) of the Internal Revenue Code and the Treasury regulations promulgated

thereunder, the provisions of which are incorporated herein by reference. The trustees shall allow a member to directly roll over his eligible rollover distribution which is paid directly to an eligible retirement plan as specified by the member.

2. For purposes of these rules and regulations, an eligible rollover distribution is any distribution from this fund of all or any portion of the balance to the credit of the member except the following:

(a) any distribution that is one of a series of substantially equal periodic payments (not less frequently than annually) made over any one of the following periods: the life of the member (or the joint lives of the member and the member's designated beneficiary), the life expectancy of the member (or the joint life and last survivor expectancy of the member and the member's designated beneficiary), or a specified period of 10 years or more; or

(b) any distribution to the extent the distribution is required under Section 401(a)(9) of the Internal Revenue Code, relating to the minimum distribution requirements; or

(c) the portion of any distribution that is not includable in gross income.

3. For purposes of this section, an eligible retirement plan is an individual retirement account under Code §408(a); an individual retirement annuity under Code §408(b); a qualified defined contribution plan under Code §401(a); an annuity plan under Code §403(a); or any other type of plan specified under the Treasury regulations.

4. A notice to participants conforming with I.R.C. Section 402(f) and all Treasury regulations promulgated thereunder shall be provided to the member and any other person receiving a distribution by the fund who is eligible to make a direct rollover no less than 30 days and no more than 90 days before the date of distribution of the pension benefit. The notice shall inform the distributee that he has the right to consider his options for at least 30 days prior to making the election described in Section 4 of these rules and regulations and shall further inform the member or distributee that he may affirmatively waive this 30-day review period by submitting the election prior to the expiration of 30-day period.

5. A member shall elect to have his eligible rollover distribution directly rolled over to an eligible retirement plan by completing and filing the applicable forms before the date of distribution of his pension benefits. The member, pursuant to the provisions hereunder, must specify the eligible retirement plan to which his eligible rollover distribution will be directly paid as a direct rollover. A member may revoke any election to directly roll over his eligible rollover distribution, provided such revocation is in writing and filed with the trustees before his date of distribution of his pension benefits.

6. The trustees shall accomplish a direct rollover under Section 401(a)(31) of the Internal Revenue Code by establishing reasonable procedures in accordance with the Treasury regulations either by a wire transfer or by mailing the distribution check directly to the eligible retirement plan specified by the member. Payment made by check must be negotiable only by the trustee of the eligible retirement plan. Payment made by wire transfer must be directed only to the trustee of the eligible retirement plan.

The trustees shall, in their sole and absolute discretion, distribute the eligible rollover distribution check directly to the member, instructing the member to deliver same to his designated eligible retirement plan, provided that if the eligible retirement plan is an individual retirement account, the check must be payable to the trustee, as trustee of the individual retirement account for the benefit of the distributee member; or if to a qualified retirement trust, the check must be payable to the trustee of the qualified plan for the benefit of the distributee member.

7. The member shall not directly roll over any eligible rollover distribution, or portion thereof, if the total amount of his eligible rollover distribution is less than \$200, or as such amount may be adjusted from time to time under Section 401(a)(31) of the Internal Revenue Code or the Treasury regulations promulgated thereunder.

8. The member shall not directly roll over a portion of his eligible rollover distribution to an eligible retirement plan if such portion is less than \$200, or such other amount as provided under Section 6 above. The remainder of the member's eligible rollover distribution not directly rolled over shall be paid to the member.

9. The member shall directly roll over his eligible rollover distribution, or a portion thereof, only to a single eligible retirement plan. The member is prohibited from dividing his eligible rollover distribution into two or more separate distributions to be paid in direct rollovers to two or more eligible retirement plans.

10. The trustees shall treat a member's election to make or not make a direct rollover with respect to one payment in a series of periodic payments as applying to all subsequent payments in a series. The member, with respect to subsequent payments, shall at any time change his previous election to make or not make a direct rollover by completing and filing the appropriate forms with the trustees.

11. A surviving spouse of a deceased member shall elect to have her eligible rollover distribution directly rolled over only to an individual retirement account in accordance with the provisions hereunder.

12. A spouse or former spouse alternate payee under a Qualified Domestic Relations Order shall elect to have her eligible rollover distribution directly rolled over to an eligible retirement plan as specified by the spouse or former spouse alternate payee in accordance with the provisions hereunder.

A nonspouse beneficiary of a deceased member is prohibited from electing a direct rollover to any eligible retirement plan.

A public hearing will be conducted by the Board of Trustees of the Firefighters' Pension and Relief Fund for the City of New Orleans and Vicinity at 10 a.m. on April 25, 1996 at 329 South Dorgenois Street, New Orleans, LA 70119.

Any interested party may submit data, views or arguments orally or in writing concerning these rules or may make inquiries concerning the adoption of these rules to Richard Hampton, Jr., Secretary-Treasurer of the Board of Trustees, 329 South Dorgenois Street, New Orleans, LA 70119.

William M. Carrouché  
President

**FISCAL AND ECONOMIC IMPACT STATEMENT  
FOR ADMINISTRATIVE RULES  
RULE TITLE: Direct Rollovers**

- I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENTAL UNITS (Summary)  
The only estimated, anticipated implementation cost is the cost of printing and distributing copies of the proposed amended and restated rules and regulations of direct rollovers to persons requesting a copy of same. Copying costs, assuming every participant requests one copy, are estimated to be \$168.
- II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)  
Adoption and implementation of the proposed amended and restated rules and regulations of direct rollovers should not have any effect on revenue collection of state or local governmental units.
- III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)  
The sole purpose for the proposed change in the rules and regulations is to conform with the final regulations recently published under Section 401(a)(31) and related sections of the Internal Revenue Code of 1986, as amended from time to time. The proposed change provides for fund notice to participants conforming with the Internal Revenue Code and Treasury regulations thereunder promulgated.  
Therefore, the adoption and implementation of the proposed amended and restated rules should not have a cost impact or provide an economic benefit to any person or nongovernmental group other than costs and benefits already incurred pursuant to the statutory requirements.
- IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)  
Adoption and implementation of the proposed amended and restated rules and regulations of direct rollovers should not have any effect on competition and employment.

Rosemarie Falcone  
Fund Counsel  
9603#055

H. Gordon Monk  
Legislative Fiscal Officer

**NOTICE OF INTENT**

**Department of Health and Hospitals  
Board of Nursing and  
Board of Medical Examiners**

Advanced Practice Registered Nurse  
Demonstration Projects (LAC 46:XLVII.4513)

Notice is hereby given, that the Board of Nursing (board) and Board of Medical Examiners, pursuant to the authority vested in the board by R.S. 37:918(K), and 37:1031-1035 in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., intend to adopt LAC 46:XLVII.4513.C., Prescriptive and Distributing Authority for Advanced Practice Registered Nurses, to standardize the process and requirements for application of prescriptive authority as a nurse practitioner, certified nurse midwife, and clinical nurse specialist in Louisiana. The proposed rules are set forth below.



**Title 46**  
**PROFESSIONAL AND OCCUPATIONAL**  
**STANDARDS**

**Part XLVII. Nurses**

**Subpart 2. Registered Nurses**

**Chapter 45. Advanced Practice Registered Nurses**

**§4513. Authorized Practice**

A. - B.8. ...

C. Prescriptive and Distributing Authority. The advanced practice registered nurse (APRN) shall practice in a manner consistent with the definition of advanced practice set forth in R.S. 37:913.3.b and the provisions of R.S. 37:1031-1035.

1. The 1995 Louisiana legislature authorized the creation of the Committee on Prescriptive Authority for Advanced Practice Registered Nurses, under the joint jurisdiction of the Louisiana State Board of Nursing and the Louisiana State Board of Medical Examiners, to recommend rules and regulations governing the formulation of demonstration projects using APRNs to provide specified prescriptive services under physician direction, in certain under-served health care areas and certain areas of demonstrated health care needs in the state as determined by appropriate and scientific criteria, including but not limited to physician to general population ratios.

2. The application for the APRN to be granted prescriptive authority to prescribe legend drugs, assessment studies and therapeutic devices, and to distribute free drug samples and other gratuitous medications supplied by drug manufacturers may be made as part of initial APRN licensure application with no additional fee or by separate application with the nonrefundable fee as set forth in LAC 46:XLVII.3361.

3. Definitions as used in this Part:

a. *Act*—Acts 1995, No. 629, R.S. 37:1031-1035.  
b. *Board*—the Louisiana State Board of Nursing.  
c. *Collaborating Physician*—the physician with whom the APRN has developed and signed guidelines for prescribing practice.

d. *Demonstration Projects*—the pilot projects established by the Joint Administration Committee allowing designated APRNs to provide specified prescriptive services for the purpose of data collection and analysis.

e. *Distribute*—the issuing of free samples and other gratuitous medications supplied by drug manufacturers, as defined by protocol.

f. *Joint Administration Committee*—the joint subcommittee comprising three members designated by the board and three members designated by the Louisiana State Board of Medical Examiners constituted to prescribe the procedures for approval, modification, or denial of demonstration projects as contemplated by the Act.

g. *Prescribe*—to direct, order, or designate the preparation, use of or manner of using by spoken or written words.

h. *Under Physician Direction*—the limited prescriptive authority as approved by the Joint Administration Committee and demonstrated in the collaborative practice agreement as provided for in R.S. 37:913.9.

4. The applicant shall meet the following requirements:

a. holds a current, unencumbered, unrestricted and valid registered nurse license in Louisiana and is without grounds for disciplinary proceedings as stated in R.S. 37:921;

b. holds a current, unencumbered, unrestricted and valid APRN license;

c. provides evidence of:

i. one year of active full-time practice in the clinical specialty for which the applicant was educationally prepared as an APRN immediately prior to applying for prescribing and distributing privileges;

ii. a notarized application on a form provided by the board;

iii. successful completion of a minimum of 36 contact hours of education in advanced pharmacotherapeutics obtained as a component of a formal educational program preparing registered nurses for advanced practice or continuing education programs, approved by the board, within the four-year time period immediately prior to the date of application for prescriptive and distributing authority, at least 12 hours of which shall have been obtained within two years prior to application, which:

(a). are related to the applicant's advanced practice category and area of specialization;

(b). include knowledge of pharmacokinetics principles and their clinical application;

(c). include the use of pharmacological agents in the prevention of illness, restoration and maintenance of health.

iv. any deviation from 4.c.iii must be submitted to the Joint Administration Committee for review and approval.

v. a collaborative practice agreement with a licensed physician or physician group which shall include a plan of accountability between both parties to include, but not be limited to:

(a). clinical practice guidelines as required by R.S. 37:913(9)(b);

(b). availability of the collaborating physician; and

(c). patient care coverage during the absence of the APRN, physician, or both parties with documented review of the guidelines with the on-call physician.

5. Application Process for Selecting the Demonstration Projects

a. The Joint Administration Committee reviews and authorizes approval for the demonstration projects.

b. Eligible APRNs are defined as:

i. certified nurse midwives (CNMs);

ii. clinical nurse specialists (CNSs) in specialty areas of diabetes, psych/mental health, cardiovascular and oncology; and

iii. nurse practitioners (NPs).

c. Eligible sites are defined to include without limitation:

i. school-based centers;

ii. nursing homes and other geriatric settings;

iii. primary care outpatient facilities;

iv. rural health clinics;

v. federally qualified health centers (FQHC);

vi. charity hospital outpatient clinics;

- vii. women's health clinics;
- viii. university student health centers;
- ix. other areas as identified with a demonstrated need.

d. Approval of demonstration sites will be authorized by the Joint Administration Committee in such a manner to insure balance in the type of setting, geographic location and reflect the ability of the committee to appropriately monitor the sites.

e. The APRN must demonstrate compliance with LAC 46:XLVII.4513.C.2.

#### 6. Limited Prescriptive Authority

a. An APRN with limited prescriptive authority approved by the boards may prescribe legend drugs, over the counter drugs, medical devices and appliances as indicated by protocol.

b. A prescription for legend drugs may be written to be refilled three times or up to three months, whichever comes first.

c. An APRN who is authorized by the Joint Administration Committee to exercise prescriptive authority shall not prescribe or distribute any controlled substance as defined, enumerated or included in federal or state statutes or regulations, 21 CFR. §1308.11-15., R.S. 40:964, or any substance which may hereafter be designated a controlled substance by amendment or supplementation of the cited regulations and statute, except as may be explicitly authorized by the Joint Administration Committee. An APRN who is so authorized shall not prescribe controlled substances of any class until and unless the APRN applies for and obtains a license from the Louisiana Division of Narcotics and Dangerous Drugs and registration with the U.S. Drug Enforcement Administration for the appropriate controlled substance schedules and files copies of such license and registration with the board.

d. Each order for a prescription shall comply with the following criteria:

- i. the name, office address, telephone number, "RN" designation and clinical specialty area of the APRN;
- ii. the collaborating physician's name shall be pre-printed, stamped, or handwritten on the prescription form and must be clearly distinguished;
- iii. the date the prescription is written;
- iv. the name and home address and telephone number of the patient;
- v. the full brand name of the drug and directions for its use;

vi. each prescription written by an APRN pursuant to authority granted under these rules shall bear the legend: "DEMONSTRATION PROJECT (per R.S. 37:1031-1035)";

vii. an APRN with prescriptive authority shall retain a duplicate or copy of each prescription written and issued to patients;

viii. prescriptions written by an authorized APRN shall comply with all the applicable state and federal laws and be signed by the prescriber with the abbreviation for the applicable category of advanced nursing practice and the identification number assigned by the board.

e. Each year the APRN with limited prescribing authority shall obtain six contact hours of continuing education in pharmacology or pharmacology management approved by a national professional accrediting organization. Documentation of completion of the above contact hours shall be submitted for license renewal.

f. APRN prescriptive authority shall be renewed as part of the APRN license.

g. The board shall be responsible for maintaining a current up-to-date public list of APRNs who have limited authority to prescribe in the state. An updated list of APRNs with limited prescriptive authority shall be sent by the board to the Louisiana State Board of Pharmacy on a monthly basis by APRN category and specialty.

h. The Board of Nursing shall supply whatever data is needed by the Office of Narcotics and Dangerous Drugs of the Department of Health and Hospitals.

#### 7. Distribution of Free Drug Samples and Other Gratuitous Medications Supplied by Drug Manufacturers

a. Distribution of free drug samples and other gratuitous medications supplied by drug manufacturers, other than controlled substances, must :

- i. be consistent with the APRN scope of practice and collaborative agreement;
- ii. be recorded in the patient record; and
- iii. be in accordance with other state and federal statutes and regulations.

b. Free drug samples issued shall be in the manufacturers' original packaging and shall be labeled to show the name of the drug, strength in the original packaging along with directions for use. With the exception of medication samples as authorized by this rule, an APRN with prescriptive authority shall not accept or distribute any controlled substance, legend drug or other medication, except as authorized by R.S. 37:933.

8. An APRN granted limited prescriptive and distributing authority shall comply with all applicable laws and rules in prescribing, distributing and administering drugs, including compliance with labeling requirements R.S. Title 37:1195.b; 37:1701; 37:911 et seq., and 37:1261 et seq.

#### 9. Limitation

a. The Joint Administration Committee shall review the application and all related material and shall approve, modify or deny the application.

b. An APRN's limited prescriptive and distributing authority is not delegable.

10. Exclusion. Nothing herein shall require a CRNA to have prescriptive authority to provide anesthesia care, including the administration of drugs or medicine necessary for anesthesia care.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:918(K), and R.S. 37:1031-1035.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, and Board of Nursing, LR 22: (April 1996), amended by the Department of Health and Hospitals, Board of Nursing and Board of Medical Examiners, LR 22:

A public hearing will be held on April 29, 1996, at 10 a.m., at the Airport Hilton, 901 Airline Highway, Kenner, LA.

Interested persons are invited to attend and submit oral comments on the proposed rules.

All interested persons are invited to submit written comments on the proposed rules. Such comments must be submitted no later than April 23, 1996 at 4:30 p.m., to Barbara L. Morvant, Executive Director, Louisiana State Board of Nursing, 150 Baronne Street, Suite 912, New Orleans, LA 70112.

Barbara Morvant, MN, RN      Delmar Rorison, MD  
Executive Director, LSBN      Executive Director, LSBME

**FISCAL AND ECONOMIC IMPACT STATEMENT  
FOR ADMINISTRATIVE RULES  
RULE TITLE: APRN Demonstration Projects**

**I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENTAL UNITS (Summary)**

Increased expenditures are expected due primarily to travel expenses of members appointed to the Committee on Prescriptive Authority; travel expenses of board members appointed to the Joint Administrative Committee; and staff travel to committee meetings. The funds necessary to implement these rules will be provided from the operating expenses from the Louisiana State Board of Nursing and Louisiana State Board of Medical Examiners.

Projected expenditures are based on five meetings of the Committee on Prescriptive Authority the first year. Six members and two staff members are anticipated for each. Also, it is projected that the Joint Committee will meet eight times during the first year and 10 times during the second year. Expenditures are estimated to be \$22,000 in FY 1995/96, and \$19,000 in both 1996/97 and 1997/98.

**II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)**

There will be no effect on revenue collections of state or local governmental units.

**III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)**

There are no anticipated cost increases to directly affected persons or nongovernmental groups. The physicians and advanced practice registered nurses (APRNs) who participate in the pilot project will need to complete a report of activities and/or participation of data collection for evaluation of the project. There may be a slight economic benefit to both the physicians in Louisiana, who would be collaborating with the advanced practice registered nurses (APRNs) with prescriptive authority privileges; and the public who would be receiving care and prescriptions from advanced practice registered nurses as a result of more efficient utilization of the APRNs' services.

**IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)**

There is no anticipated effect on competition and employment, as the APRNs who participate in the demonstration projects were already employed in their current positions.

Barbara L. Morvant  
Executive Director, LSBN

Richard W. England  
Assistant to the  
Legislative Fiscal Officer

Delmar Rorison  
Executive Director, LSBME  
9603#059

**NOTICE OF INTENT**

**Department of Health and Hospitals  
Office of Public Health**

**Bacteriological Laboratory Certification**

In accordance with R.S. 49:950 et seq., the Department of Health and Hospitals, Office of Public Health proposes to establish a certification program to approve private laboratories to provide bacteriological analytical services needed to aid owners of individual water supplies in Louisiana in assuring that drinking waters are bacteriologically safe.

Such certification program will be implemented to the extent funding and staff resources permit. Each individual will be responsible for paying the private laboratory for the analytical services provided.

Laboratories seeking certification pursuant to this proposed rule will be certified in accordance with regulations contained in a proposed Department of Health and Hospitals manual for the certification of laboratories analyzing drinking water. A copy of the proposed manual will be available for inspection at the following locations:

REGION I	Metropolitan	3308 Tulane Avenue Fifth Floor New Orleans, LA 70119
REGION II	Capitol	1772 Wooddale Boulevard Baton Rouge, LA 70806
REGION III	Tech	206 East Third Street Drawer 1369 Thibodaux, LA 70301
REGION IV	Acadian	825 Kaliste Saloom, Suite 100 Lafayette, LA 70508
REGION V	Southwest	4240 Legion Street Box 16826 Lake Charles, LA 70615
REGION VI	Central	1335 Jackson Street Box 4207 Alexandria, LA 71301
REGION VII	Northwest	Allen Memorial State Office Building Fifth Floor 1525 Fairfield Avenue Shreveport, LA 71101-4388
REGION VIII	Northeast	2913 Betin Street Box 6118 Monroe, LA 71201
REGION IX	Southeast	520 Old Spanish Trail Slidell, LA 70459

Interested persons may submit written comments to: Dr. Henry Bradford, Laboratory Director, DHH/OPH, Box 60630, New Orleans, LA 70160. Such comments will be received until the close of business April 28, 1996. A public hearing on the proposed change will be held at 10:30 a.m., April 24, 1996, in the State Office Building Conference Room, 150 Third Street, Baton Rouge, LA 70802. All interested persons

will be afforded an opportunity to submit data, views or arguments, orally or in writing at said hearing.

Bobby P. Jindal  
Secretary

**FISCAL AND ECONOMIC IMPACT STATEMENT  
FOR ADMINISTRATIVE RULES  
RULE TITLE: Bacteriological Laboratory Certification**

- I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENTAL UNITS (Summary)  
There is no impact on local governmental units. The bacteriological certification program will be implemented to the extent funding and staffing resources permit.
- II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)  
It is estimated that 15 laboratories will seek certification under this program. It is anticipated that these laboratories will request certification for both Total Coliform, FecalE. coli and heterotrophic plate count analyses. There is currently no fee in place for certifying these laboratories. At the earliest opportunity, authorization for the collection of fees relative to the certification program will be requested.
- III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)  
Individual with new or rebuilt domestic well that must test their drinking water and contract laboratories providing the analytical services are affected by this rule. It is not possible to estimate how many individual need testing done, and how much the laboratories will charge for their analytical services.
- IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)  
Competition between laboratories to provide these analytical services will drive the price of the analysis down which benefits the individual paying for the testing. Employment opportunities in the laboratories may increase as a result of this rule.

Procedural Terminology (CPT) codes, locally assigned codes, and HCPC codes. Effective July 7, 1995 and October 28, 1995 (*Louisiana Register*, Volume 21 Nos. 7 and 11) the bureau reduced the per diem rates for the following procedure codes in the following amounts:

- CPT code 99295 - \$323.90
- CPT code 99296 - \$190.20
- CPT code 99297 - \$150.10
- CPT code 99297-52 ("step-down" babies) - \$60.04

The department subsequently determined that it was necessary to make an adjustment in the above per diem rates in order to meet federal assurance requirements that there are sufficient number of Medicaid providers for the delivery of these services. An emergency rule was adopted to adjust the above rates (*Louisiana Register*, Volume 22 Number 1) as follows.

- CPT code 99295 - \$596.46
- CPT code 99296 - \$279.52
- CPT code 99297 - \$143.42
- CPT code 99297-52 ("step-down" babies) - \$57.37

The following proposed rule adopts the above payment amounts for the specified neonatology procedure codes.

**Proposed Rule**

The Department of Health and Hospitals, Bureau of Health Services Financing proposes to adopt the following per diem rates for neonatology professional services in the amounts listed for the following procedure codes:

- CPT code 99295 - \$596.46
- CPT code 99296 - \$279.52
- CPT code 99297 - \$143.42
- CPT code 99297-52 ("step-down" babies) - \$57.37

Interested persons may submit written comments to the following address: Thomas D. Collins, Bureau of Health Services Financing, Box 91030, Baton Rouge, LA 70821-9030. He is responsible for responding to inquiries regarding this proposed rule. A public hearing will be held on this matter at 9:30 a.m. Tuesday April 23, 1995, in the first floor auditorium of the Department of Transportation and Development, 1201 Capitol Access Road, Baton Rouge, LA. At that time all interested parties will be afforded an opportunity to submit data, views or arguments, orally or in writing. The deadline for the receipt of all comments is 4:30 p.m. on the day following the public hearing.

Bobby P. Jindal  
Secretary  
9603#054

Richard W. England  
Assistant to the Legislative  
Fiscal Officer

**NOTICE OF INTENT**

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

Bobby P. Jindal  
Secretary

Neonatology Services

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

The Department of Health and Hospitals, Bureau of Health Services Financing reimburses neonatology services according to established per diem rates for applicable Current

**FISCAL AND ECONOMIC IMPACT STATEMENT  
FOR ADMINISTRATIVE RULES  
RULE TITLE: Professional Services Program-Neonatology Services**

- I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENTAL UNITS (Summary)  
It is anticipated that implementation of this proposed rule will result in increased expenditures for neonatology services by approximately \$190,079 for SFY 1995-96; \$506,926 for SFY 1996-1997; and \$539,722 for SFY 1997-1998.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

It is anticipated that federal revenue collections for neonatology services will increase by approximately \$288,998 for SFY 1995-96; \$1,296,440 for SFY 1996-97 and \$1,335,779 for SFY 1997-1998.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

It is anticipated that the providers of neonatology services will experience the combined state and federal expenditure increases shown above for the provision of these services.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

There is no known effect on competition and employment.

Thomas D. Collins  
Director  
9603#053

Richard W. England  
Assistant to the  
Legislative Fiscal Officer

**NOTICE OF INTENT**

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

**Pharmacy Program—Reimbursement**

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

The Bureau of Health Services Financing provides reimbursement to enrolled pharmacy providers for services provided to Medicaid recipients who also have Medicare Part B coverage. The Medicaid Program has identified drugs for which Medicare Part B is currently providing coverage and reimbursement. The bureau has determined that a cost savings will be achieved by providing coverage under the Medicaid Program for the co-insurance and deductible of the Medicare Part B claims and requiring the pharmacy provider to bill Medicare prior to the Medicaid Program. Medicare claims for covered outpatient drug services would then crossover to the Medicaid Program for reimbursement of the co-insurance up to the Medicare allowable and the deductible, if it has not been met. The bureau has determined that there is Medicaid cost-savings attributed by electing to pay co-insurance and the Medicare deductible for these pharmacy services. Medicare will be the primary payor for these services by cost avoiding these claims and the bureau will be in compliance with Medicaid and Medicare regulations.

**Proposed Rule**

The Department of Health and Hospitals, Bureau of Health Services Financing proposes to pay the full co-insurance and the Medicare deductible on pharmacy claims for services provided to Medicaid recipients covered by Medicare Part B.

Interested persons may submit written comments to the

following address: Thomas D. Collins, Bureau of Health Services Financing, Box 91030, Baton Rouge, LA 70821-9030. He is responsible for responding to inquiries regarding this proposed rule. A public hearing will be held on this matter on Tuesday, April 23, 1996 at 9:30 a.m. in the Auditorium of the Department of Transportation and Development, 1201 Capitol Access Road, Baton Rouge, LA. At that time all interested parties will be afforded an opportunity to submit data, views or arguments, orally or in writing. The deadline for the receipt of all comments is 4:30 p.m. on the day following the public hearing.

Bobby P. Jindal  
Secretary

**FISCAL AND ECONOMIC IMPACT STATEMENT  
FOR ADMINISTRATIVE RULES**

**RULE TITLE: Pharmacy Program—Reimbursement**

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

It is anticipated that implementation of this proposed rule will result in decreased expenditures for pharmacy services by approximately \$223,193 for SFY 1996; \$433,071 for SFY 1997; and \$446,063 for SFY 1998.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

Implementation of this proposed rule will decrease federal revenue collections for pharmacy services by approximately \$559,665 for SFY 1996; \$814,458 for SFY 1997; and \$838,892 for SFY 1998.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

Individual pharmacists might experience an initial lag in reimbursement for hard copy claims as they transfer billing from Medicaid to Medicare as the primary payor for these type of claims.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

There is no known effect on competition and employment.

Thomas D. Collins  
Director  
9603#051

Richard W. England  
Assistant to the  
Legislative Fiscal Officer

**NOTICE OF INTENT**

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

**Private ICF/MR Facility Services**

The Department of Health and Hospitals, Bureau of Health Services Financing is proposing to adopt the following rule under the Medical Assistance Program as authorized by R.S. 46:153 et seq. and pursuant to Title XIX of the Social Security Act and as directed by the 1995-96 General Appropriation Act, which states: "The Secretary shall implement reductions in the Medicaid program as necessary to control expenditures

to the level approved in this schedule. The Secretary is hereby directed to utilize various cost containment measures to accomplish these reductions, including but not limited to pre-certification, pre-admission screening, and utilization review, and other measures as allowed by federal law." This proposed rule is in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

The Bureau of Health Services Financing provides coverage for intermediate care facility services for the handicapped and/or mentally retarded (ICF/MR) provided by private intermediate care facilities and reimbursement is made according to prospective rates established under the Reimbursement for Private ICF-MR Facilities rule (*Louisiana Register*, October 20, 1989, Volume 15, Number 10). The department determined that it was necessary to reduce the reimbursement rates by limiting administrative and general support costs to 24 percent of all other programmatic costs including plant operation and maintenance, costs related to capital assets, dietary expenses, linen and laundry expenses, housekeeping expenses, personal recipient needs, medical and nursing expenses, therapeutic and training expenses, recreational expenses, consultant expenses, educational expenses and in-house ancillary services expenses. An emergency rule was adopted and published in the *Louisiana Register*, Volume 21 Number 10 which amended the rule on Reimbursement for Private ICF-MR Facilities cited above by limiting administrative and general support costs to 24 percent of all other programmatic costs. The following proposed rule establishes this reduction methodology as a permanent provision of the rule on Reimbursement for Private ICF-MR Facilities.

#### Proposed Rule

The Department of Health and Hospitals, Bureau of Health Services Financing amends the rule on Reimbursement for Private ICF-MR Facilities (*Louisiana Register*, October 20, 1989, Volume 15, Number 10) by limiting administrative and general support costs to 24 percent of all other programmatic costs including plant operation and maintenance, costs related to capital assets, dietary expenses, linen and laundry expenses, housekeeping expenses, personal recipient needs, medical and nursing expenses, therapeutic and training expenses, recreational expenses, consultant expenses, educational expenses and in-house ancillary services expenses.

Interested persons may submit written comments to the following address: Thomas D. Collins, Bureau of Health Services Financing, Box 91030, Baton Rouge, LA 70821-9030. He is responsible for responding to inquiries regarding this proposed rule. A public hearing will be held on this matter at 9:30 a.m. Tuesday April 23, 1996, in the first floor auditorium of the Department of Transportation and Development, 1201 Capitol Access Road, Baton Rouge, LA. At that time all interested parties will be afforded an opportunity to submit data, views or arguments, orally or in writing. The deadline for the receipt of all comments is 4:30 p.m. on the day following the public hearing.

Bobby P. Jindal  
Secretary

## FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES

### RULE TITLE: Private ICF/MR Facility Services

- I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENTAL UNITS (Summary)  
It is anticipated that implementation of this proposed rule will result in decreased expenditures for Private ICF/MR Facility services by approximately \$229,063 for SFY 1995-1996; \$1,765,153 for SFY 1996-1997; and \$1,873,789 for SFY 1997-1998.
- II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)  
It is anticipated that federal revenue collections for Private ICF/MR Facility services will decrease by approximately \$608,461 for SFY 1995-96; \$4,974,382 for SFY 1996-97 and \$5,062,660 for SFY 1997-1998.
- III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)  
It is anticipated that the providers of the Private ICF/MR Facility will experience the combined state and federal expenditure decreases shown above for the provision of these services.
- IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)  
There is no known effect on competition and employment.

Thomas D. Collins  
Director  
9603#052

Richard W. England  
Assistant to the  
Legislative Fiscal Officer

### NOTICE OF INTENT

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

#### Transplant Services—Reimbursement

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

On July 1, 1994 the department adopted the prospective payment reimbursement methodology for inpatient hospital services (referenced in *Louisiana Register*, June 20, 1994 Volume 20, Number 6.) which included specific methodology for the reimbursement of transplant services. The department has determined that systems limitations prohibit the implementation of the transplant reimbursement provision of the prospective payment reimbursement methodology. Therefore, the department proposes to adopt the following rule which re-institutes the Tax Equity and Fiscal Responsibility Act (TEFRA) provisions for the reimbursement of transplant services. An emergency rule was first adopted on this change on April 1, 1995 and subsequently published in the *Louisiana Register* on April, August and December 20, 1995 Volume 21, Numbers 4, 8, and 12.

### Proposed Rule

The Department Health and Hospitals, Bureau of Health Services Financing proposes to repeal the reimbursement provisions governing organ transplant services contained in the "Hospital Prospective Reimbursement Methodology" rule referenced in the June 20, 1994 *Louisiana Register* (Volume 20, Number 6) and proposes to adopt the following provisions to govern Medicaid reimbursement for nonexperimental organ transplant services which are prior authorized by the Medicaid Program. Payment is allowable only in accordance with a per diem limitation established for inpatient discharges for organ transplant services reflected for a distinct carve-out unit. Each type of organ transplant service must be reported as a separate distinct carve-out unit cost. Organ procurement costs shall be included in the distinct carve-out unit cost and shall be subject to the per diem limitation. The per diem limitation shall be calculated based on inpatient routine and ancillary costs for the transplant carve-out discharges derived from each hospital's base period. The base period is the first cost reporting period beginning with September 30, 1983 through August 31, 1984 in which an allowable transplant was performed on a Medicaid patient. The base period per diem costs for transplant distinct carve-out units shall be inflated annually using the target rate percentage increase for inpatient prospective payment systems (PPS) exempt hospitals' operating costs established by federal statute and published annually in the *Federal Register*. Reimbursement for transplant distinct carve-out unit services shall not exceed the per diem limitation and no incentive payment shall be allowed. The Tax Equity and Fiscal Responsibility Act (TEFRA) provisions governing exceptions and adjustments for inpatient hospital services shall also apply to the per diem limitation for the reimbursement of distinct carve-out units for organ transplant services. The Medicaid share of each transplant unit's costs subject to the per diem limitation shall be included in the total Medicaid reimbursement at the hospital's cost settlement at fiscal year end.

Interested persons may submit written comments to the following address: Thomas D. Collins, Office of the Secretary, Bureau of Health Services Financing, Box 91030, Baton Rouge, LA 70821-9030. He is responsible for responding to inquiries regarding this proposed rule. A public hearing will be held on this matter at 9:30 a.m., Tuesday, April 23, 1996 in the DOTD Auditorium, 1201 Capitol Access Road, Baton Rouge, LA. At that time all interested parties will be afforded an opportunity to submit data views or arguments, orally or in writing. The deadline for the receipt of all comments is 4:30 p.m. on the day following the public hearing.

Bobby P. Jindal  
Secretary

### FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES RULE TITLE: Organ Transplant Services Reimbursement Methodology

- I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENTAL UNITS (Summary)  
It is anticipated that implementation of this proposed rule will decrease state expenditures for transplant services by approximately \$4,494 for SFY 1994-1995; \$74,916 for SFY 1995-1996; and \$81,002 for SFY 1996-1997.
- II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)  
Implementation of this proposed rule will decrease federal revenue collections by \$11,493 for SFY 1994-1995; \$193,407 for SFY 1995-1996; and \$200,474 for SFY 1996-1997.
- III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)  
Hospital providers of organ transplant services will experience the combined federal and state reductions shown above.
- IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)  
There is no known effect on competition and employment.

Thomas D. Collins  
Director  
9603#050

Richard W. England  
Assistant to the  
Legislative Fiscal Officer

### NOTICE OF INTENT

#### Department of Insurance Commissioner of Insurance

#### Regulation 59—Health Insurance Data Collection Program

Under the authority of R.S. 22:3 and 22:9.1, the Department of Insurance gives notice that the following proposed regulation is to become effective June 20, 1996. This intended action complies with the statutory law administered by the Department of Insurance.

#### Proposed Regulation 59 Health Insurance Data Collection Program

##### Section 1. Purpose

The purpose of this rule is to implement the requirements of R.S. 22:9.1. The intent of R.S. 22:9.1 is to establish a health insurance data collection program for the state of Louisiana. The health insurance data collection program's intent is to establish and maintain an information collection program to gather data demonstrating the availability and affordability of health insurance coverage in the state. Such data and analysis of the data is to be used to evaluate the performance of past and future health care and health insurance reform measures.

##### Section 2. Authority

This regulation is promulgated by the Department of Insurance under the authority granted by R.S. 22:3 and 22:9.1, and the Administrative Procedures Act, R.S. 49:950 et seq.

### Section 3. Applicability and Scope

R.S. 22:9.1 applies to all health insurance coverage in the state. For purposes of this regulation, health insurance shall mean, and data shall be reported from, all who issue group accident and health insurance policies, group certificates, or other entities that engage in the furnishing of hospital services, medical or surgical benefit plans, health maintenance organization plans or subscriber agreements, and partially self-insured health benefit plans, individually underwritten limited benefit and supplemental health insurance policies, family group, blanket, franchise, and individual health and accident insurance policies written or issued in the state of Louisiana.

### Section 4. Definitions

*Administrative Service Fees*—fees earned to provide self-insured and/or partially self-insured employers with certain administrative services in the delivery of health care services to employees. Such fees shall include operational expenses, actuarial, marketing, commissions, legal, and research and development, but shall not include risk or pooling charges or stop-loss premiums.

*Group Carrier*—any entity writing, delivering or issuing for delivery in the state of Louisiana accident and health insurance policies, group certificates, medical or surgical benefit plans, health maintenance organization plans or subscriber agreements, partially self-insured health benefit plans, or other entity that engages in the furnishing of hospital, medical or surgical services to employers who employed on at least 50 percent of its working days during the preceding year more than 35 employees.

*Health Maintenance Organizations (HMOs)*—an entity as defined in R.S. 22:2002.7.

*Individual Carrier*—any entity writing, delivering or issuing for delivery in the state of Louisiana any hospital, health or medical expense insurance policy, hospital or medical services contract, health and accident insurance policy, health maintenance organization subscriber agreement, or any other insurance contract of this type covering any one person with or without eligible family members. Not included under this definition are continuation or conversion policies, or insurance policies written to cover specified disease, hospital indemnity, accident only, credit, dental, disability income, Medicare supplementary or long-term care, or other limited, supplemental benefit insurance policies. *Individual policy* shall also mean a policy issued to an individual or individual member of an association where the individual pays for the entire premium.

*Limited Benefit Policy*—for purposes of this regulation, any health and accident policy designed, advertised, and marketed to supplement major medical insurance, specified disease, dental, fixed indemnity, vision, and any other health and accident or health maintenance organization subscriber agreement. *Limited benefit policy* shall include the Louisiana Basic Health Insurance Plan Pilot Program (LA Health), but shall not include Medicare supplement insurance.

*Medicare Supplement Carrier*—any entity writing, delivering or issuing for delivery in the state of Louisiana a Medicare supplement policy.

*Small Group Carrier*—any entity writing, delivering or issuing for delivery in the state of Louisiana group accident and health insurance policies, group certificates, medical or surgical benefit plans, health maintenance organization plans or subscriber agreements, partially self-insured health benefit plans, or other entity that engages in the furnishing of hospital, medical or surgical services to employers who employed no less than three nor more than 35 eligible employees on at least 50 percent of its working days during the preceding year.

*Supplement Carrier*—any entity writing, delivering or issuing for delivery in the state of Louisiana a limited benefit policy.

*Third-party Administrator*—any individual, partnership, corporation, or other person as defined in R.S. 22:3031.1.

### Section 5. Data Submission and Penalties

A. All data shall be submitted annually in a written format and shall include all data required in Section 7 of this regulation. The statements filed shall contain the letters and captions of all data elements. The text of the data elements may be omitted provided in the answers thereto are stated in such a manner as to clearly indicate the scope and coverage of the data elements. Unless expressly provided otherwise, if any data element is inapplicable, an appropriate statement to that effect shall be made.

All information shall be filed with the Commissioner of Insurance before the first day of March by U.S. Mail, or as provided in Rule 12. Filings should be addressed to: Insurance Commissioner of the State of Louisiana, Box 94214, Baton Rouge, LA 70804-9214.

B. Failure to timely submit this information will lead to penalties as provided in R.S. 22:1457.

### Section 6. Categories to be Submitted

A. Each carrier, health maintenance organization or third-party administrator shall submit to the Louisiana Department of Insurance the data elements contained in Section 7 according to the following lines or blocks of their business:

1. group,
2. small group,
3. individual,
4. supplementary,
5. Medicare supplement.

B. For entities that transact more than one of the above lines of business, the data elements in Section 7 should be reported separately according to each line of business.

C. For entities that transact business in both the HMO market and the indemnity market, the two should also be reported separately for each of the data elements in Section 7.

### Section 7. Data Elements to be Reported

A. Number of health insurance policies in force as of December 31.

B. Number of fully insured lives (including all participating funding arrangements) including dependents covered as of December 31. Where composite rating utilized, use actuarial assumptions for estimating the number of lives.

C. Direct fully-insured premiums written during the year ending December 31.

D. All administrative services fees earned as of December 31.



E. Dividends paid or credited on direct business as of December 31.

F. Direct losses incurred during the period from January 1 to December 31. This number is calculated as Paid Claims + Change in IBNR + Change in Reserves.

G. Number of new health insurance policies written during the period of January 1 to December 31.

H. Net gain or loss in the number of fully insured lives (including all participating funding arrangements) written during the period from January 1 to December 31. Where composite rating utilized, use actuarial assumptions for estimating the number of lives.

I. Average annual premium per life as of December 31. This number should be based on the annualized premium inforce divided by the number of insured lives inforce at December 31.

J. Lowest premium rate charged per life as of December 31.

K. Highest premium rate charged per life as of December 31.

L. Percentage of the number of fully insured lives paying a rate above the average premium per life as of December 31.

M. Indicate the overhead/administrative load (premiums minus claims) for the fully insured block (including all participating funding arrangements) of business as of December 31. This should be calculated as a percentage.

N. Indicate whether there is a minimum percentage of employees required to participate in the groups that your company will consider insuring and if so, what that participating percentage is.

O. Indicate the group sizes which would require individual underwriting of group members based on your companies underwriting requirements:

- 1. 5 or fewer \_\_\_\_\_
- 2. 10 or fewer \_\_\_\_\_
- 3. 15 or fewer \_\_\_\_\_
- 4. 25 or fewer \_\_\_\_\_
- 5. 35 or fewer \_\_\_\_\_
- 6. 50 or fewer \_\_\_\_\_
- 7. Other (Please Specify) \_\_\_\_\_
- 8. Do not individually underwrite group applicants \_\_\_\_\_

P. Please indicate the percentage of insured lives covered under policies with the annual deductible-per-person listed below. Where composite rating utilized, use actuarial assumptions for the number of lives.

- 1. \$ 0 - 100 \_\_\_\_\_
- 2. 101 - 200 \_\_\_\_\_
- 3. 201 - 300 \_\_\_\_\_
- 4. 301 - 500 \_\_\_\_\_
- 5. 501 - 800 \_\_\_\_\_
- 6. 801 - 1,000 \_\_\_\_\_
- 7. More than 1,000 \_\_\_\_\_
- 8. No deductible used \_\_\_\_\_

Q. Please indicate the percentage of insured lives covered under policies with coinsurance requirements listed below. Where composite rating utilized, use actuarial assumptions for the number of lives. Please round off to the higher coinsurance if level not given.

- 1. 10 percent \_\_\_\_\_
- 2. 20 percent \_\_\_\_\_
- 3. 30 percent \_\_\_\_\_
- 4. 40 percent \_\_\_\_\_
- 5. More than 40 percent \_\_\_\_\_
- 6. Do not use coinsurance \_\_\_\_\_

R. Please indicate the percentage of insured lives covered under policies with lifetime maximum benefit levels listed below. Where composite rating utilized, use actuarial assumptions for the number of lives.

- 1. \$100,000 - 250,000 \_\_\_\_\_
- 2. 251,000 - 500,000 \_\_\_\_\_
- 3. 501,000 - 750,000 \_\_\_\_\_
- 4. 751,000 - 1,000,000 \_\_\_\_\_
- 5. More than 1,000,000 \_\_\_\_\_
- 6. No lifetime limit \_\_\_\_\_

S. Please indicate the percentage of insured lives covered under policies with out-of-pocket limits listed below. Where composite rating utilized, use actuarial assumptions for the number of lives.

- 1. \$ 0 - 250 \_\_\_\_\_
- 2. 251 - 500 \_\_\_\_\_
- 3. 501 - 1,000 \_\_\_\_\_
- 4. 1,001 - 1,500 \_\_\_\_\_
- 5. More than 1,500 \_\_\_\_\_

**Section 8. General Provisions**

A. Prior to any distribution of the analysis of these data elements as required by R.S. 22:9.1, the data elements and the analysis of such elements shall be reviewed by a qualified actuary.

B. As required by R.S. 22:9.1.E, the data submitted by carriers shall not be subject to public disclosure and shall be afforded confidentiality by those reviewing the data. Data is only to be released in a composite form so as not to reveal the identity of any single carrier or individual.

A public hearing on this proposed regulation will be held on April 26, 1996 in the Plaza Hearing Room of the Insurance Building at 950 North Fifth Street, Baton Rouge, Louisiana at 9 a.m. All interested persons will be afforded an opportunity to make comments.

Interested persons may obtain a copy of this proposed regulation from, and may submit oral or written comments to Denise Cassano, Assistant Director, Louisiana Health Care Commission, Louisiana Department of Insurance, Box 94214, Baton Rouge, LA 70804-9214, telephone (504) 342-0819 or 342-5075. Comments will be accepted through the close of business at 4:30 p.m. on April 26, 1996.

James H. "Jim" Brown  
Commissioner of Insurance

**FISCAL AND ECONOMIC IMPACT STATEMENT  
FOR ADMINISTRATIVE RULES  
RULE TITLE: Regulation 59—Health Insurance Data  
Collection Program**

- I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENTAL UNITS (Summary)  
It is not anticipated that adoption of Regulation 59 would result in any implementation costs (savings) to the Department

of Insurance; however, should any costs result from the adoption of Regulation 59, such costs would be absorbed by the Department of Insurance within its existing appropriation.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

Adoption of Regulation 59 may result in penalties paid to the Department of Insurance; however, there is insufficient data available at this time to determine the extent of those penalties or the impact of such penalties on state or local governmental units. If any additional revenue were collected by the Department of Insurance as a result of the adoption of Regulation 59, that revenue would be deposited in the department's self-generated revenue fund.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

There is not sufficient data available at this time to determine if there could be any costs and/or economic benefits to the health care insurers or insureds as a result of this proposed regulation.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

It is not anticipated that adoption of Regulation 59 would have any effect on employment or competition.

Patrick J. Frantz  
Deputy Commissioner  
Management and Finance  
9603#057

H. Gordon Monk  
Senior Fiscal Analyst

**NOTICE OF INTENT**

**Department of Labor  
Office of Employment Security**

**Electronic Transfer as Method of Payment  
(LAC 40:IV.375)**

In accordance with the provisions for rule adoption under R.S. 49:950 et seq. of the Administrative Procedure Act, and under the statutory authority of R.S. 23:1653, notice is hereby given that the administrator of the Office of Employment Security proposes to adopt the following rule.

This proposed rule is currently in effect by virtue of an emergency rule published in the January, 1996 issue of the *Louisiana Register*, Volume 22, Number 1.

The proposed adoption of such rule shall serve to comply with and implement the statutory amendment of R.S. 23:1532.1 of Act 46 of the 1995 Regular Session of the Louisiana Legislature, which requires, in part, that post-defeasance proceeds of the special assessment for debt service, collected subsequent to September 1, 1993, be pledged and dedicated to the establishment of an electronic transfer system for the administration of the state unemployment compensation program. Such proposed rule shall pertain only to the electronic payment of contributions and shall not affect the accrual of quarterly contributions under the Louisiana Employment Security Law.

**Title 40  
LABOR AND EMPLOYMENT  
Part IV. Employment Security  
Subpart 3. Unemployment Compensation and  
Contributions**

**Chapter 3. Employment Security Law**

**§ 375. Electronic Transfer as Method of Payment**

A. Any taxable employer which reports 250 or more employees in any calendar quarter, including any agent or entity which pays contributions either on behalf of any such employer or on behalf of a multiple of 50 or more taxable employers in any calendar quarter, shall remit any such payment(s) by electronic-fund transfer on or before the last day of the calendar month following the calendar quarter in which contributions accrue, subject to penalty and interest under R.S. 23:1543 for failure to timely remit electronic transfer of funds for any such payment(s).

B. Any reimbursable employer which employs 250 or more employees in any calendar quarter, including any agent or entity which pays reimbursement either on behalf of any such employer or on behalf of a multiple of 50 or more reimbursable employers in any calendar quarter, shall remit any such payment(s) of reimbursement by electronic-fund transfer not later than 30 days after quarterly billing was mailed by the administrator or was otherwise delivered to such employer or designated agent or entity, subject to penalty and interest under R.S. 23:1543 for failure to timely remit electronic transfer of funds for any such payment(s).

C. Any agent or entity which pays on behalf of any combination of a multiple of 50 or more of taxable and reimbursable employers shall remit any such payment(s) of contributions or reimbursements by electronic transfer pursuant to the respective statutory due-dates for each such employer, as recited in above Subsections A and B.

D. The requirement of such form of payment under this rule shall commence with the first calendar quarter of 1996, ending March 31, 1996, and shall continue each calendar quarter thereafter.

E. Such payment(s) by electronic transfer shall be in accordance with the manner or format prescribed by the administrator and shall include reporting of all pertinent tax information.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1653.

HISTORICAL NOTE: Promulgated by the Department of Labor, Office of Employment Security, LR 22:

All interested persons are invited to submit data, views, comments, or arguments, in writing, on the proposed rule to Denise Nagel, Attorney, UI Legal Unit, Room 142, Department of Labor, Box. 94094, Baton Rouge, LA 70804, or by FAX 504-342-7596 not later than Monday, April 22, 1996, at 4 p.m.

A public hearing shall be held of Thursday, April 25, 1996, at 1:30 p.m. in the Conference Room of the Fourth Floor of the Administrative Building of the Department of Labor, 1001 North 23rd Street, Baton Rouge, LA 70802.

Gayle F. Truly  
Secretary

**FISCAL AND ECONOMIC IMPACT STATEMENT  
FOR ADMINISTRATIVE RULES**

**RULE TITLE: Electronic Transfer as Method of Payment**

- I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENTAL UNITS (Summary)  
The estimated costs for FY 95-96 are \$87,070 to cover first year implementation of the Electronic Funds Transfer System. Anticipated costs for FY 96-97 are \$38,710 and for FY 97-98, \$42,581. Act 46 of the Regular Legislative Session provides funding from delinquent special assessments for the Electronic Funds Transfer System. Federal Unemployment Insurance Grants will fund subsequent years' costs.
- II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)  
There will be no estimated effect on state or local government units. However, accelerated unemployment tax receipts could increase interest earnings on the Unemployment Insurance Trust Fund.
- III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)  
There will be no charge to employers using the department's Electronic Funds Transfer System.
- IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)  
There is no estimated effect on competition and employment.

Denise A. Nagel  
Attorney  
9603#021

Richard W. England  
Assistant to the  
Legislative Fiscal Officer

**NOTICE OF INTENT**

**Department of Public Safety and Corrections  
Board of Private Investigator Examiners**

**Apprentice Licensing (LAC 46:LVII.512)**

In accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., and under the authority of R.S. 37:3505(B)(1), the Louisiana Department of Public Safety and Corrections, Louisiana State Board of Private Investigators Examiners, hereby gives notice of its intent to amend Part LVII of Title 46, by adding Chapter 5, §512 pertaining to licensing of apprentice private investigators.

This rule and regulation is an amendment to the initial rules and regulations promulgated by the Louisiana State Board of Private Investigator Examiners.

**Title 46**

**PROFESSIONAL AND OCCUPATIONAL  
STANDARDS**

**Part LVII. Board of Private Investigator Examiners**

**Chapter 5. Application, Licensing, Training,  
Registration and Fees**

**§512. Licensing of Apprentices**

A. A licensed agency and a previously unlicensed individual may apply for the licensing of the previously unlicensed individual as an apprentice as follows:

1. A letter of intent to sponsor shall be sent to the board by the licensed agency, along with the apprentice application,

indicating the agency's intent to accept the sponsorship and responsibility for the apprentice applicant.

2. Upon receipt of a letter of intent to sponsor and the completed application from the apprentice candidate, the chairman of the board shall issue a letter acknowledging the receipt of same, provided the apprentice license applicant satisfies the requirements of R.S. 37:3507 and all fees required by law have been paid. The letter shall serve as a temporary apprentice registration card until the board meets to consider the application and the issuance of the official apprentice registration card.

3. No agency may sponsor any more than six apprentice investigators at any one time; and no person shall be licensed as an apprentice if he has ever been licensed as an apprentice before.

B. An apprentice license shall be effective for one year only; and the apprentice shall operate as a private investigator only under the immediate direction, control and supervision of the sponsoring agency during that time. For the first three months of apprenticeship, the apprentice must be accompanied on all investigative work regulated by R.S. 37:3500 et seq., by a licensee with three years experience.

C.1. The sponsoring agency shall be directly responsible for the supervising and training of the apprentice, and shall maintain, on a form furnished by the board, a separate personnel file containing: the types of cases worked; the date the cases were worked; the number of hours worked on each case; and the name of the supervisor accompanying licensee. These forms shall be subject to inspection by the board on demand.

2. In addition, the sponsoring agency shall be responsible for educating the apprentice in the following areas:

a. knowledge of the private investigator business and the laws regulating same, including R.S. 37:3500 et seq., and the rules and regulations regulating the practice as a private investigator in this state;

b. general federal and state constitutional principles;

c. general information regarding invasion of privacy laws, search and seizure laws and related procedures, and state concealed weapons law;

d. surveillance techniques;

e. photograph principles: video and still; and

f. general information regarding the assembling of public information from clerk of court offices and court records.

D.1. The apprentice license shall remain valid for only one year from the date of the letter serving as the temporary registration card or issuance of the official apprentice registration card, whichever is first; and only so long as the apprentice is working under the supervision of a licensed sponsor agency.

2. During the apprenticeship period, the apprentice must attend the 40-hour training course approved by the board.

3. An apprentice license may be transferred to another agency provided the other agency meets all the requirements of law and this Section of the rules and regulations, particularly the filing of the letters of intent, regarding sponsorship.

AUTHORITY NOTE: Promulgated in accordance with La. R.S. 37:3505A(3) and B(1); and La. R.S. 37:3514A.(4)(a).

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Louisiana State Board of Private Investigator Examiners, LR 22:

Comments should be forwarded to Gary Hyatt, Chairman of the Board, State Board of Private Investigator Examiners, 2051 Silverside Drive, Suite 190, Baton Rouge, LA 70808. Written comments will be accepted through the close of business on April 10, 1996.

Gary Hyatt  
Chairman

**FISCAL AND ECONOMIC IMPACT STATEMENT  
FOR ADMINISTRATIVE RULES**

**RULE TITLE: Licensing of Apprentices**

- I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENTAL UNITS (Summary)  
The operating expenditures for the Louisiana State Board of Private Investigator Examiners for fiscal year 1995-1996 are estimated to be approximately \$180,000.  
It is estimated that costs of \$325 will be incurred in fiscal year 1995-1996 to print and distribute this amended rule and regulation. Minimal costs will also be incurred to print the form required by the rule.
- II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)  
There will be no estimated effect on revenue collections caused by the adoption of this rule. The board is currently licensing apprentices. The rule simply specifies those licensing requirements.
- III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)  
Licensees and supervising agencies will incur costs for training and supervision of apprentices.
- IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)  
There will be no effect on competition and employment as all persons and companies wishing to be licensed will have to comply with these rules and regulations.

Celia R. Cangelosi  
Attorney  
9603#058

Richard W. England  
Assistant to the  
Legislative Fiscal Officer

**NOTICE OF INTENT**

**Department of Revenue and Taxation  
Excise Taxes Division**

**Sale and Use of Dyed Special Fuels (LAC 61:I.Chapter 33)**

Under the authority of R.S. 47:802(1)(C) and R.S. 47:814(A) and in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., the Department of Revenue and Taxation, Excise Taxes Division, proposes to amend Chapter 33 of Title 61 of the Louisiana Administrative Code to reflect recent amendments to R.S. 47:803, 812, 814 and the enactment of R.S. 47:802(1).

Act 603 of the 1995 Regular Legislative Session amended R.S. 47: 803, 812, and 814 to make provision for the use of dyed special fuels and for penalties associated with the improper on-road use of the dyed fuel. Also enacted was R.S. 47:802(1) to authorize a mechanism for a credit or refund of taxes paid on fuel purchased for nontaxable use when and only when untaxed dyed fuel is not available and to direct the Excise Taxes Division to promulgate rules necessary to regulate these activities.

**Title 61**

**REVENUE AND TAXATION**

**Part I. Taxes Collected and Administered By the  
Secretary of Revenue and Taxation**

**Chapter 33. Petroleum Products: Special Fuels Tax  
Subchapter A. Retail Dealers of Special Fuels**

\* \* \*

**§3307. Sale of Dyed Special Fuels**

A. All suppliers and dealers of special fuels who have separate facilities for storing dyed special fuels on which no fuel tax has been paid, other than liquefied petroleum gas or compressed natural gas, shall clearly mark the storage facility with notice that the fuel is dyed and/or chemically marked. Such marking shall conform to requirements of R.S. 47:804(D) or as provided by 26 U.S.C. 4082 and the regulations promulgated thereunder. Dyed special fuels are to be used for nontaxable purposes only.

B. Any supplier or dealer of special fuels or any other person who shall sell or offer to sell dyed and/or chemically marked special fuels for any use other than a nontaxable use shall be in violation of R.S. 47:812 and shall be subject to a penalty. The penalty increases with subsequent violations.

C. Exception: Fuel sold for use in those vehicles which are subject to state tax and allowed to use dyed fuel on the highway under 26 U.S.C. 4082 or the regulations adopted thereunder. This use shall not be considered a violation of R.S. 47:812.

AUTHORITY NOTE: Promulgated in accordance with R.S. 47:812.

HISTORICAL NOTE: Promulgated by the Department of Revenue and Taxation, Excise Taxes Division, LR 22:

\* \* \*

**Subchapter B. Users of Special Fuels**

\* \* \*

**§3355. Refunds or Credits; Undyed Diesel Fuel Used for  
Other than Highway Purposes**

The intent of R.S. 47:802(1) is to provide a mechanism for a credit or refund of taxes paid on fuel purchased for nontaxable use only when untaxed dyed fuel is not available.

1. A registration form must be completed and submitted to the secretary of the Department of Revenue and Taxation for approval prior to first purchasing any tax-paid special fuel for a nontaxable use when dyed fuel is not available, if the user intends to obtain a credit or file for a refund of special fuel taxes paid on fuel purchased for nontaxable use. Upon approval, a permit certificate will be furnished to the applicant.

2. Users may assign, to the approved licensed suppliers who sold or delivered the fuel to the user, the right to their refund of the taxes paid on special fuels. The licensed supplier to whom assignment is made must have made

application to and received approval from the Department of Revenue and Taxation prior to being able to issue a credit to the user for the amount of tax. Approved licensed suppliers must claim the credit on the return filed for the reporting period in which the fuel was purchased and credit given. Users who opt to assign the right to their refund to the approved licensed suppliers who sold or delivered the fuel to the user must submit a new registration for approval prior to filing their own refund claims.

3. Users who file their own refund claims must file the claims with the secretary within 30 days after the end of the quarter in which the fuel purchases were made. The claims must set forth the amount of fuel purchased during the quarter with the amount of tax paid, the original fuel invoices, the licensed suppliers from whom purchased, and the purpose for which the fuel was used. The claim must also contain, on a form to be supplied by the department, a list of highway and nonhighway vehicles in which fuel was used. Fuel used to power reefers, power take-off units or similar auxiliary equipment is not eligible for refund or credit when these items are powered off the main fuel tanks.

4. If a claimant does not submit a claim during a period of 12 consecutive months, 60 days after the end of such period, his registration will be voided and removed from the files, unless notification is received that claimant expects to make a claim in the near future. When a registration has been voided for this reason, a new registration must be submitted before purchasing special fuels on which a refund will be claimed.

5. Not more than one claim may be filed for any particular period and all claims must be signed by the claimant or his authorized agent. When submitting a claim, only the designated claim form should be completed and returned to the Department of Revenue and Taxation. A seller's invoice must be submitted with the claim. In order to be acceptable for review, all invoices submitted must have the amount of special fuel taxes paid marked by the dealer before a refund can be made.

6. Claims that are returned to the claimant for correction must be corrected and returned to the Department of Revenue and Taxation within 30 days.

7. Adequate records must be maintained by refund claimants to disclose the nature of the work performed, number of gallons used, and the type of vehicle or equipment in which the special fuel was used. Each refundable purchase of tax paid fuel intended for a nontaxable use must be invoiced by the dealer separately.

AUTHORITY NOTE: Promulgated in accordance with R.S. 47:802(1).

HISTORICAL NOTE: Promulgated by the Department of Revenue and Taxation, Excise Taxes Division, LR 22:

#### **§3357. Use by State Agencies, Parish and Municipal Governments, and Other Political Subdivisions**

A. Clear, dyed or chemically marked fuel purchased by state agencies, parish and municipal governments and other political subdivision intended for on-road use is subject to state fuel tax.

B. When dyed fuel is not available, clear fuel intended for off-road use may be purchased without state tax from a contracted supplier upon presentation of a certificate issued by

the Louisiana Department of Revenue and Taxation authorizing said purchase.

AUTHORITY NOTE: Promulgated in accordance with R.S. 47:803.

HISTORICAL NOTE: Promulgated by the Department of Revenue and Taxation, Excise Taxes Division, LR 22:

#### **§3359. Sales; Uses of Dyed Fuel**

A. All users who have separate facilities for storing dyed special fuels on which no fuel tax has been paid, other than liquefied petroleum gas or compressed natural gas, shall clearly mark the storage facility with notice that the fuel is dyed and/or chemically marked. Such marking shall conform to requirements of R.S. 47:804(D) or as provided by 26 U.S.C. 4082 and the regulations promulgated thereunder. Dyed special fuels is to be used for nontaxable purposes only.

B. Any supplier, dealer or user of special fuels or any other person who shall sell or offer to sell dyed and/or chemically marked special fuels for any use other than a nontaxable use shall be in violation of R.S. 47:812 and shall be subject to a penalty. The penalty increases with subsequent violations.

C. Exception: fuel sold for use in those vehicles which are subject to state tax and allowed to use dyed fuel on the highway under 26 U.S.C. 4082 or the regulations adopted thereunder. This use shall not be considered a violation of R.S. 47:812.

AUTHORITY NOTE: Promulgated in accordance with R.S. 47:812.

HISTORICAL NOTE: Promulgated by the Department of Revenue and Taxation, Excise Taxes Division, LR 22:

#### **§3361. Use by Farmers**

A. In the case of farmers who operate farm use trucks which use undyed special fuels other than liquefied petroleum gas and compressed natural gas in operating for both taxable and nontaxable purposes, the secretary shall, when requested, reach an agreement with the farmer wherein the amount of fuel used in each truck shall be estimated and the tax paid each month on the basis of the estimate.

B. The minimum estimate will be no less than 75 gallons per month per vehicle.

AUTHORITY NOTE: Promulgated in accordance with R.S. 47:814.

HISTORICAL NOTE: Promulgated by the Department of Revenue and Taxation, Excise Taxes Division, LR 22:

All interested persons may submit data, views, or arguments, in writing to R. Charles Bradley, Director, Excise Taxes Division, Department of Revenue and Taxation, Box 3863, Baton Rouge, LA 70821. All comments must be submitted by 4:30 p.m., Tuesday, April 23, 1996. A public hearing will be held on Wednesday, April 24, 1996, at 10 a.m. in the Secretary's Conference Room of Department of Revenue and Taxation, 330 North Ardenwood Boulevard, Baton Rouge, LA 70806.

John N. Kennedy  
Secretary

**FISCAL AND ECONOMIC IMPACT STATEMENT  
FOR ADMINISTRATIVE RULES**

**RULE TITLE: Sale and Use of Dyed Special Fuels**

**I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENTAL UNITS (Summary)**

There is no explicit increase in costs to implement this rule. The department will absorb any costs associated with the application, certification and review of refund/credit claims with existing personnel and budget authority.

**II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)**

There should be no significant effect on revenue collections of state or local governmental units as a result of this proposed rule. There may be a marginal indeterminable increase in Transportation Trust Fund revenue due to increased tax compliance, based upon results of similar federal tax and dye requirements.

**III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)**

This proposed rule provides a mechanism for obtaining reimbursement of taxes that were paid on taxed clear fuel that had to be purchased for a nontaxable use when untaxed dyed fuel was not available. These costs and/or benefits cannot be determined with accuracy because the current level of noncompliance cannot be ascertained.

**IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)**

This proposed rule should have no effect on competition or employment.

John Neely Kennedy  
Secretary  
9603#062

Richard W. England  
Assistant to the  
Legislative Fiscal Officer

**NOTICE OF INTENT**

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

Resident Game Hunting Season, 1996-97  
(LAC 76:XIX.101,103)

The Wildlife and Fisheries Commission does hereby give notice of its intent to promulgate rules and regulations governing the hunting of resident game birds and game quadrupeds.

**Title 76  
WILDLIFE AND FISHERIES  
Part XIX. Hunting**

**Chapter 1. Resident Game Hunting Season  
§101. General**

The Resident Game Hunting Season, 1996-97 regulations are hereby adopted by the Wildlife and Fisheries Commission. A complete copy of the Regulation Pamphlet may be obtained from the department.

**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 21:707 (July 1995), amended LR 22:

**§103. Resident Game Birds and Animals 1996-1997**

**A. Shooting Hours.** One-half hour before sunrise to one-half hour after sunset.

**B. Consult Regulation Pamphlet** for seasons or specific regulations on Wildlife Management Areas or specific localities.

Species	Season Dates	Daily Bag Limit	Possession Limit
Quail	Nov 28— Feb 28	10	20
Rabbit	Oct 5— Feb 28	8	16
Squirrel	Oct 5— Jan 26	8	16
Deer	See Schedule	1 Antlered and 1 Antlerless (When Legal)	6

**C. Deer Hunting Schedule**

Area	Archery	Still Hunt	Muzzleloader (All Either Sex)	With or Without Dogs
1	Oct 1— Jan 31	Nov 16— Dec 1 Jan 4— Jan 19	Dec 2— Dec 8	Dec 9— Jan 3
2	Oct 1— Jan 31	Oct 26— Dec 6	Jan 6— Jan 12	Dec 7— Jan 5
3	Oct 1— Jan 31	Oct 19— Dec 6 Dec 21— Jan 5	Jan. 6— Jan 12	
4	Oct 1— Jan 31	Nov 23— Jan 5	Jan 6— Jan 12	
5	Oct 1— Jan 31	Nov 23— Dec 1	Dec 2— Dec 8 (Bucks Only)	
6	Oct 1— Jan 31	Nov 16— Dec 1	Dec 2— Dec 8	Dec 9— Jan 19
7	Oct 1— Jan 31	Oct 19— Nov 3 Nov 16— Dec 1	Dec 2— Dec 8	Dec 14— Jan 19

**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 21:707 (July 1995), amended LR 22:

Public hearings will be held at regularly scheduled Wildlife and Fisheries Commission Meetings from April through July. Additionally, interested persons may submit written comments relative to the proposed rule until May 20, 1996 to

Hugh A. Bateman, Administrator, Wildlife Division,  
Department of Wildlife and Fisheries, Box 98000, Baton  
Rouge, LA 70898.

Glynn Carver  
Chairman

**FISCAL AND ECONOMIC IMPACT STATEMENT  
FOR ADMINISTRATIVE RULES  
RULE TITLE: Hunting of Resident Game**

- I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENTAL UNITS (Summary)  
Establishment of hunting regulations is an annual process. The cost of implementing the proposed rules, aside from staff time, is the production of the regulation pamphlet. Cost of printing the 1995-96 pamphlet was \$14,800 and no major increase in expenditures is anticipated.
- II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)  
Projected hunting license fee collections for FY 95-96 will be approximately 4.5-5.0 million dollars. Additionally hunting and related activities generates approximately \$13 million in states sales tax and 3.5 million in state income tax (Southwick and Assoc., 1991). Failure to adopt rule changes would result in no hunting season being established and a potential loss of these revenues.
- III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)  
Hunting in Louisiana generates in excess of \$629,166,000 annually through the sale of outdoor related equipment, associated items and other economic benefits. Figures are based on the national surveys by Southwick and Associates for the IAFWA.
- IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)  
Hunting in Louisiana provides 9,370 jobs (Southwick and Assoc., 1991). Not establishing hunting seasons might have a negative and direct impact on these positions.

Fredrick J. Prejean, Sr.  
Undersecretary  
9603#023

Richard W. England  
Assistant to the  
Legislative Fiscal Officer

## Potpourri

### POTPOURRI

**Department of Environmental Quality  
Office of Air Quality and Radiation Protection  
Air Quality Division**

Revisions to the State Implementation Plan (SIP),  
Inspection and Maintenance Program (I/M)

Under the authority of the Louisiana Environmental Quality Act, R.S. 30:2001 et seq., the secretary gives notice that the Office of Air Quality and Radiation Protection will submit revisions to the State Implementation Plan (SIP) for the

Inspection and Maintenance (I/M) Program for motor vehicles in the Baton Rouge ozone nonattainment area. The program is mandated under the requirements of the 1990 Clean Air Act Amendments.

A public hearing will be held at 1:30 p.m. on Thursday, April 25, 1996, in Room 326, Maynard Ketcham Building, 7290 Bluebonnet, Baton Rouge, LA. Interested persons are invited to attend and submit oral comments on the proposal. All interested persons are invited to submit written comments concerning the SIP. Such comments should be submitted no later than 4:30 p.m., May 2, 1996 to Teri Lanoue, Air Quality Compliance Division or by phone at (504) 765-0219, or (504) 765-0222 (FAX). Written comments should be mailed to her at the following address: Air Quality Compliance Division, Box 82135, Baton Rouge, LA, 70884-2135. A copy of the SIP may be viewed at the Air Quality Compliance Division from 8 a.m. to 4:30 p.m., Monday through Friday, 7290 Bluebonnet, Second Floor, Baton Rouge, LA or the Capital Regional Office, 11720 Airline Highway, Baton Rouge, LA.

Gustave Von Bodungen, P. E.  
Assistant Secretary

9603#065

### POTPOURRI

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

#### Vaccines for Children Program

The Vaccines for Children Program (VFC) was initially implemented by emergency rule published in the January 20, 1995 *Louisiana Register* (Volume 21, Number 1) and re-declared in May, 1995 (Volume 21, Number 5), September, 1995 (Volume 21, Number 9), and January, 1996 (Volume 22, Number 1). Item 3 of these emergency rules noted that when the distribution system for the immunizations under the Vaccines for Children Program was fully implemented, the Bureau of Health Services Financing would begin to reimburse only the \$9.45 for the administration-related cost of the vaccines. The Office of Public Health has been distributing vaccines to all VFC enrolled providers (both public and private) since October 1995. Therefore, effective for dates of service April 1, 1996, the Bureau of Health Services Financing will no longer reimburse the cost of vaccines and will pay only the administration fee of \$9.45 for all vaccines available through VFC including the following:

- A. DTaP-Diphtheria, Tetanus and Acellular Pertussis;
- B. DTP-Diphtheria, Tetanus and Pertussis;
- C. MMR-Measles, Mumps and Rubella;
- D. Poliovirus;
- E. Hep B-Hepatitis B;
- F. HIB-Hemophilus Influenza B;
- G. Td-Tetanus and Diphtheria;
- H. DTP-HIB combination vaccine

Medicaid enrolled providers not already enrolled in the VFC

should immediately contact the Office of Public Health's Immunization Section to enroll in VFC if they provide vaccines to Medicaid eligibles.

Bobby P. Jindal  
Secretary

9603#063

**POTPOURRI**

**Department of Social Services  
Office of Community Services**

**1996 Homeless Shelter Grants Anticipated Availability**

The Louisiana Department of Social Services (DSS) anticipates the availability of \$1,176,000 in grant funds for distribution to applicant units of local government under the 1996 State Emergency Shelter Grants Program (ESGP). Program funds are allocated to the state by the U.S. Department of Housing and Urban Development (HUD) through authorization by the Stewart B. McKinney Homeless Assistance Act, as amended. Funding available under the Emergency Shelter Grants Program is dedicated for the rehabilitation, renovation or conversion of buildings for use as emergency shelters for the homeless, and for payment of certain operating costs and social services expenses in connection with emergency shelter for the homeless. The program also allows use of funding in homeless prevention activities as an adjunct to other eligible activities. As specified under current state ESGP policies, eligible applicants are limited to units of general local government for all parish jurisdictions and those municipal or city governmental units for jurisdictions with a minimum population of 10,000 according to recent census figures. Recipient units of local government may make all or part of grant amounts available to private nonprofit organizations for use in eligible activities.

Application packages for the state ESG Program shall be issued by mail to the chief elected official of each qualifying unit of general local government. In order to be considered for funding, applications must be received by DSS/Office of Community Services by 4 p.m., Friday, May 17, 1996.

Nonprofit organizations in qualifying jurisdictions which are interested in developing a project proposal for inclusion in an ESGP funding application should contact their respective unit of local government to apprise of their interest. To be eligible for funding participation, a private nonprofit organization as defined by ESGP regulations must be one which is exempt from taxation under subtitle A of the Internal Revenue Code, has an accounting system and a voluntary board, and practices nondiscrimination in the provision of assistance.

The state DSS will continue use of a geographic allocation formula (initially implemented for the 1992 state ESG Program) in the distribution of the state's ESG funding to ensure that each region of the state is allotted a specified

minimum of state ESG grant assistance for eligible ESGP projects. Regional allocations for the state's 1996 ESG Program have been formulated based on factors for low income populations in the parishes of each region according to U.S. Census Bureau data. Within each region, grant distribution shall be conducted through a competitive grant award process.

The following table lists the allocation factors and amounts for each region:

Region	Factor	Allocation
Region I New Orleans	.1572303	184,903
Region II Baton Rouge	.1120504	131,771
Region III Thibodaux	.0698830	82,182
Region IV Lafayette	.1522065	178,995
Region V Lake Charles	.0531706	62,530
Region VI Alexandria	.0764176	89,867
Region VII Shreveport	.1248105	146,777
Region VIII Monroe	.0985996	115,953
Region IX Northshore	.0746534	87,792
Region X Jefferson	.0809781	95,230

Regional funding amounts for which applications are not received shall be subject to statewide competitive award to applicants from other regions and/or shall be reallocated among other regions in accordance with formulations consistent with the above factors. Should an eligible local government wish to apply for supplemental funds above the applicable maximum amount specified below, a separate second stage proposal may be submitted for consideration of award of funds remaining from grant distribution to other regions.

Grant awards shall be for a minimum of \$30,000. Applicable grant maximums for first stage applications are as follows:

Individual grant awards to applicant jurisdictions of less than 49,000 population shall not exceed \$70,000.

For a jurisdiction of over 49,000 population, the maximum grant award shall not exceed the ESGP allocation for that jurisdiction's respective region.

A jurisdiction applying for grant funding through primary and second stage applications may receive up to the following maximum award:

An applicant jurisdiction of less than 49,000 population may be awarded total grant amounts not to exceed \$110,000.

An applicant jurisdiction of over 49,000 population may be awarded total grant amounts not to exceed \$225,000.

The jurisdiction with the largest homeless population may be awarded grant funding up to \$300,000.

Grant specifications, minimum and maximum awards may be revised at DSS's discretion in consideration of individual applicant's needs, total program funding requests, and available funding. DSS reserves the right to negotiate the



final grant amounts, component projects, and local match with all applicants to ensure judicious use of program funds.

Program applications must meet state ESGP requirements and must demonstrate the means to assure compliance if the proposal is selected for funding. If, in the determination of DSS, an application fails to meet program purposes and standards, even if such application is the only eligible proposal submitted from a region or subregion, such application may be rejected *in toto*, or the proposed project(s) may be subject to alterations as deemed necessary by DSS to meet appropriate program standards.

Proposals accepted for review will be rated on a comparative basis based on information provided in grant applications. Award of grant amounts between competing applicants and/or proposed projects will be based upon the following selection criteria:

Nature and extent of unmet need for emergency shelter, transitional housing and supportive services in the applicant's jurisdiction--40 points

The extent to which proposed activities will address needs for shelter and assistance and/or complete the development of a comprehensive system of services which will provide a continuum of care to assist homeless persons to achieve independent living--30 points

The ability of the applicant to carry out the proposed activities promptly--15 points

Coordination of the proposed project(s) with available community resources, so as to be able to match the needs of homeless persons with appropriate supportive services and assistance--15 points

ESGP recipients are required to provide matching funds (including in-kind contributions) in an amount at least equal to its ESG Program funding unless a jurisdiction has been granted an exemption in accordance with program provisions.

The value of donated materials and buildings, voluntary activities and other in-kind contributions may be included with "hard cash" amounts in the calculation of matching funds. A local government grantee may comply with this requirement by providing the matching funds itself, or through provision by nonprofit recipients. A recipient local government may at its option elect to use up to 2.5765 percent of grant funding for costs directly related to administering grant assistance, or may allocate all grant amounts for eligible program activities. Programs rules do not allow the use of ESGP funds for administrative costs of nonprofit subgrantees.

Availability of ESGP funding is subject to HUD's approval of the state's FY 96 Consolidated Annual Action Plan for Housing and Community Development Programs, and is conditioned upon the appropriation of federal funds. [As of February 9, 1996, HUD issued notification that the state was eligible to receive a portion (\$543,000) of its anticipated FY 96 ESGP allocation based on the funds HUD had received under the continuing resolutions in effect through March 15, 1996. Additional ESGP funds are dependent upon subsequent continuing resolutions or budget agreement for FY 96.] No expenditure authority or funding obligations shall be implied based on the information in this notice of funds availability.

Inquiries and comments regarding the 1996 Louisiana Emergency Shelter Grants Program may be submitted in writing to the Office of Community Services, Grants Management Division, Box 3318, Baton Rouge, LA 70821, or telephone (504) 342-2277.

Madlyn B. Bagneris  
Secretary

9603#064

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