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**V. POTPOURRI**

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# Executive Orders

## EXECUTIVE ORDER MJF 97-10

### Child Care and Development Block Grant Advisory Council

WHEREAS: Executive Order MJF 96-59, signed on October 17, 1996, established the Advisory Council on the Child Care and Development Block Grant Program (hereafter "Advisory Council"); and

WHEREAS: it is necessary to expand the voting membership of that Advisory Council to include four at-large members;

NOW THEREFORE I, M.J. "MIKE" FOSTER, JR., Governor of the State of Louisiana, by virtue of the authority vested by the Constitution and laws of the State of Louisiana, do hereby order and direct as follows:

SECTION 1: Section 1 of Executive Order MJF 96-59, is amended to add Subsection L to the voting membership, which shall provide as follows:

L. Four at-large members.

SECTION 2: All other Sections and Subsections of Executive Order MJF 96-59 shall remain in full force and effect.

SECTION 3: The provisions of this Order are effective upon signature and shall remain in effect until amended, modified, terminated, or rescinded by the Governor, or terminated by operation of law.

IN WITNESS WHEREOF, I have set my hand officially and caused to be affixed the Great Seal of the State of Louisiana, at the Capitol, in the City of Baton Rouge, on this 14th day of February, 1997.

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

ATTEST BY  
THE GOVERNOR  
Fox McKeithen  
Secretary of State  
9703#004

## EXECUTIVE ORDER MJF 97-11

### School Based Health Clinics Investigation

WHEREAS: Executive Order MJF 96-73, signed on December 16, 1996, ordered and directed that the secretary of the Department of Health and Hospitals (hereafter "secretary") head an investigation regarding allegations of violations of R.S. 40:31.3(c) by a few of the personnel employed by school based health clinics, and to issue a report on the findings of the investigation by February 15, 1997; and

WHEREAS: it is necessary to extend the period for investigation and amend the date on which the secretary shall issue his report on the findings of the investigation;

NOW THEREFORE I, M.J. "MIKE" FOSTER, JR., Governor of the State of Louisiana, by virtue of the authority vested by the Constitution and laws of the State of Louisiana, do hereby order and direct as follows:

SECTION 1: Section 4 of Executive Order MJF 96-73, is amended to provide as follows:

The secretary shall issue a report on the findings of the investigation to the governor, the House and Senate Committees on Health and Welfare, and the School Based Health Clinic Task Force, no later than March 31, 1997.

SECTION 2: All other Sections and Subsections of Executive Order MJF 96-73 shall remain in full force and effect.

SECTION 3: The provisions of this Order are effective upon signature and shall remain in effect until amended, modified, terminated, or rescinded by the governor, or terminated by operation of law.

IN WITNESS WHEREOF, I have set my hand officially and caused to be affixed the Great Seal of the State of Louisiana, at the Capitol, in the City of Baton Rouge, on this 14th day of February, 1997.

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

ATTEST BY  
THE GOVERNOR  
Fox McKeithen  
Secretary of State  
9703#012

## EXECUTIVE ORDER MJF 97-12

### International Trade Commission

WHEREAS: the State of Louisiana is the premier agricultural product embarkation state in the United States;

WHEREAS: the abundance of the agriculture products, natural resources, and manufactured products in the State of Louisiana makes those products and resources desirable for direct sale and value added processing in international markets; and

WHEREAS: the location of the State of Louisiana, at the mouth of the Mississippi River, is geographically advantageous for the dissemination of goods and services from the United States and Canada to the vast global markets of the world;

NOW THEREFORE I, M.J. "MIKE" FOSTER, JR., Governor of the State of Louisiana, by virtue of the authority vested through the Constitution and the laws of the State of Louisiana, do hereby order and direct as follows:

SECTION 1: The Louisiana International Trade Commission (hereafter "commission") is created and established within the Executive Branch, Department of Economic Development.

SECTION 2: The duties and functions of the commission shall include, but are not limited to, advising the secretary of the Department of Economic Development on policies, programs, and activities that have the following objectives:

A. stimulating growth in international trade and investment;

B. coordinating international trade and investment programs and activities;

C. insuring Louisiana products are competitive in international markets;

D. attracting foreign trade and investments;

E. creating international transportation routes between Louisiana and other states and counties; and

F. promoting mutually beneficial cultural, educational, medical, and/or environmental exchanges between Louisiana and other counties.

SECTION 3: The advice and recommendations of the commission shall be consistent with the goals and objectives of the Louisiana Economic Development Council.

SECTION 4: The commission shall be comprised of 19 members who shall be appointed by and serve at the pleasure of the governor. The membership of the commission shall be selected as follows:

A. the secretary of the Department of Economic Development, or the secretary's designee;

B. the commissioner of the Department of Agriculture and Forestry, or the commissioner's designee;

C. a member of the Louisiana Economic Development Council;

D. two at-large members; and

E. fourteen Louisiana residents who have at least seven years of experience in international trade, finance, relations, business improvement, or economics, selected from nomination lists submitted by each of the following organizations:

1. the Alexandria Chamber of Commerce;

2. the Baton Rouge Chamber of Commerce;

3. the Lake Charles Chamber of Commerce;

4. the METROVISION, the Greater New Orleans Region Chamber of Commerce;

5. the Monroe Chamber of Commerce;

6. the Freight Forwarders Association;

7. the International Trade Council - Red River Region;

8. the Lafayette International Trade Development Group;

9. the Louisiana Bankers Association for international bankers employed in Louisiana;

10. the Louisiana District Export Council;

11. the Port Association of Louisiana;

12. the South Louisiana Economic Council;

13. the World Trade Center of New Orleans Board of Directors; and

14. the Southern United States Trade Association.

SECTION 5: The secretary of the Department of Economic Development, or the secretary's designee, shall chair the commission. The membership of the commission shall elect its other officers.

SECTION 6: The commission shall meet at regularly scheduled intervals, and at the call of the chair.

SECTION 7: Support staff for the commission and facilities for their meetings shall be provided by the Department of Economic Development.

SECTION 8: Commission members shall not receive compensation or a per diem. Nonetheless, contingent upon the availability of funds, commission members who are not employed by the state may receive reimbursement for actual travel expenses, in accordance with state guidelines and procedures, upon the approval of the commissioner of Administration.

SECTION 9: All departments, commissions, boards, agencies, and officers of the state, or any political subdivision thereof, are authorized and directed to cooperate with the commission in implementing the provisions of this Order.

SECTION 10: This Order is effective upon signature and shall remain in effect until amended, modified, terminated, or rescinded by the governor, or terminated by operation of law.

IN WITNESS WHEREOF, I have set my hand officially and caused to be affixed the Great Seal of the State of Louisiana, at the Capitol, in the City of Baton Rouge, on this 21st day of February 1997.

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

ATTEST BY  
THE GOVERNOR  
Fox McKeithen  
Secretary of State  
9703#011

#### EXECUTIVE ORDER MJF 97-13

##### School Based Health Clinic Task Force

WHEREAS: Executive Order MJF 96-74, signed on December 16, 1996, created and established within the Executive Department, Office of the Governor, the School Based Health Clinic Task Force (hereafter "Task Force"), and ordered it to submit two reports to the governor by specified dates; and

WHEREAS: it is necessary to change the dates on which the Task Force shall submit its reports to the governor on the progress and/or fulfillment of its primary and secondary objectives and duties;

NOW THEREFORE I, M.J. "MIKE" FOSTER, JR., Governor of the State of Louisiana, by virtue of the authority vested by the Constitution and laws of the State of Louisiana, do hereby order and direct as follows:

SECTION 1: Section 4 of Executive Order MJF 96-74, is amended to provide as follows:

The Task Force shall prepare and submit a report to the governor on the progress and/or fulfillment of its primary objectives and duties, no later than May 15, 1997, and on the progress and/or fulfillment of its secondary objectives and duties, no later than June 30, 1997.

SECTION 2: All other Sections and Subsections of Executive Order MJF 96-74 shall remain in full force and effect.

SECTION 3: The provisions of this Order are effective upon signature and shall remain in effect until amended,

modified, terminated, or rescinded by the governor, or terminated by operation of law.

IN WITNESS WHEREOF, I have set my hand officially and caused to be affixed the Great Seal of the State of Louisiana, at the Capitol, in the City of Baton Rouge, on this 25th day of February, 1997.

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

ATTEST BY  
THE GOVERNOR  
Fox McKeithen  
Secretary of State  
9703#010

# Emergency Rules

## DECLARATION OF EMERGENCY

### Department of Agriculture and Forestry Office of Agricultural and Environmental Sciences Structural Pest Control Commission

#### Wood Destroying Insects (LAC 7.XXV. Chapter 141)

In accordance with the Administrative Procedure Act (R.S. 49:950 et seq.) and R.S. 3:3203(A), the commissioner of Agriculture and Forestry is amending the following Rules for the implementation of Regulations governing wood destroying insects.

This emergency adoption is necessary in order that the department may immediately put into place more stringent Regulations governing the qualifications required for pest control licensees and their technicians making wood destroying inspections, and to implement new Regulations for inspecting structures and completing the wood destroying insect report.

The department has further deemed these Regulations necessary to help ensure the citizens of the state have a more accurate inspection for wood destroying insects used in property transfer.

The effective date of these Emergency Rules is February 19, 1997 and shall remain in effect for 120 days or until these Rules take effect through the normal promulgation process, whichever occurs first.

#### Title 7

#### AGRICULTURE AND ANIMALS

#### Part XXV. Structural Pest Control

#### Chapter 141. Structural Pest Control Commission

#### §14101. Definitions

\* \* \*

*License*—a document issued by the commission which authorizes the practice and/or supervision of one or more phases of structural pest control work as follows:

1. *General Pest Control*—the application of remedial or preventive measures to control, prevent or eradicate household pests by use of pesticides used as sprays, dusts, aerosols, thermal fogs, barriers, traps and baits. Residential rodent control will be limited to the use of anti-coagulants rodenticide and traps.

2. *Commercial Vertebrate Control*—the application of remedial or preventive measures to control, prevent or eradicate vertebrates, including baits, chemicals, barriers, gases and traps, in nonresidential establishments, but not including tarpaulin fumigation.

3. *Termite Control*—the application of remedial or preventive measures for the control, prevention or eradication of termites and other wood-destroying insects.

4. *Fumigation*—the use of lethal gases and/or rodenticide in a gaseous form for the control, prevention or eradication of insect pests, rodents, or other pests in a sealed enclosure with or without a tarpaulin.

5. *Wood Destroying Insect Report (WDIR) Inspector*—the application of remedial or preventive measures for the control, prevention or eradication of termites and other wood-destroying insects and the inspection of structures for wood-destroying insects.

\* \* \*

*Registered Wood Destroying Insect Report (WDIR) Technician*—an employee qualified to conduct wood destroying insect report inspections.

\* \* \*

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:3366.

HISTORICAL NOTE: Promulgated by the Department of Agriculture, Structural Pest Control Commission, LR 11:323 (April 1985), amended by the Department of Agriculture and Forestry, Structural Pest Control Commission, LR 15: 954 (November 1989), LR 17:251 (March 1991), LR 23:

**§14107. License to Engage in Structural Pest Control; Work Required; Qualifications of Applicant; Requirements for Licensure; Phases of Structural Pest Control License; Conditions of the License**

A. - G. ...

H. All applicants who are approved by the commission will, upon successfully completing the examination for licensure as set forth in §14109 hereof, receive a single license to engage in structural pest control work, which license shall specify on the face thereof the specific phase or phases of structural pest control work for which the license is issued, as follows:

1. General Pest Control
2. Commercial Vertebrate Control
3. Termite Control
4. Structural Fumigation
5. Ship Fumigation
6. Commodity Fumigation
7. Wood Destroying Insect Report (WDIR) Inspector

I. - P. ...

Q. Persons licensed in Termite Control on or before September 30, 1997 shall attend a wood destroying insect report training session prior to being qualified to become a licensed WDIR inspector. Said training session must have prior approval by LDAF. Persons licensed on or after October 1, 1997 and persons licensed in Termite Control on or before September 30, 1997 that do not attend a wood destroying insect report training session, shall complete the requirements set forth in §14107.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:3366.

HISTORICAL NOTE: Promulgated by the Department of Agriculture, Structural Pest Control Commission, LR 11:326 (April 1985), amended by the Department of Agriculture and Forestry, Structural Pest Control Commission, LR 15: 955 (November 1989), LR 19:1009 (August 1993), LR 23:

**§14112. Registered Wood Destroying Insect Report Technician Requirements**

A. Persons, prior to registering as WDIR technicians, shall attend a wood destroying insect report training session and have conducted with licensed or registered WDIR inspector/technician, 40 WDIR inspections, approved by licensee, or shall have a wood destroying insect report training session and a minimum of one year of experience as a registered employee in the termite phase of pest control work under a termite phase licensee; and shall pass the appropriate test with a grade of 70 percent or better. Licensee shall verify in writing of technicians' work experience.

B. The fee for the examination for the WDIR technician shall be \$25.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:3366.

HISTORICAL NOTE: Promulgated by the Department of Agriculture and Forestry, Structural Pest Control Commission, LR 23:

**§14113. Obligations of the Licensee**

A. - E. ...

F.1. The licensee must maintain his commercial applicator certification in current status by:

- a. attending a continuing educational program for recertification approved by the Louisiana Department of Agriculture and Forestry;
- b. recertification at least once every three years;
- c. a minimum of six hours of technical training which shall include but not limited to the categories of general pest control, termite control, wood destroying insect report (WDIR) inspector and commercial vertebrate control;
- d. a minimum of six hours of technical training for the category of fumigation;

2. A licensee attending an approved recertification seminar must attend the entire approved program; otherwise the licensee shall not be recertified at this approved seminar;

3. Time and location for each licensee certification can be obtained by calling or writing to the Louisiana Department of Agriculture and Forestry.

\* \* \*

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:3366.

HISTORICAL NOTE: Promulgated by the Department of Agriculture, Structural Pest Control Commission, LR 11:327 (April 1985), amended by the Department of Agriculture and Forestry, Structural Pest Control Commission, LR 15: 956 (November 1989), LR 21:930 (September 1995), LR 23:

**§14116. Wood Infestation Report**

A. A wood infestation report approved by the Structural Pest Control Commission shall be issued when any inspection is made to determine the presence of wood destroying insects, specifically for acts of sale of structures, but not limited for this purpose.

B. Any wood infestation report or written instrument issued for the transfer of real property, shall be issued by a person who is licensed by the Structural Pest Control

Commission as a wood destroying insect report (WDIR) inspector or a registered wood destroying insect technician and is working under the supervision of a person who is licensed by the Structural Pest Control Commission as a WDIR inspector. This instrument shall carry a guarantee that the property will be treated without charge should live wood destroying insects with the exception, the presence of frass will be acceptable as evidence of a live infestation of Power Post Beetles; however, frass must be exuding or streaming from the holes on the outside of the wood, covered by this report, and be found within 90 days from date of inspection.

1. A contract approved by the Structural Pest Control Commission shall be issued on date of treatment.

2. This contract shall be reported to the commission and a fee paid as required by the Structural Pest Control Commission Law.

C. Regulations for completing wood destroying insect reports (LPCA-142). The following numbered sections correspond to the numbered sections on WDIR form LPCA - 142. LPCA - 142, and shall be completed as follows:

- 1. Enter HUD/FHA/VA Case number (if available).
- 2. Enter date of structure(s) inspection.
- 3A. Enter name of inspection company.
- 3B. Enter address (including street, city, state, and zip code) of inspection company.
- 3C. Enter telephone number (include area code) of inspection company.
- 4. Enter pest control inspector license number.
- 5A. Enter name and address of property owner/seller at the time of inspection.
- 5B. Enter address of property inspected (including street, city, state, and zip code).
- 5C. List only structures located at address in 5B that are part of this report.
- 5D. Information only. This area shall NOT be checked, circled or marked in any way.
- 6. If any areas of the property were obstructed or inaccessible mark box YES. If no, mark box NO.
- 7. Check the appropriate block as to the construction of the structure(s) inspected. More than one block can be checked.
- 8. This area shall NOT be checked, circled or marked in anyway.
- 9A. Check this block only when there is no visible evidence of wood destroying insects in accessible areas on the structure(s) inspected. Evidence includes but is not limited to: live or dead wood destroying insects, wood destroying insect parts, shelter tubes, shelter tube stains, frass, exit holes or damaged wood due to wood destroying insects. When this block is checked, no other block in Section 9 shall be checked.
- 9B. Check this block if evidence of wood destroying insects is observed. Evidence includes but is not limited to: live or dead wood destroying insects, wood destroying insect parts, shelter tubes, shelter tube stains, frass, exit holes or evidence of damage due to wood destroying insects. If live wood destroying insects are observed, identify and list the insect(s) observed and the location(s) in this Section.
- 9C. Check this box if visible evidence of damage due to wood destroying insects was observed. Evidence of damage is defined as obvious feeding or removal of wood by wood destroying insects including "etching" or "scabbing" marks on the wood surface(s). Identify the wood destroying insect and list the location(s) of evidence of damage caused by wood destroying insects in this Section.
- 9D. Treatment was or will be performed by inspection company? YES or Number If YES, explain as follows:
  - 12. Property disclosure statement provided to pest control company prior to or at the time of the inspection. Check "yes" if provided, Check "no" if not.
  - 13. Make no marks in this Section.
    - a. If any of the conditions listed in this Paragraph on the WDIR (LPCA-142) are present on or adjacent to the inspected structure(s), list them in Section Number 10 of this report.
  - 14. Signature and registration/licensee number of inspector conducting the inspection.
  - 15. Enter date of inspector signature.

16. Enter name of person requesting the WDIR (if available).
17. Signature of person WDIR received by (if available).
18. Title of person in Number 17 (if available).
19. Date of signature of Number 17 (if available).

**D. Minimum Specifications for conducting a Wood Destroying Insect Report**

1. No person shall conduct a WDIR inspection unless that person is properly licensed with the Louisiana Structural Pest Control Commission to conduct WDIR inspections or is working under the supervision of a licensed WDIR inspector and is properly registered to conduct WDIR inspections.

2. WDIR inspector/technician shall inspect all unobstructed or accessible areas.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:3366.

HISTORICAL NOTE: Promulgated by the Department of Agriculture, Structural Pest Control Commission, LR 12:285 (May 1986), amended by the Department of Agriculture and Forestry, Structural Pest Control Commission, LR 23:

Bob Odom  
Commissioner

9703#006

**DECLARATION OF EMERGENCY**

**Department of Agriculture and Forestry  
Office of the Commissioner**

**Emergency Airstrip for  
Agricultural Purposes (LAC 7:I.107)**

In accordance with Administrative Procedure Act, R.S. 49:953(B) and R.S. 3:18, the commissioner of Agriculture and Forestry finds that this Emergency Rule setting forth a program to designate certain roads for use as emergency airstrips for agricultural purposes is necessary for the health, safety and welfare of the citizens of Louisiana. The department published a Notice of Intent in the February 20, 1997 edition of the *Louisiana Register* of its intent to promulgate regulations setting forth a program to designate certain roads for use as emergency airstrips pursuant to the authority of R.S. 3:18; however, the earliest the department can adopt these regulations is 90 days from the publication date in the *Louisiana Register*. Weather conditions during the past several weeks have rendered unusable the agricultural turf airstrips normally employed by agricultural interests at this time of the year in preparing the planting fields. The inability of the agricultural interests to use agricultural turf airstrips creates an extreme hardship on the agricultural interests in that the cost of planting crops rises. The rise in costs has a direct adverse impact on the agricultural economy of the state.

For the reasons set forth above, the commissioner has determined that this Emergency Rule is necessary in order to implement the emergency airstrip program during the current growing season.

The Rule is effective March 3, 1997 and will remain in effect 120 days or until the final Rule becomes effective, whichever occurs first.

**Title 7  
AGRICULTURE AND ANIMALS**

**Part I. Administration**

**Chapter 1. Administrative Procedure**

**§107. Emergency Airstrip for Agricultural Purposes Program**

A. Creation. There is hereby established within the Department of Agriculture and Forestry a program to designate certain roads as emergency airstrips to aid in the use of aircraft for agricultural purposes to be known as the "Emergency Airstrip for Agricultural Purposes Program."

**B. Declaration of Emergency**

1. The department may declare an agricultural emergency to exist which requires the use of portions of designated roads as airstrips for agricultural purposes when conditions are such that agricultural turf airstrips are rendered unavailable for safe use.

2. Each declaration of agricultural emergency shall be in writing and contain a declaration number, the date, and a list of the portions of designated roads which may be utilized as airstrips during the agricultural emergency.

3. The department shall provide a copy of the declaration to the sheriff and police jury for the parish in which each of the designated roads is located, and the Aviation Division of the State Department of Transportation and Development (hereinafter referred to as "DOTD") prior to utilization of the emergency airstrip. If the designated road is a state road, a copy of the declaration should also be provided to the communications center at State Police Headquarters and to the secretary of DOTD. If a designated road is located on the parish line, a copy of the declaration must be provided to the sheriff and police jury for both parishes.

4. The appropriate law enforcement entity as set forth in Subsection B.3 of this Section shall be responsible for implementing security and safety requirements for road traffic during periods when a road designated for use as an emergency airstrip to aid in the use of aircraft for agricultural purposes is actually utilized for that purpose. At a minimum, the appropriate law enforcement entity shall have at least one officer at the site and signs shall be placed at each end and at all approach ramps of a designated road to notify persons that the road is designated for use as an emergency airstrip to aid in the use of aircraft for agricultural purposes. The officer will insure that whenever aircraft are in the process of landing, taking off, or taxiing, there shall be no movement of vehicles on the emergency airstrip or within 500 feet of each landing threshold of the emergency airstrip. The enforcement entity providing said officer shall have the option of cost recovery for services from the party requesting use of the emergency airstrip.

**C. Designation of Roads**

1. Upon declaration by the department that an agricultural emergency exists, certain roads, including but not limited to dead-end roads and strategically placed parish roads, may be designated by the department for use as airstrips to aid in the use of aircraft for agricultural purposes.

2. Whenever possible, the department shall pre-designate a portion of a road for use as an emergency agricultural airstrip for use in the event a declaration of an agricultural emergency is made by the department. The request for pre-designation must be made by mail or facsimile to the department and include the following information:

- a. location of the road marked on a topography map;
- b. reason for designation; and
- c. a statement that the road meets all the criteria set forth in Subsection C.3 or a statement setting forth the reasons why a waiver under Subsection C.4 should be issue.

3. Predesignated emergency agricultural airstrips shall be inspected and registered by DOTD Aviation using similar criteria as utilized by DOTD in the registration of an agricultural use permanent airstrip. The registration certificate shall be issued to and held by the department. The registered and designated airstrip shall be marked and signed as such. Persons seeking predesignation must contact the Aviation Division of DOTD for specifications regarding the appropriate marking and signage required for the registered and designated emergency airstrip.

4. The department may authorize use of airstrips which have not been pre-designated and registered with the Aviation Division of DOTD, on a case by case basis, when safety and aircraft performance would not be compromised by such waiver and the use of said road as an emergency agricultural airstrip is deemed necessary by the department. Any such airstrip authorized shall, at a minimum, meet all of the following:

- a. the surface must be flat and straight for a minimum distance to 2,000 feet;
- b. the width shall be a minimum of 20 feet for the full length of the landing area. Sufficient wing tip clearance shall be provided as required for the aircraft utilizing the emergency agricultural airstrip;
- c. there shall be no potholes or depressions greater than 3 inches in depth over the entire landing surface;
- d. there shall be no vertical obstructions such as utility poles, trees, buildings, road signs, mail boxes, etc., on more than one longitudinal side of the landing surface;
- e. there shall be no overhead obstructions such as utility lines, overpasses, bridges, etc., for the full length of the landing area and within 500 feet of each landing area threshold;
- f. each landing area threshold shall be marked in such a way as to be readily identified from an aircraft in flight (e.g., white or orange cones, buckets, or painted tires); and
- g. threshold markers shall be placed on either side of the landing area at the thresholds and shall be no taller than 24 inches.

**AUTHORITY NOTE:** Promulgated in accordance with R.S. 3:18.

**HISTORICAL NOTE:** Promulgated by the Department of Agriculture and Forestry, Office of the Commissioner, LR 23:

Bob Odom  
Commissioner

9703#015

## DECLARATION OF EMERGENCY

### Department of Economic Development Racing Commission

Qualifications for Jockey/Apprentice Jockey and  
Applicant for License (LAC 46:XLI.701 and 703)

The Racing Commission is exercising the emergency provisions of the Administrative Procedure Act, R.S. 49:953(B), and pursuant to the authority granted under R.S. 4:141 et seq., amends the following Emergency Rule effective March 7, 1997, and it shall remain in effect for 120 days or until this Emergency Rule takes effect through the normal promulgation process, whichever occurs first.

The Racing Commission finds it necessary to amend this Rule to eliminate probationary rides/mounts. This will prevent any jockey or apprentice jockey from riding while unlicensed.

#### Title 46

### PROFESSIONAL AND OCCUPATIONAL STANDARDS

#### Part XLI. Horseracing Occupations

#### Chapter 7. Jockeys and Apprentice Jockeys

#### §701. Qualifications for Jockey/Apprentice Jockey

Any person desiring to participate in this state as a jockey and has never ridden in a race may be issued a jockey or apprentice jockey license upon the recommendation of the stewards granting permission to such person for the purpose of riding in two races to establish the qualifications and ability of such person for the license, provided, however:

1. such person has the qualifications of a permittee and has at least one year of experience with racing stables;
2. a licensed trainer certifies in writing to the stewards that such person has demonstrated sufficient horsemanship to be granted a jockey or apprentice jockey license;
3. the starter has schooled such person breaking from the starting gate with other horses and approves such person as capable of starting a horse properly from the starting gate in a race;
4. the stewards in their sole discretion are satisfied such person intends to become a licensed jockey, possesses the physical ability and has demonstrated sufficient horsemanship to ride in a race without jeopardizing the safety of horses or other riders in the race.

**AUTHORITY NOTE:** Promulgated in accordance with R.S. 4:148, R.S. 4:150 and R.S. 4:169.

**HISTORICAL NOTE:** Adopted by the Racing Commission in 1971, amended by the Department of Commerce, Racing Commission, LR 2:430 (December 1976), LR 3:26 (January 1977), repromulgated LR 4:275 (August 1978), amended by the Department of Economic Development, Racing Commission, LR 23:

#### §703. Applicant for a License

A. In addition to Rules applicable to permittees, an applicant for a license as a jockey or apprentice jockey:

1. must have served at least one year with racing stables;
2. must provide an annual medical affidavit certifying such person is physically and mentally capable of performing the activities and duties of a licensed jockey or exercise person.

B. The stewards may require that any jockey or exercise person provide blood or urine samples for analysis after consultation with the track physician. Should a jockey or exercise person fail to comply with this requirement this person shall be suspended and referred to the commission to show cause for refusing to do so.

AUTHORITY NOTE: Promulgated in accordance with R.S. 4:148, R.S. 4:150, R.S. 4:151 and R.S. 4:169.

HISTORICAL NOTE: Promulgated by the Department of Commerce, Racing Commission, LR 2:430 (December 1976), LR 3:27 (January 1977), repromulgated LR 4:275 (August 1978), amended LR 10:593 (August 1984), amended by the Department of Economic Development, Racing Commission, LR 23:

Paul D. Burgess  
Executive Director

9703#039

## DECLARATION OF EMERGENCY

Department of Environmental Quality  
Office of Water Resources

Produced Water Discharge Extension  
[Adoption of Emergency Rule]  
(WP023E-B)

In accordance with the emergency provisions of R.S. 49:953(B) of the Administrative Procedure Act, which allow the Department of Environmental Quality (department) to use emergency procedures to establish Rules, and of R.S. 30:2011 and R.S. 30:2074, which allow the department to establish standards, guidelines, and criteria, to promulgate Rules and Regulations, and to issue compliance schedules, the secretary of the department hereby finds that imminent peril to the public welfare exists. The department adopts the Emergency Rule published below (LAC 33:IX.708.C)(WP023E-B) effective February 26, 1997, for 120 days, or until promulgation of the final Rule, whichever occurs first.

This Emergency Rule replaces WP023E and WP023E-A, published in the *Louisiana Register* on January 20, 1997. Accordingly, Emergency Rules WP023E and WP023E-A are repealed by the adoption of Emergency Rule WP023E-B. Adopted this 26th day of February, 1997.

J. Dale Givens  
Secretary

9703#009

## DECLARATION OF EMERGENCY

Department of Environmental Quality  
Office of Water Resources

Produced Water Discharge Extension  
[Declaration of Emergency]  
(LAC 33:IX.708) (WP023E-B)

In accordance with the emergency provisions of R.S. 49:953(B) of the Administrative Procedure Act, which allow the Department of Environmental Quality (department) to use emergency procedures to establish Rules, and of R.S. 30:2011 and R.S. 30:2074, which allow the department to establish standards, guidelines, and criteria, to promulgate Rules and Regulations, and to issue compliance schedules, the secretary of the department made a finding that imminent peril to the public welfare exists. The department adopted Emergency Rule WP023E-B effective February 26, 1997, for 120 days, or until promulgation of the final Rule, whichever occurs first.

Adoption of Emergency Rule WP023E-B repealed and replaced Emergency Rules WP023E and WP023E-A, published in the *Louisiana Register* on January 20, 1997.

This Declaration of Emergency provides the reasons for the secretary's finding and includes specific reasons why the failure to adopt the Rule on an emergency basis would result in imminent peril to the public welfare.

### Regulatory History of Produced Water

The secretary hereby finds the following to be the history of produced water and its regulation in the State of Louisiana:

1. Discharges of produced water have existed since the 1940's.
2. A 1953 Rule allowed produced water discharges to any stream not used for drinking water purposes.
3. By 1968, discharge to most freshwater areas was banned.
4. Many LWDPs permits have prohibited discharges of produced water beginning in 1988.
5. In March of 1991, state regulations were promulgated concerning produced water. DEQ's 1991 regulations required a phase-out of coastal produced water discharges by 1997.
  - a. Continued produced water discharges to major deltaic passes of the Mississippi and Atchafalaya Rivers could be authorized in a valid LWDPs permit.
  - b. DEQ Regulations provided for extensions of time to discharge produced water in coastal regions up to January 1, 1997.
  - c. All discharges of produced water (except for those to Mississippi and Atchafalaya River areas) had to cease by January 1, 1997.
6. EPA Region 6 issued NPDES general permits effective February 1995.
  - a. The general permits prohibit discharge of produced water to Louisiana and Texas coastal waters.
  - b. Although the general permits absolutely prohibit any discharge of produced water of coastal origin, exceptions to that prohibition are found in an EPA administrative order, effective February 1995. That order allowed extensions of time to comply with the prohibition until January 1997.

c. The general permit effective in Louisiana did not cover discharges of produced water from the offshore subcategory to the Mississippi River and the Atchafalaya River (below Morgan City).

7. EPA guidelines and standards for coastal waters were promulgated in December 1996 and effective on January 14, 1997 (the guidelines).

a. The guidelines banned *all* discharges to the coastal area.

b. The guidelines required all remaining Mississippi and Atchafalaya River discharges to cease.

c. The federal guidelines note at page 66122-23 the following:

"EPA received numerous comments from operators in the Gulf of Mexico coastal region claiming that they would need additional time to comply with the Rule's zero discharge requirement for produced water. EPA recognizes that it may take some time for operators to determine the best and most cost effective mechanism of compliance and to implement that mechanism. EPA also recognizes that the NPDES permit issuing authority has discretion to use administrative orders to provide the requisite additional time to meet zero discharge."

d. The Department's Office of Water Resources became the NPDES permit issuing authority for the State of Louisiana on August 27, 1996.

e. Consistent with the guidelines, EPA has recognized the need to allow additional time for facilities to come into compliance with the ban.

f. EPA issued administrative orders in the State of Texas that document continued produced water discharges after the January 14, 1997 deadline and which set forth compliance schedules for the termination of such discharges over a period of two years.

8. On December 30, 1996, the department issued Emergency Rule WP023E to prevent imminent peril to the public welfare, specifically to prevent the loss of employment, taxes, and royalties that would result if all remaining produced water discharges were eliminated on January 1, 1997.

a. The Emergency Rule allowed additional time for a limited number of facilities to cease produced water discharges.

b. Emergency Rule WP023E-A was issued on January 6, 1997, to correct an omission in the original Emergency Rule.

c. Emergency Rule WP023E-B repealed and replaced Emergency Rules WP023E and WP023E-A.

#### **Additional Findings**

The secretary also finds the following:

1. Facilities were still discharging produced water on January 1, 1997.

2. Facilities still discharging produced water after January 1, 1997 are subject to enforcement action by both DEQ and EPA.

3. Produced water is a commonly produced byproduct of oil and gas production.

4. To continue operating, an oil and gas production facility for which produced water is a natural byproduct must either discharge the produced water or inject it into an injection well approved by the Department of Natural Resources.

5. For various reasons, certain facilities would not be able to cease all discharges by January 1, 1997:

a. The Department of Natural Resources experienced a personnel shortage, which prevented it from processing before January 1, 1997, all of the applications for injection wells on file in December 1996.

b. Some Mississippi and Atchafalaya River dischargers had valid state permits allowing continued discharge (in conflict with the December 1996 federal guidelines and standards).

c. Some bay dischargers had relied on Department of Energy study results to allow continued discharge by state permit.

6. The federal guidelines at page 66087 note the reliance of bay dischargers on the DOE study:

"The United States Department of Energy (DOE) has provided the State of Louisiana with comments and analyses suggesting a change to the Louisiana state law requiring zero discharge of produced waters to open bays by January 1997. Promulgation of [these December 16, 1996 federal guidelines] would generally preclude issuance of permits allowing discharges."

7. The department accepted information that was part of the DOE study referenced in LAC 33:IX.708.C.2.b.iv.(e), as documented at 61 Federal Regulation 66087.

8. The DOE study results focus on minimal water quality impact to urge discharges be allowed.

9. The EPA guidelines use Best Available Technology (BAT) to require all discharges to cease.

#### **Findings and Considerations Regarding Environmental and Economic Costs and Benefits**

The secretary is the primary public trustee of the environment. He has a duty to provide environmental protection insofar as possible and consistent with the health, safety, and welfare of the people of the State of Louisiana. In fulfillment of that duty, the secretary finds that the adverse environmental impacts resulting from issuance of Emergency Rule WP023E-B have been minimized or avoided as much as possible consistent with the public welfare, as detailed below.

#### **Environmental Costs and Benefits**

Environmental costs and benefits were considered. During the 1953 to 1997 time frame, produced water discharges to areas of greatest environmental impact were limited or eliminated. Of the coastal area discharges which now remain, the majority of discharges are to major passes of the Mississippi River or to bay areas. These areas have less potential for environmental damage than locations such as dead end canals, due to greater water circulation.

As part of the development and consideration for the March 1991 regulations that prohibited produced water discharges, DEQ, in cooperation with the Louisiana State University Institute for Environmental Studies, performed a

# DECLARATION OF EMERGENCY

## Office of the Governor Crime Victims Reparations Board

### Definitions (LAC 22:XIII.103)

The following amendments are published in accordance with the emergency provisions of R.S. 49:953(B), the Administrative Procedure Act, and R.S. 46:1801 et seq., the Crime Victims Reparations Act, which allows the Crime Victims Reparations Board to promulgate Rules necessary to carry out its business or the provisions of the Chapter. The board hereby finds that an emergency exists whereby victims, or the claimants in the case of deceased victims, will suffer an immediate, detrimental financial loss in federal grants estimated at \$6,724,000 over the next year if these amendments are not immediately implemented. This Emergency Rule provides for a broader definition of a victim to include those Louisiana residents who are victims of an act of terrorism whether the terrorism occurs in the United States or in another country. Furthermore, the changes remove any restrictions that would prohibit a victim from receiving compensation solely because another state or country had a compensation program, and will ensure compliance with federal grant requirements. In order to prevent additional harm to victims and their families, the board adopts this Emergency Rule effective April 1, 1997. It shall remain in effect for 120 days or until the final Rule takes effect through the normal promulgation process, whichever comes first.

### Title 22

## CORRECTIONS, CRIMINAL JUSTICE AND LAW ENFORCEMENT

### Part XIII. Crime Victims Reparations Board

#### Chapter 1. Authority and Definitions

##### §103. Definitions

\* \* \*

*Victim*—

\* \* \*

b. a resident of Louisiana who is a victim of an act of terrorism(as defined in Section 2331 of Title 18, *United States Code*) occurring outside the U.S., or

c. a Louisiana resident who suffers personal injury or death as a result of a crime described in R.S. 46:1805 except that the criminal act occurred outside of this state. The resident shall have the same rights under this Chapter as if the Act had occurred in this state upon a showing that the state in which the act occurred does not have an eligible crime victims reparations program and the crime would have been compensable had it occurred in Louisiana. In this Subparagraph, *Louisiana Resident* means a person maintained a place of permanent abode in this state at the time the crime was committed for which reparations are sought.

AUTHORITY NOTE: Promulgated in accordance with R.S.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Crime Victims Reparations Board, LR 20:538 (May 1994), amended LR 20:709 (August 1996), LR 23:

Lamarr Davis  
Chairman

9703#008

# DECLARATION OF EMERGENCY

## Department of Health and Hospitals Board of Veterinary Medicine

### Animal Euthanasia Technicians Suspension of Rule (LAC 46:LXXXV.1201)

The Board of Veterinary Medicine has adopted the following Emergency Rule, effective March 10, 1997, in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B), and it shall be in effect for 120 days.

It has come to the attention of the Board of Veterinary Medicine that persons have completed the board's approved certified animal euthanasia technician course, but, acting in good faith, did not complete the certification process. Further, these persons have been performing the functions of certified animal euthanasia technicians. Upon learning of this violation of the Rules for certification, these persons have reported themselves to the board and requested certification. Under its current Rule LAC 46:LXXXV.1201.E, the board may not accept the application for certification from these persons for a two-year period. The rejection of these applications has the great potential of leaving some animal shelters in the state without a certified animal euthanasia technician, thereby hindering these shelters' ability to control the animal population in their communities, including the ability to euthanize diseased or otherwise dangerous animals.

Therefore, to protect the public health and safety, the board has suspended LAC 46:LXXXV.1201.E for a period of 120 days, to allow persons who have already completed the board's approved course for certified animal euthanasia technicians to receive temporary certificates in accordance with LAC 46:LXXXV.1207.

### Title 46

## PROFESSIONAL AND OCCUPATIONAL STANDARDS

### Part LXXXV. Veterinarians

#### Chapter 12. Certified Animal Euthanasia Technicians

##### §1201. Applications for Certificates of Approval

A. - D. ...

E. *Suspended for 120 days, effective March 10, 1977.*

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1558.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Veterinary Medicine, LR 19:1424 (November 1993), amended LR 23:

Charles B. Mann  
Executive Director



**DECLARATION OF EMERGENCY**

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

Professional Conduct— Specialty  
List (LAC 46:LXXXV.1063)

The Board of Veterinary Medicine has adopted the following Emergency Rule, effective March 10, 1997, in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B), and it shall be in effect for the maximum period allowed under the Administrative Procedure Act or until adoption of the Rule, whichever occurs first.

This Emergency Rule is necessary to promote the public health, safety, and welfare by safeguarding the people of this state from veterinarians who may state or imply that they are certified or recognized specialists without appropriate board certification in such specialty, thereby protecting the public from the actions of persons who could otherwise claim to be specialists.

**Title 46  
PROFESSIONAL AND OCCUPATIONAL  
STANDARDS**

**Part LXXXV. Veterinarians**

**Chapter 10. Rules of Professional Conduct**

**§1063. Specialty List**

A. ...

B. A veterinarian may not use the term *specialist* for an area of practice for which there is not AVMA recognized certification.

C. A diplomate of the American Board of Veterinary Practitioners can claim only a specialty for the class of animals in which he specializes, not for medical specialties unless he is board-certified in those medical specialties.

D. The term *specialty* or *specialists* is not permitted to be used in the name of a veterinary hospital unless all veterinary staff are board-certified specialists.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1518(A)(9).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Veterinary Medicine, LR 16:232 (March 1990), LR 23:

Charles B. Mann  
Executive Director

9703#055

**DECLARATION OF EMERGENCY**

**Department of Health and Hospitals  
Office of Public Health**

Orleans Parish Individual Sewage

In accordance with the Administrative Procedure Act, R.S. 49:950 et seq., and under the authority of R.S. 36:258(B) and 40:5(9), the secretary of the Department of Health and Hospitals is adopting the following Emergency Rule governing installation of individual sewage systems in certain

areas of Orleans Parish. Concurrently, a Notice of Intent to establish a permanent Rule is being published in accordance with the Administrative Procedure Act, R.S. 49:953(B).

The present Rule inadvertently prohibits those individuals with failing and/or inadequate sewage treatment systems from upgrading or replacing their systems thereby exposing their families to disease and pollution of the state's waterways.

The effective date of this Emergency Rule is February 17, 1997, and shall remain in effect for 120 days or until the Rule takes effect through the normal promulgation process, whichever occurs first.

**Emergency Rule**

The Department of Health and Hospitals, Office of Public Health prohibits the installation of individual sewage systems in the following areas of Orleans Parish:

- 1) property between the Chef Pass and the Rigolets, outside the hurricane protection levee; and
- 2) property on the Lake Pontchartrain side of the LandM Railroad tracks that parallel Hayne Boulevard outside the hurricane protection levee; and
- 3) property on either side of US Highway 11 between Powers Junction and Interstate 10, commonly referred to as Irish Bayou.

This does not preclude the installation of approved individual sewage disposal systems on individually owned lots of record, i.e., those legally established and duly recorded with the parish prior to July 28, 1967, or those lots legally established and duly recorded with the parish that meet the minimum lot size prescribed in the State Sanitary Code.

Bobby P. Jindal  
Secretary

9703#013

**DECLARATION OF EMERGENCY**

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

Case Management Services Reimbursement  
Infants and Toddlers with Special Needs

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing adopts the following Emergency Rule in accordance with the Administrative Procedure Act, R.S. 49:953(B) et seq., and it shall be in effect for the maximum period allowed under the Administrative Procedure Act or until adoption of the Rule, whichever occurs first.

The Department of Health and Hospitals, Bureau of Health Services Financing currently provides reimbursement for optional targeted case management services to infants and toddlers who are categorized as developmentally disabled under the ChildNet Program.

An Emergency Rule was adopted on September 24, 1996, limiting case management services to those infants and toddlers who either receive services under the MR/DD waiver or who receive two or more specified Medicaid services

(Louisiana Register, Volume 22, Number 9). The department subsequently repealed the September 24, 1996 Emergency Rule and reduced the reimbursement rate for these services, effective December 1, 1996, in a subsequent Emergency Rule (Louisiana Register, Volume 22, Number 11).

After consultation with the Department of Education regarding ChildNet Services, the bureau has now determined it is necessary to increase the reimbursement for case management services for infants and toddlers. This action is necessary to maintain the health and welfare of these children by assuring continued access to case management services to assist their families in obtaining necessary medical, social and educational services.

It is anticipated that implementation of this Emergency Rule will increase expenditures by approximately \$88,400 for the remainder of fiscal year 1996-1997.

#### **Emergency Rule**

Effective for dates of service on or after March 13, 1997, the Department of Health and Hospitals, Bureau of Health Services Financing increases reimbursement for case management services for infants and toddlers with special needs to \$115.

Interested persons may submit written comments to Thomas D. Collins, Bureau of Health Services Financing, Box 91030, Baton Rouge, LA 70821-9030. He is responsible for responding to inquires 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

9703#044

### **DECLARATION OF EMERGENCY**

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

#### **Disproportionate Share Hospital Payment Methodology**

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. 46:153 et seq. and pursuant to 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 allowed under the Administrative Procedure Act or until adoption of the Rule, whichever occurs first.

Hospital disproportionate share (DSH) payment limits were established by the Omnibus Budget Reconciliation Act of 1993 (P.L. 103-66) which amended Section 1923 of the Social Security Act. In order to comply with the budgetary limitations imposed by that federal regulation and to avoid a

budget deficit in the medical assistance programs, the bureau amended the payment methodologies for public state-operated hospitals, private hospitals, and public nonstate hospitals effective July 1, 1995. Under that methodology, public state-operated hospitals receive DSH payments equal to 100 percent of the hospital's net uncompensated costs, and private hospitals and public nonstate hospitals received DSH payments according to a formula based on an eight-pool methodology.

In order to assure continued fiscal viability of community hospitals, Act Number 17 (House Bill Number 1) of the 1996 Louisiana Legislature provides for separate treatment of disproportionate share funds for uncompensated costs in small (60 beds or less) nonstate-operated local government hospitals and small (60 beds or less) private rural hospitals. To accommodate this proviso, this Emergency Rule provides that all hospitals other than public state-operated hospitals are separated into two groups: the first is composed of small (60 beds or less) nonstate-operated local government hospitals and small (60 beds or less) private rural hospitals, and the second contains all other hospitals. The latter group is composed of two pools, acute care hospitals and psychiatric hospitals. Previous provisions concerning DSH methodology for public state-operated hospitals continues unchanged. There is no increase or decrease in DSH funds as the result of this Emergency Rule, therefore there is no fiscal impact to the state or federal government.

Failure to adopt this Emergency Rule on an emergency basis could result in unavailability of local hospital services for Medicaid recipients in areas served by these hospitals, and would cause imminent peril to the public health, safety, or welfare of affected Medicaid recipients.

#### **Emergency Rule**

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.

#### **I. General Provisions**

A. Reimbursement will no longer be provided for indigent care as a separate payment in hospitals qualifying for disproportionate share payments.

B. 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 or 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.

C. Appropriate action shall be taken to recover any overpayments resulting from the use of erroneous data, or if it is determined upon audit that a hospital did not qualify.

D. DSH payments to a hospital determined under any of the methodologies below shall not exceed the hospital's

uncompensated cost for the state fiscal year to which the payment is applicable.

E. Qualification is based on the hospital's latest year end cost report for the year ended during the period July 1 through June 30 of the previous year. Only hospitals that return DSH qualification documentation timely will be considered for disproportionate share payments. For hospitals with distinct part psychiatric units, qualification is based on the entire hospital's utilization.

F. Hospitals/units which close or withdraw from the Medicaid Program shall become ineligible for further DSH pool payments for the remainder of the current DSH pool payment cycle and thereafter.

G. Net Uncompensated Cost—cost 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 patients. It is mandatory that qualifying hospitals seek all third-party payments including Medicare, Medicaid, and other third-party carriers. Hospitals not in compliance with free care criteria will be subject to recoupment.

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

## II. Reimbursement Methodologies

### A. Public State-Operated Hospitals

#### 1. Definitions:

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

2. Payment Methodology. DSH payments to individual public state-owned or operated hospitals are equal to 100 percent of the hospital's net uncompensated costs subject to the adjustment provision in II.A.3 below. Final payment will be based on the uncompensated cost data per the audited cost report for the period(s) covering the state fiscal year.

3. In the event it is necessary to reduce the amount of disproportionate share payments to remain within the federal disproportionate share allotment each year or the state DSH appropriated amount, 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 or state DSH appropriated amount.

### B. Small Nonstate-Operated Local Government Hospitals and Small Private Rural Hospitals

1. Criteria for hospitals to be included in this group are as follows:

Qualifying hospitals must be 1) small and 2) either a nonstate public-owned and operated or a private rural hospital as defined below. Hospitals/beds located outside the service district area or rural area may not be included in this pool, but will be included in the all other hospitals pools. Beds located outside the service district will be used by DHH to determine

qualification, but costs associated with these beds will not be used to determine reimbursement. Freestanding psychiatric hospitals are not included.

#### 2. Definitions

*Public Local Government Acute Hospitals*—local government-owned acute care general, rehabilitation, and long term care hospitals including distinct part psychiatric units are qualified for this designation. Only uncompensated costs attributable to beds/units located within the service district area qualify for inclusion.

*Private Rural Hospitals*—privately owned acute care general, rehabilitation and long-term care hospitals designated as rural hospitals by Medicare, including distinct part psychiatric units are qualified for this designation. Only uncompensated cost attributable to beds/units located within the rural area qualify for inclusion.

*Small*—having 60 or less licensed beds as of July 1 of the state fiscal year to which the payment is applicable. The number of beds includes distinct part psychiatric beds, and excludes nursery and skilled nursing beds.

*Rural*—rural area as it applies to small private rural hospitals is considered rural areas of the parish in which the facility is domiciled.

3. Payment is based on each qualifying hospital's pro rata share of uncompensated cost for the previous state fiscal year for all hospitals meeting these criteria multiplied by the amount set for these facilities.

4. A pro rata decrease necessitated by conditions specified in I.B above for nonstate hospitals described in this Section will be calculated based on the ratio determined by dividing the hospitals' uncompensated costs by the uncompensated costs for all qualifying nonstate hospitals in this Section, then multiplying by the amount of disproportionate share payments calculated in excess of the federal DSH allotment or the state DSH apportioned amount.

### C. All Other Hospitals (Private Rural Hospitals over 60 Beds, All Private Urban Hospitals, Public Nonstate Hospitals over 60 Beds, and All Free-standing Psychiatric Hospitals Exclusive of State Hospitals)

1. Annualization of days for the purposes of the Medicaid days pools is not permitted. Payment is based on actual paid Medicaid days for a six-month period ending on the last day of the latest month at least 30 days preceding the date of payment which will be obtained by DHH from a report of paid Medicaid days by service date.

2. Payment is based on Medicaid days provided by hospitals in the following two pools:

a. Acute Care Hospital—acute care, rehabilitation, and long-term care hospitals not described in II above (excluding distinct part psychiatric units) are qualified for this designation. Acute care, rehabilitation, and long-term care hospitals/beds of small nonstate-operated local government hospitals (defined in II above) located outside the service district area are included in this pool. Acute care, rehabilitation, and long-term care hospitals/beds of small private rural hospitals (defined in II above) located outside the rural area are included in this pool.

b. Psychiatric Hospital—Freestanding psychiatric hospitals and distinct part psychiatric units not included in II

above are qualified for this designation. Psychiatric hospitals/beds of small nonstate-operated local government hospitals (defined in II above) located outside the service district area are included in this pool. Psychiatric hospitals/beds of small private rural hospitals (defined in II above) located outside the rural area are included in this pool.

3. Disproportionate share payments for each pool shall be calculated based on the product of the ratio determined by dividing each qualifying hospital's actual paid Medicaid inpatient days for a six-month period ending on the last day of the month preceding the date of payment (which will be obtained by DHH from a report of paid Medicaid days by service date) total Medicaid inpatient days obtained from the same report of all qualified hospitals in the pool, and 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.

4. 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.

5. A pro rata decrease necessitated by conditions specified in I.B above for hospitals described in this Section will be calculated based on the ratio determined by dividing the hospitals' Medicaid days by the Medicaid days for all qualifying hospitals in this Section, 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 written comments to 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 Emergency Rule.

Bobby P. Jindal  
Secretary

9703#043

## **DECLARATION OF EMERGENCY**

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

Home Care for the Elderly Waiver

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing has adopted the following Emergency Rule in the Medical Assistance Program as authorized by R.S. 46:153 and 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. 49:953(B) et seq. and shall be in effect for the maximum period allowed under the Administrative Procedure Act or until adoption of the Rule, whichever occurs first.

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing administers four Home and Community Based Services Waiver Programs. Participation in each home and community based services waiver is limited to a specific number of participants based on the approval of the waiver application by the Health Care Financing Administration. Home and community based services waiver programs are based on federal criteria which allows services to be provided in a home or community based setting for a recipient who would otherwise require institutional care. Costs for participants of the program must not exceed the costs for recipients of institutional care. Currently, daily costs in the Home Care for the Elderly waiver are exceeding the costs of comparable residents of nursing homes, thus jeopardizing the program. Therefore, in order to be able to continue this program the bureau is making changes in admissions criteria, the target population, management of services, and types of services available.

The following Emergency Rule is necessary to maintain federal financial participation for the Home Care for the Elderly waiver program and to preserve the health and welfare of individuals participating in that program. It is anticipated that implementation of this Emergency Rule will decrease expenditures by approximately \$210,000 for state fiscal year 1996-1997.

### **Emergency Rule**

Effective April 1, 1997, the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing adopts the following regulations governing the Home Care for the Elderly waiver program to:

- 1) redefine the target population served by the waiver and rename the waiver;
- 2) establish an average cost per day limit each participant of the waiver;
- 3) establish and define new services;
- 4) establish methodology for the assignment of slots; and
- 5) clarify admission and discharge criteria, mandatory reporting requirements and the reimbursement requirement for the prior approval of the plan of care.

The total number of slots assigned shall not exceed the maximum number of slots approved by the Health Care Financing Administration. The assignment of vacated and previously unoccupied waiver slots; admission and discharge criteria; the array of services; calculation of waiver costs; mandatory reporting requirements and reimbursement for services provided prior to the approval of the plan of care shall be determined in accordance with the following guidelines.

### **Definition of Targeted Population for the Waiver**

This home and community based services waiver is targeted at persons who qualify for admission to a nursing facility and are over age 65 or adults, age 21 or over, who are disabled according to Medicaid standards. It shall be called the Elderly and Disabled Adult waiver.

### **Guarantee of Waiver Costs**

In order to assure the cost effectiveness of this entire home and community based services waiver each participant shall be limited to an array of services whose average cost per day shall not exceed a limit set by the bureau. This figure shall be set annually at a percentage of the average costs borne by the Medicaid program for the equivalent population receiving nursing facility services, with an allowance for temporary, brief periods of excess costs in order to maintain a participant in the community. Case managers shall complete a budget analysis form as part of each care plan which shall list the types and number of services necessary to maintain the waiver participant safely in the community, the cost of those services and the average cost per day covered by the care plan.

### **Programmatic Allocation of Waiver Slots**

The waiting list shall be used to protect the individual's right to be evaluated for waiver eligibility. Each waiver slot may be filled only once during each waiver year. When funding becomes available for a new waiver slot or a slot that has been vacated in the previous waiver year, staff of the Intake Offices at the local Councils on Aging shall notify the next individual in order of application on the waiting list in writing that a slot is available and that they are next in line to be evaluated for possible waiver slot assignment. A copy of the notification letter shall be forwarded to the Health Standards Section of BHSF. A case manager assists in the gathering of the documents needed for both the financial and medical certification eligibility process. If the individual is determined to be ineligible either financially or medically, that individual is notified in writing and a copy of the notice is forwarded to the Council on Aging office. The next person on the waiting list is notified as stated above and the process continues until an eligible person is encountered. A waiver slot is assigned to an individual when eligibility is established and the individual is certified.

### **Waiver Admission Criteria**

Admission to this Waiver Program shall be determined in accordance with the following criteria.

1. initial and continued Medicaid eligibility as determined by the parish BHSF Office;
2. initial and continued eligibility for a nursing facility level of care as determined by the Health Standards Section of BHSF;
3. the plan of care must provide justification that the waiver services are appropriate, cost effective and represent the least restrictive treatment alternative for the individual; and
4. assurance that the health and safety of the individual can be maintained in the community with the provision of reasonable amounts of waiver services as determined by the Health Standards Section of BHSF.

### **Waiver Discharge Criteria**

Participants shall be discharged from this Waiver Program if one of the following criteria is met:

1. loss of Medicaid eligibility as determined by the parish BHSF Office;
2. loss of eligibility for a nursing facility level of care as determined by the Health Standards Section of BHSF;

3. incarceration or placement under the jurisdiction of penal authorities, or courts;

4. change of residence to another state with the intent to become a resident of that state;

5. admission to a nursing facility or any other long term care institutional setting;

6. the health and welfare of the waiver participant cannot be assured in the community through the provision of amounts of waiver services within the cost cap as determined by the Health Standards Section of BHSF, i.e., the waiver participant presents a danger to himself or others;

7. failure to cooperate in either the eligibility determination process or the performance of the care plan; or

8. continuity of services is interrupted as a result of the participant not receiving waiver services during a period of 14 or more consecutive days. This does not include interruptions in services because of hospitalization.

### **Mandatory Reporting Requirements**

Case managers and waiver service providers are obligated to report changes that could affect the waiver participant's eligibility, including but not limited to those changes cited in the discharge criteria, to either the parish BHSF Office or the Health Standards Section of BHSF within five working days. In addition, case managers and waiver service providers are responsible for documenting the occurrence of incidents or accidents that affect the health, safety and well-being of the waiver participant and completing an incident report. The incident report shall be submitted to the Health Standards Section of BHSF within five working days of the incident.

### **Definition of Services**

The following services will be made available to participants in this waiver by employees of Personal Attendant Provider agencies in half hour increments:

1. *Personal Care Attendant*—assistance with eating, bathing, dressing, personal hygiene, or activities of daily living.

2. *Household Supports*—services consisting of general household activities (meal preparation and routine household care) provided by a trained homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home.

3. *Personal Supervision (day)*—non-medical care, supervision and socialization, provided to a functionally impaired adult. Personal supervisors may assist or supervise the individual with such tasks as meal preparation, laundry and shopping, but do not perform these activities as discrete services as the household support worker does. The provision of this service does not entail hands-on nursing care.

4. *Personal Supervision (night)*—this type of supervision is to provide for the safety of individuals living alone who are limited in mobility or cognitive function to such an extent that they may not be able to preserve their own safety in dangerous situations.

### **Reimbursement of Waiver Services**

Reimbursement shall not be made for waiver services provided prior to the BHSF approval of the care plan.

Interested persons may submit written comments to 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 Emergency Rule. A copy of this Emergency Rule is available at parish Medicaid offices for review by interested parties.

Bobby P. Jindal  
Secretary

9703#045

## DECLARATION OF EMERGENCY

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

Hospital Program—Outpatient Laboratory Services

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing is adopting the following Emergency Rule in the Medical Assistance Program as authorized by R.S. 46:153 and pursuant to Title XIX of the Social Security Act and as directed by the 1996-97 General Appropriation Act, which states: "The Secretary shall implement reductions in the Medicaid Program as necessary to control expenditures to the level approved in this schedule. The Secretary is hereby directed to utilize various cost containment measures to accomplish these reductions, including but not limited to pre-certification, pre-admission screening, and utilization review, and other measures as allowed by federal law." This Emergency Rule is adopted in accordance with the Administrative Procedure Act, R.S. 49:950 et seq., and shall remain in effect for the maximum period allowed.

The Department of Health and Hospitals, Bureau of Health Services Financing reimburses hospitals for outpatient laboratory services. The bureau has differentiated in the reimbursement rate for outpatient hospital laboratory services from laboratory services performed in a nonhospital setting. Effective July 7, 1995, the bureau reduced the reimbursement for laboratory services except for those services performed in an outpatient hospital setting (*Louisiana Register*, Volume 21 Number 7, page 649). The bureau adopted two Emergency Rules effective August 1, 1996 and November 20, 1996 which reduced the reimbursement for outpatient hospital laboratory services subject to the Medicare fee schedule in order to achieve a uniform reimbursement methodology for all laboratory services subject to the Medicare fee schedule regardless of the setting in which the services are performed (*Louisiana Register*, Volume 22, Numbers 7 and 11, pages 573 and 1082). The following Emergency Rule is necessary to maintain the cost savings initiated by the August 1, 1996 and November 20, 1996 Emergency Rulemaking, thereby avoiding a budget deficit in the Medical Assistance Program.

### Emergency Rule

Effective March 20, 1996, the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing reimburses hospitals for outpatient laboratory services as described below:

A uniform reimbursement methodology for all laboratory services subject to the Medicare fee schedule is established regardless of the setting in which the services are performed. The reimbursement rate for outpatient hospital laboratory services subject to the Medicare fee schedule are reimbursed at the same reimbursement rate for laboratory services provided in a nonhospital setting.

Bobby P. Jindal  
Secretary

9703#046

## DECLARATION OF EMERGENCY

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

Targeted Case Management  
Services and Reimbursement

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

The Bureau of Health Services Financing currently funds case management services to the following specific population groups:

1. 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. participants in Home- and Community-Based Services Waiver Program who receive case management as a separate service;

The following groups have previously received case management services: seriously mentally ill, MR/DD persons who were not participants of the MR/DD Waiver Program; and ventilator-assisted children.

Previously, these services have been implemented and governed under specific program regulations. The department seeks to enhance all these services to the optimal level while streamlining their administration and establishes enhanced regulations governing consumer eligibility, provider enrollment, provider standards for participation and reimbursement methodology and requirements, 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; November 20, 1995, Volume 21, Number 11; March 20, 1996, Volume 22, Number 3; and July 20, 1996, Volume 22, Number 7). In addition the Bureau adopted emergency rulemaking to revise the reimbursement methodology based on the 15-minute unit of service for the on-going services component to adoption of the flat rate. This revised reimbursement methodology was implemented effective October 1, 1995 (*Louisiana Register* Volume 21 Number 10) which included a monthly reimbursement rate for both components of case management services, the initial assessment/service plan development and the ongoing services. Monthly reimbursement rates were assigned for each population group based upon minimum standards for service delivery for each of these groups. Effective March 1, 1996 the department adopted an Emergency Rule (*Louisiana Register*, Volume 22, Number 3) which provided for the payment of a one-hour minimum of service delivery and additional 15-minute incremental units up to a cap of the monthly rate once the initial one-hour service minimum is met. The June 11, 1996 Emergency Rule (*Louisiana Register*, Volume 22, Number 6) continued the flat rate methodology and the subsequent modification of this methodology as cited above. These provisions were continued with the adoption of the October 9, 1996 Emergency Rule (*Louisiana Register*, Volume 22, Number 10) which also continued the program reductions implemented this state fiscal year (*Louisiana Register*, Volume 22, Number 6, pages 556 and 574). In addition the department also adopted emergency rulemaking effective September 24, 1996 (*Louisiana Register*, Volume 22, Number 9) limiting case management services to infants and toddlers who either receive services under the MR/DD waiver or who receive two or more specified Medicaid services. The department repealed the limitations on Infants and Toddler Case Management Services in the September 24, 1996 Emergency Rule and reduced the reimbursement rate for these services (*Louisiana Register*, Volume 22, Number 11). The department has now determined it is necessary to amend the December 1, 1996 Emergency Rule to remove the reimbursement rates, but maintain the reimbursement methodology as part of the Rule. In addition, we are reinstating those components of the standards for participation and payment that were inadvertently omitted from the December 1, 1996 Emergency Rule. This action is necessary to continue the provisions of this initiative in force until a final Rule is adopted.

#### **Emergency Rule**

Effective for dates of service March 31, 1997, the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing adopts the following provisions to govern case management services including consumer eligibility requirements, provider enrollment, provider standards for participation and reimbursement methodology and general provisions. These provisions apply

to case management services provided either to targeted population groups or to waiver participants who receive case management services as a separate service. These include the following groups of individuals:

1. infants and toddlers with special needs;
2. high-risk pregnant women;
3. persons infected with HIV;
4. persons in Waiver Program(s) who receive case management as a separate service.

All case management providers must follow the policies and procedures included in this notice 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.

The department amends the December 1, 1996 Emergency Rule to remove the reimbursement rates, but continues the reimbursement methodology set forth in the Emergency Rule for the Targeted Case Management Services Program. In addition, we are reinstating those components of the standards for participation and payment that were inadvertently omitted from the December 1, 1996 Emergency Rule.

#### **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 as determined by 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. 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 the 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 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 listed in 1-16 below to participate as a case management provider in the Medicaid Program, regardless of the targeted or waiver group served:

1. have 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. have established linkages with the resources available in the consumer's community;

b. maintain a current resource file of medical, mental health, social, financial assistance, vocational, educational, housing and other support services available to the target population;

c. demonstrate knowledge of the eligibility requirements and application procedures of federal, state, and local government assistance programs which are applicable to consumers served;

d. employ 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 this document;

2. possess a current license to provide case management/service coordination in Louisiana or written proof of application for licensure;

3. demonstrate 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 certified public accountant 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 define the target population or waiver group to be served;

4. assure 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. assure 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. have a written plan to determine the effectiveness of the program and agrees to implement a continuous quality improvement plan approved by the department;

7. document and maintain an individual record on each consumer which includes all of the elements described in licensing standards for case management and in this document;

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

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

10. assure 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 enrolled as a Medicaid case management provider after July 20, 1994, assure that the agency and case managers will not provide case management and Medicaid reimbursed direct services to the same consumer(s);

12. have 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. maintain a written policy for intake screening, including referral criteria;

14. maintain a written policy for transition and closure;

15. with the consumer's permission, agree 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 comply with the *Code of Governmental Ethics*.

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

17. demonstrate the capacity to participate and agree to participate in the Case Management Information System (CAMIS) and provide up-to-date data to the Regional Office and/or Program Office on a weekly basis via electronic mail applicable to infants and toddlers with special needs. CAMIS

and electronic mail software will be provided without charge to the provider;

18. have demonstrated successful experience with delivery and/or coordination of services for pregnant women; have a working relationship with a local obstetrical provider/acute care hospital providing deliveries for 24-hour medical consultation; have a multidisciplinary team consisting, at a minimum, of: a physician; primary nurse associate or certified nurse manager; registered nurse; social worker; and nutritionist. All team members must meet DHH licensure and perinatal experience requirements (applicable to high-risk pregnant women only);

19. satisfactorily complete a one-day training as approved by the Department of Health and Hospitals HIV Program Office.

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 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 as determined by 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 on or after July 22, 1994, 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; 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.

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

d. additional qualifications are required for service provision to High-Risk Pregnant Women and MR/DD waiver participants:

1. 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; or

2. 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

3. 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

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

5. case managers who provide services to MR/DD waiver participants must have a minimum of one-year paid post-degree experience working directly with persons with mental retardation or developmental disabilities.

2. Education and Experience for Case Management Supervisors. A case management supervisor hired or promoted on or after July 22, 1994, 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 must meet the same qualifications as the case managers for these populations:

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

b. a bachelor's degree in social work from a social work program accredited by the Council on Social Work Education; and three years of paid post-bachelor's degree experience in a human-service-related field providing direct consumer services or case management. 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 field providing direct consumer services or case management. 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;

The above general minimum qualifications for case management supervisors are applicable for all targeted and waiver groups. Thirty hours of graduate level course credit in the human-service-related field may be substituted for one year of required paid experience. Additional qualifications for specific targeted or waiver groups are delineated below:

e. each Medicaid-enrolled provider must ensure that all case management supervisory staff for high-risk pregnant women have demonstrated knowledge about perinatal care and meet the following qualifications:

(1) 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; two years of this experience must be in providing direct services to the target population to be served;

(2) 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; or

(3) 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

(4) 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.

a. 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. 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. Other topics covered by the orientation must include, at a minimum:

- (1) provider policies and procedures;
- (2) Medicaid/Program Office policies and procedures;
- (3) confidentiality;
- (4) documentation in case records;
- (5) consumer rights protection and reporting of violations;
- (6) consumer abuse and neglect policies and procedures;
- (7) professional ethics;
- (8) emergency and safety procedures;
- (9) data management and record keeping;
- (10) infection control and universal precautions.

b. 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:

- (1) assessment techniques;
- (2) service planning;
- (3) resource identification;
- (4) interviewing and interpersonal skills;
- (5) data management and record keeping;
- (6) communication skills.

c. 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 Department of Health and Hospitals *Case Management Provider Manual* contains a list of suggested additional training topics.

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

- (1) professional identification/ethics;
- (2) process for interviewing, screening, and hiring of staff;
- (3) orientation/in-service training of staff;
- (4) evaluating staff;
- (5) approaches to supervision;
- (6) managing caseload size;

- (7) conflict resolution;
- (8) documentation;
- (9) 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.

d. Training—Infants and Toddlers with Special Needs

(1) 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. 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.

(2) 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. 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 without sufficient justification. 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.

e. 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 when provided.

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:

1. direct review, assessment, problem solving, and feedback regarding the delivery of case management services;
2. teaching and monitoring of the application of consumer centered principles and practices;
3. assuring quality delivery of services;
4. managing assignment of caseloads; and

5. arranging for training as appropriate.

The case manager supervisor must assess staff performance, review individual cases, provide feedback and help staff develop problem solving skills using two or more of the following methods:

- a. individual, face-to-face sessions with staff;
- b. group face-to-face sessions with all case management staff; or
- c. sessions in which the supervisor accompanies a case manager to meet with consumers.

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

- (1) date and content of the supervisory sessions; and
- (2) 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.

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

GROUP	CASES
MR/DD Waiver	4.5
Infants and toddlers with special needs	35
High-risk pregnant women	60
HIV infected	45
Fragile elderly	40

*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 MR/DD waiver participants in addition to those who are infants and toddlers with special needs, the maximum caseload is 35. For other "mixed" caseloads, the number of cases must be 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 Multidisciplinary 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. The infant/toddler must meet the following criteria:

- a. have a medical condition established and documented by a licensed medical doctor. In the case of a hearing impairment, a licensed audiologist or licensed medical doctor must make the determination; or
- b. be developmentally delayed 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. 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 by DHH;

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

3. HIV Infected Persons

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 be unable to access the necessary services.

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

5. MR/DD Waiver. The consumer must be participant in the MR/DD 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 consist of intake, assessment, service planning, linkage/service coordination, monitoring/follow-up, re-assessment, 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 include 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.

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.

g. *Intake for Infants and Toddlers with Special Needs* is defined as a comprehensive interagency multidisciplinary, 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:

1. 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;

2. 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;

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

h. Intake for High-Risk Pregnant Women must include 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 by DHH.

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:

- a. identifying information;
- b. medical/physical;
- c. psychosocial/behavioral;
- d. developmental/intellectual;
- e. socialization/recreational;
- f. financial;
- g. educational/vocational;
- h. family functioning;
- i. personal and community support systems;
- j. housing/physical environment; and